CHIME Cheat Sheet – April 30, 2024
CMS Inpatient Prospective Payment System (IPPS) Proposed Rule for Fiscal Year (FY) 2025

On April 10, 2024, the Centers for Medicare & Medicaid Services (CMS) issued the annual proposed rule to update the Fiscal Year (FY) 2025 Medicare payment and policies for the hospital inpatient prospective payment system (IPPS) and the long-term care hospital (LTCH) prospective payment system (PPS). You can find CMS's press release here, fact sheet here, and the proposed rule here. Additionally, you can find more information on the CMS IPPS FY 2025 website. Comments are due June 10, 2024. The final rule is released in August, with many proposals effective at the beginning of the federal FY (Oct. 1, 2024).

Key Takeaways

This proposed rule would revise the Medicare hospital IPPS for operating and capital-related costs of acute care hospitals; make changes relating to Medicare graduate medical education (GME) for teaching hospitals; update the payment policies and the annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by LTCHs; and make other policy-related changes.

Medicare Promoting Interoperability (PI) Program Proposals

In the Medicare Promoting Interoperability (PI) Program, CMS is proposing to separate the Antimicrobial Use and Resistance (AUR) Surveillance measure into two measures, an Antimicrobial Use (AU) Surveillance measure and an Antimicrobial Resistance (AR) Surveillance measure, beginning with the electronic health record (EHR) reporting period in CY 2025. CMS is also proposing to increase the performance-based scoring threshold from 60 to 80 points beginning with the EHR reporting period in CY 2025. They are proposing to adopt two new eCQMs and modify one eCQM, in alignment with the Hospital Inpatient Quality Reporting (IQR) Program. Additionally, CMS is proposing changes to the reporting and submission requirements for eCQMs, also in alignment with the Hospital IQR Program.

Proposal to Change the Antimicrobial Use and Resistance (AUR) Surveillance Measure Beginning with the EHR Reporting Period in Calendar Year (CY) 2025

The Medicare PI Program encourages healthcare data exchange for public health purposes through the Public Health and Clinical Data Exchange objective. Under current policy, if an eligible hospital or CAH meets the exclusion criteria with respect to reporting either Antimicrobial Use (AU) data or Antimicrobial Resistance (AR) data, the hospital is excluded from the entire AUR Surveillance measure.

In collaboration with the Centers for Disease Control and Prevention (CDC), CMS identified the need to separate the AUR Surveillance measure into two measures to clarify reporting requirements and incentivize greater data reporting from eligible hospitals and critical access hospitals (CAHs). Given that AU and AR reporting rely on different data sources, such as an electronic medication administration record (eMAR)/bar-coded medication administration (BCMA) for AU, and lab information systems (LISs) for AR, CMS believes that separating the measure into two measures would more appropriately target the availability of exclusions for participants who have difficulty with data transmission using a single data source.

Thus, CMS is proposing to separate the AUR Surveillance measure into two measures, beginning with the EHR reporting period in CY 2025:

- **AU Surveillance measure:** The eligible hospital or CAH is in active engagement with CDC's National Healthcare Safety Network (NHSN) to submit AU data for the selected EHR reporting period and receives a report from NHSN indicating its successful submission of AU data for the selected EHR reporting period.
- **AR Surveillance measure:** The eligible hospital or CAH is in active engagement with CDC's NHSN to submit AR data for the selected EHR reporting period and receives a report from NHSN indicating its successful submission of AR data for the selected EHR reporting period.

Under both the proposed AU and AR Surveillance measures, eligible hospitals and CAHs would be required to report the respective data to CDC's NHSN. Additionally, eligible hospitals and CAHs must report a "yes" response or claim an exclusion, separately, to receive credit for reporting the AU Surveillance measure and the AR Surveillance measure. CMS notes that the separation of the AUR Surveillance measure does not expand on the previously finalized requirements of it; the proposed separation from one measure into two measures allows for the opportunity to submit data for either AU or AR if an eligible hospital or CAH can only submit data for one of the two, versus an all or nothing approach.

Additionally, for both measures, CMS is proposing that eligible hospitals and CAHs be required to use technology certified to the Office of the National Coordinator for Health IT (ONC) Certification Program for Health Information Technology (health IT) certification criterion,[1] "Transmission to public health agencies—antimicrobial use and resistance reporting," as they are for the AUR Surveillance measure. Further, this proposal supports the Medicare PI Program's administrative requirements with respect to scoring, because the current scoring methodology for the Public Health and Clinical Data Exchange objective does not grant partial credit for reporting on individual measures.

Proposal to Adopt Exclusions for the AU Surveillance Measure and the AR Surveillance Measure Beginning with the EHR Reporting Period in CY 2025

CMS previously finalized the availability of three exclusions for an eligible hospital or CAH reporting on the AUR Surveillance measure that: 1) Does not have any patients in any patient care location for which data are collected by NHSN during the EHR reporting period; 2) Does not have an eMAR/BCMA records or an electronic admission discharge transfer (ADT) system during the EHR reporting period; or 3) Does not have an electronic LIS or electronic ADT system during the EHR reporting period.

CMS states that the current policy inadvertently causes difficulties for eligible hospitals and CAHs, because manual reporting of NHSN AUR data is both infeasible and against NHSN AUR recommendations. Therefore, CMS believes an exclusion that applies to eligible hospitals and CAHs that lack discrete electronic access to required data elements, including interface or configuration issues beyond their control, would address the difficulties for eligible hospitals and CAHs engaging in manual data collection to conduct AU or AR reporting.

CMS is proposing to add a new exclusion to account for scenarios where eligible hospitals or CAHs lack a data source containing discrete electronic data elements that are required for reporting the AUR Surveillance measure, meaning an eligible hospital or CAH cannot query, extract, or download the data elements in a discrete, structured manner from the systems to which it has access. Under this new exclusion, an eligible hospital or CAH would be excluded from reporting the AUR Surveillance measure when it does not have a data source containing the minimal discrete data elements that are required for

[1] 45 CFR 170.315(f)(6)

reporting. If CMS finalizes the proposal to separate the AUR Surveillance measure into two separate measures, they would modify the existing exclusions under the AUR measure, the new exclusion would be available for both the AU Surveillance measure and the AR Surveillance measure.

Proposal to Adopt Active Engagement for the Proposed AU Surveillance Measure and AR Surveillance Measure Beginning with the EHR Reporting Period in CY 2025

In the FY 2023 IPPS/LTCH PPS final rule, CMS finalized a policy to limit the amount of time an eligible hospital or CAH may spend in the Option 1: Pre-production and Validation level of active engagement to one EHR reporting period. As finalized, this limitation applies beginning with the EHR reporting period in CY 2024. Should CMS finalize their proposal to modify the AUR Surveillance measure into two new measures (AU Surveillance and AR Surveillance), they are proposing to treat these two measures as new measures with respect to active engagement, beginning with the EHR reporting period in CY 2025 and subsequent years.

CMS is proposing to evaluate the level of active engagement for the AU Surveillance and AR Surveillance measures beginning with the EHR reporting period in CY 2025, independent of the participant's prior level of active engagement for the AUR Surveillance measure in the EHR reporting period in CY 2024. If the two measures are finalized, CMS is proposing that for each measure, eligible hospitals and CAHs may spend only one EHR reporting period at the Option 1: Pre-production and Validation level of active engagement, and they must progress to the Option 2: Validated Data Production level for the next EHR reporting period for which they report the measure. CMS asserts that this proposal would offer eligible hospitals and CAHs an additional year to gain familiarity with reporting in the NHSN AUR Module before they are required to participate in Option 2: Validated Data Production, and if finalized, the AU Surveillance and AR Surveillance measures.

Proposal to Maintain the Scoring Approach for Reporting Required Measures in the Public Health and Clinical Data Exchange Objective Beginning with the EHR Reporting Period in CY 2025

If CMS finalizes the proposal to separate the AUR Surveillance measure into two measures, they do not believe this change should affect scoring or the exclusion redistributions for the Public Health and Clinical Data Exchange objective, previously adopted in the FY 2024 IPPS/LTCH PPS final rule. Thus, CMS is proposing to maintain a scoring value of 25 points for reporting all required measures in the Public Health and Clinical Data Exchange objective, which would increase from five measures to six measures, including the four previously finalized measures and the two proposed required measures (AU Surveillance and AR Surveillance).

CMS is also proposing to maintain the exclusion redistribution policy adopted in the FY 2024 IPPS/LTCH PPS final rule – but modify it to indicate there are six measures as opposed to five measures. If an eligible hospital or CAH claims an exclusion for each of the six required measures, the 25 points of the Public Health and Clinical Data Exchange objective would continue to be redistributed to the Provide Patients Electronic Access to their Health Information measure.

Updates to the Definition of CEHRT in the Medicare PI Program Beginning with the EHR Reporting Period in CY 2024

In consideration of the updates finalized in the CY 2024 PFS final rule and ONC's HTI-1 final rule, CMS refers to "ONC health IT certification criteria" throughout this proposed rule where they would have previously referred to "2015 Edition health IT certification criteria." This aligns with the ONC health IT certification criteria which has transitioned to the "edition-less" approach finalized in the HTI-1 final rule. Table IX.F.-02 (on pages 1042-1043 of the proposed rule pdf) lists the ONC health IT certification criteria required to meet the Medicare PI Program objectives and measures. CMS is also highlighting

certain updates to ONC health IT certification criteria finalized in the ONC HTI–1 final rule that impact certification criteria referenced under the Certified EHR Technology (CEHRT) definition.

ONC adopted the certification criterion, "decision support interventions (DSI)" to replace the "clinical decision support (CDS)" certification criterion included in the Base EHR definition. The finalized DSI criterion ensures that Health IT Modules certified to the Program must, among other functions, enable a limited set of identified users to select (activate) evidence-based and Predictive DSIs and support "source attributes" – categories of technical performance and quality information – for both evidence-based and Predictive DSIs.

ONC further finalized that a Health IT Module may meet the Base EHR definition by either being certified to the existing CDS version of the certification criterion, or being certified to the revised DSI criterion, for the period up to, and including, December 31, 2024. On and after January 1, 2025, ONC finalized that only the DSI criterion in the HTI-1 final rule will be included in the Base EHR definition, and the adoption of the existing criterion will expire on January 1, 2025.

In addition to the DSI criterion, which is required to meet the Base EHR definition after January 1, 2025, ONC finalized other updates related to health IT certification criteria referenced in the CEHRT definition in the HTI-1 final rule. For these updates, health IT developers must update and provide certified Health IT Modules to their customers by January 1, 2026, including several updates resulting from finalized policies. For complete information about the updates to ONC health IT certification criteria finalized in the HTI–1 Final Rule, CMS refers readers to the text of the final rule, as well as resources available on ONC's website. **Additionally, you can find CHIME's Cheat Sheet on the ONC HTI-1 final rule here.**

Overview of Objectives and Measures for the Medicare PI Program for the EHR Reporting Period in CY 2025

For ease of reference, Table IX.F.-01 (on pages 1029 – 1028 of the proposed rule pdf) lists the objectives and measures for the Medicare PI Program for the EHR reporting period in CY 2025, as revised, to reflect the proposals in this proposed rule.

Proposal to Change Scoring Methodology Beginning with the EHR Reporting Period in CY 2025

For the EHR reporting period in CY 2025 and subsequent years, CMS is proposing to increase the minimum scoring threshold from 60 points to 80 points. Our review of the CY 2022 Medicare Promoting Interoperability Program's performance results found 98.5 percent of eligible hospitals and CAHs (that is 97 percent of CAHs and 99 percent of eligible hospitals) that reported to the Medicare PI Program successfully met the minimum threshold score of 60 points, and 81.5 percent of eligible hospitals and CAHs (that is 78 percent of CAHs and 83 percent of eligible hospitals) that reported to the Medicare PI Program exceeded the score of 80 points. Given the widespread success of eligible hospitals and CAHs participating in the Medicare PI Program in CY 2022, CMS believes that by adopting a higher scoring threshold, they would incentivize more eligible hospitals and CAHs to align their health information systems with evolving industry standards and would encourage increased data exchange.

If finalized, this would take effect for the EHR reporting period in CY 2025 and subsequent years. As shown in below table, the points associated with the required measures sum to 100 points, and reporting one of the optional measures under the Public Health and Clinical Data Exchange Objective adds an additional 5 bonus points. The scores for each of the measures are added together to calculate a total score of up to 100 possible points for each eligible hospital or CAH. The below table also reflects the objectives, measures, maximum points available, and whether a measure is required or optional for

the EHR reporting period in CY 2025 based on CMS's previously adopted policies, and the proposals included in this proposed rule.

Performance-Based Scoring Methodology for EHR Reporting Periods in CY 2025 and Subsequent Years			
Objective	**Measure**	**Maximum Points**	**Required/Optional**
e-Prescribing	e-Prescribing	10 points	Required
	Query of PDMP	10 points	Required
HIE	Support Electronic Referral Loops by Sending Health Information	15 points	Required (eligible hospitals and CAHs must choose one of the three reporting options)
	-AND-		
	Support Electronic Referral Loops by Receiving and Reconciling Health Information	15 points	
	-OR-		
	HIE Bi-Directional Exchange	30 points	
	-OR-		
	Enabling Exchange Under TEFCA	30 points	
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	25 points	Required
Public Health and Clinical Data Exchange	Report the following six measures: - Syndromic Surveillance Reporting - Immunization Registry Reporting - eCR - Electronic Reportable Laboratory Result Reporting - AU Surveillance* - AR Surveillance*	25 points	Required
	Report one of the following measures: - Public Health Registry Reporting - Clinical Data Registry Reporting	5 points *(bonus)*	Optional

Notes: The Security Risk Analysis measure, SAFER Guides measure, and attestations required by section 106(b)(2)(B) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) are required but will not be scored. Reporting eCQMs is required but will not be scored. Eligible hospitals and CAHs must also submit their level of active engagement for measures under the Public Health and Clinical Data Exchange objective. Participants may spend only one EHR reporting period at the Option 1: Pre-production and Validation level per measure and must progress to Option 2: Validated Data Production level for the following EHR reporting period. See the FY 2023 IPPS/LTCH PPS final rule for more details about active engagement. *Signifies a proposal made in this FY 2025 IPPS/LTCH PPS proposed rule.

The maximum points available, by measure, in this proposed rule, as shown in the table above, do not include the points that would be redistributed in the event an exclusion is claimed for a given measure. CMS is not proposing any changes to their policy for point redistribution in the event an exclusion is claimed. CMS refers to Table IX.F.–04 (on pages 1047-1047 of the proposed rule pdf), which shows how points would be redistributed among the objectives and measures for the EHR reporting period in CY 2025, in the event an eligible hospital or CAH claims an exclusion.

Clinical Quality Measurement for Eligible Hospitals and CAHs Participating in the Medicare PI Program

Tables IX.F.-05. and IX.F.-06 (page 1048 of the proposed rule pdf) summarize the previously finalized

eCQMs available for eligible hospitals and CAHs to report under the Medicare PI Program for the CY 2024 and CY 2025 reporting periods, as finalized in the FY 2024 IPPS/LTCH PPS final rule. To maintain alignment with the Hospital Inpatient Quality Reporting (IQR) program, the order of the eCQMs displayed in these tables mirrors that of the Hospital IQR program. Additionally, the short names and the Consensus-Based Entity (CBE) numbers of the measures in the tables match the measures on the Electronic Clinical Quality Improvement Resource Center website.

Proposal to Adopt eCQMs

CMS is continuing to align the eCQM reporting requirements and eCQM measure set for the Medicare PI Program with similar requirements under the Hospital IQR Program, to the extent feasible. With respect to the Hospital IQR Program, CMS is proposing to adopt two new eCQMs for the Medicare PI Program and to modify one eCQM, beginning with the CY 2026 reporting period.

CMS is proposing to add the following two eCQMs to the Medicare PI Program eCQM measure set from which eligible hospitals and CAHs could self-select to report, beginning with the CY 2026 reporting period: 1) the Hospital Harm – Falls with Injury eCQM (CBE #4120e); and 2) the Hospital Harm – Postoperative Respiratory Failure eCQM (CBE #4130e). These would be added to the measure set from which eligible hospitals and CAHs could self-select to report, and CMS is proposing to modify the Global Malnutrition Composite Score eCQM (CBE #3592e), in the Medicare PI Program for the CY 2026 and CY 2027 reporting periods, respectively, and subsequent years.

Proposal to Revise the eCQM Reporting and Submission Requirements for the CY 2026 Reporting Period and Subsequent Years

Consistent with the goal to align the eCQM reporting periods and criteria in the Medicare PI Program with the Hospital IQR Program, eligible hospitals and CAHs are currently required to report four calendar quarters of data for each required eCQM: 1) the Safe Use of Opioids – Concurrent Prescribing eCQM; 2) the Severe Obstetric Complications eCQM; 3) the Cesarean Birth eCQM; and 4) three self-selected eCQMs, for the CY 2024 reporting period and subsequent years.

In alignment with the Hospital IQR Program, if CMS's proposals to adopt the Hospital Harm – Falls with Injury eCQM and the Hospital Harm – Postoperative Respiratory Failure eCQM are finalized, these measures would be available for eligible hospitals and CAHs to select as one of their three self-selected eCQMs for the CY 2026 reporting period and subsequent years.

CMS is seeking comment on their proposals to increase the number of mandatory eCQM measures to a total of nine beginning with the CY 2026 reporting period, and to increase the number of mandatory eCQM measures to a total of eleven beginning with the CY 2027 reporting period and subsequent years.

Potential Future Update of the SAFER Guides Measure

In the FY 2024 IPPS/LTCH PPS final rule, CMS finalized a proposal to modify their requirement for the SAFER Guides measure beginning with the EHR reporting period in CY 2024, and continuing in subsequent years, to require eligible hospitals and CAHs to attest "yes" to having conducted an annual self-assessment using all nine SAFER Guides, at any point during the calendar year in which the EHR reporting period occurs – in order to be considered a meaningful user.

CMS notes that they received comments in the FY 2024 IPPS/LTCH PPS proposed rule recommending that they work with ONC to update the SAFER Guides, citing that the SAFER Guides were last updated in 2016. CHIME was among the organizations that specifically noted and requested this in our comment letter to last year's proposed rule.

In response to these comments, CMS noted that while the current SAFER Guides reflect relevant and valuable guidelines for safe practices with respect to current EHR systems, they would consider exploring updates in collaboration with ONC. CMS also stated that any updates to the SAFER Guides would be provided with accompanying educational and promotional materials to notify participants, in collaboration with ONC, when available. **In this proposed rule, CMS is seeking to make readers aware that efforts to update the SAFER Guides are currently underway.**

CMS anticipates that updated versions of the SAFER Guides may become available as early as CY 2025, and they would consider proposing a change to the SAFER Guides measure for the EHR reporting period beginning in CY 2026 to permit use of an updated version of the SAFER Guides at that time. CMS encourages eligible hospitals and CAHs to become familiar with the updated versions of the SAFER Guides when they become available and consider them as they implement appropriate EHR safety practices.

Proposal to Update the Definition of Meaningful EHR User for Healthcare Providers That Have Committed Information Blocking

The Department of Health and Human Services (HHS) proposed rule, "21st Century Cures Act: Establishment of Disincentives for Health Care Providers That Have Committed Information Blocking" (hereafter referred to as the Disincentives proposed rule) was published in the *Federal Register* on November 1, 2023. You can find CHIME's comment letter in response to this proposed rule here.

If finalized, the final rule would implement the provision of the 21st Century Cures Act specifying that a healthcare provider, determined by the HHS Office of the Inspector General (OIG) to have committed information blocking, shall be referred to the appropriate agency to be subject to appropriate disincentives set forth through notice and comment rulemaking. In the Disincentives proposed rule, CMS proposed that an eligible hospital or CAH would not be considered a meaningful EHR user in an EHR reporting period if the OIG refers, during the calendar year of the reporting period, a determination that the eligible hospital or CAH committed information blocking.

Furthermore, CMS proposed to revise the definition of "Meaningful EHR User" to state that an eligible hospital or CAH is not a meaningful EHR user in a payment adjustment year if the OIG refers a determination that the eligible hospital or CAH committed information blocking during the calendar year of the EHR reporting period. Based upon these proposed revisions, the downward payment adjustment would apply 2 (two) years after the year of the referral and the EHR reporting period in which the eligible hospital was not a meaningful EHR user. For CAHs, the downward payment adjustment would apply to the payment adjustment year in which the OIG referral was made.

If the Disincentives proposed rule is finalized, an eligible hospital subject to this disincentive would be subject to a three quarters reduction of the annual market basket increase, while a CAH subject to this disincentive would have its payment reduced to 100 percent of reasonable costs, from the 101 percent of reasonable costs it might have otherwise earned, for failing to qualify as a meaningful EHR user in an applicable year. Additional regulatory provisions have been proposed,[2] related to the disincentives application process. CMS notes that if the Disincentives proposed rule is finalized as proposed, the revised definition of Meaningful EHR User[3] would become effective when that final rule takes effect.

Future Goals of the Medicare PI Program

[2] 45 CFR 171 Subpart J
[3] 42 CFR 495.4

Future Goals with Respect to FHIR APIs for Patient Access
In partnership with ONC, CMS envisions a future where patients have timely, secure, and easy access to their health information through the health application of their choice. CMS is working with ONC to enable this type of access to health information by requiring the use of Application Programming Interface (APIs) that utilize the Health Level Seven International® (HL7) Fast Healthcare Interoperability Resources (FHIR). CMS works with ONC and other federal partners to improve timely and accurate data exchange, partner with industry to enhance digital capabilities, advance adoption of FHIR, support enterprise transformation efforts that increase their technological capabilities, and promote interoperability.

By adopting new and updated standards, implementation specifications, certification criteria, and conditions of certification, CMS notes that the provisions in ONC's HTI–1 final rule advance interoperability, improve transparency, and support the access, exchange, and use of electronic health information. CMS aims to further advance the use of FHIR APIs through policies in the Medicare PI Program to advance interoperability, encourage the exchange of health information, and promote innovative uses of health information technology (IT). Additionally, they hope to gain insights into the adoption and use of FHIR APIs by eligible hospitals and CAHs due to the ONC Health IT Certification Program Insights Condition. CMS believes that maintaining their focus on promoting interoperability, alignment, and simplification would reduce healthcare provider burden while allowing flexibility to pursue innovative applications that improve care delivery.

Improving Cybersecurity Practices
The Medicare PI Program encourages the advancement of patient safety by promoting appropriate cybersecurity practices through the Security Risk Analysis and SAFER Guides measures. On February 14, 2023, the National Institute of Standards and Technology (NIST) published updated guidance for health care entities implementing requirements of the Health Insurance Portability and Accountability (HIPAA) Security Rule.[4]

The guidance, NIST SP 800-66r2, provides information and resources to HIPAA-covered entities to improve their cybersecurity risk practices. CMS is also alerting readers of additional HHS resources and activities regarding cybersecurity best practices as recently summarized in an HHS strategy document that provides an overview of the Department's recommendations to help the health care sector address cyber threats. HHS has also recently published a website detailing recommended cybersecurity performance goals (HHS-CPGs). **CMS intends to consider how the Medicare PI Program can promote cybersecurity best practices for eligible hospitals and CAHs in the future.**

Request for Information (RFI) Regarding Public Health Reporting and Data Exchange

Efforts across HHS to advance the public health information infrastructure offer opportunities to further evolve the Medicare Promoting Interoperability Program. In 2020, the CDC launched the Data Modernization Initiative (DMI), a multi-year, billion-plus dollar public health ecosystem initiative aimed at moving the public health community from a siloed and static public health data system to connected, resilient, adaptable, and sustainable 'response-ready' systems capable of meeting present and future health challenges. The DMI seeks to answer the need for a longer-term, whole-of-public health strategy that prioritizes collaboration and continuous improvement and recognizes that modernization is not a one-time event.

To establish clear near-term priorities and milestones that complement the DMI's longer term focus

[4] 45 CFR Part 160 and Subparts A and C of Part 164; see also, most recently, 75 FR 40868 and 78 FR 5566

and improve alignment of data modernization efforts at all levels of public health and across partners, CDC released its first Public Health Data Strategy (PHDS) in 2023. The PHDS outlines the data, technology, policy, and administrative actions essential to exchange critical core data efficiently and securely across healthcare and public health.

In tandem with these efforts to chart a new strategic direction for improvements to the nation's public health infrastructure, evolving technical approaches are offering opportunities to automate and expand information exchange between healthcare providers and public health agencies (PHAs). ONC is exploring updates to existing certification criteria for health IT that support current measures in the Medicare PI Program's Public Health and Clinical Data Exchange objective, new criteria that incorporate modern approaches to exchange, support additional types of information needed by PHAs, and criteria that focus on entities receiving public health data.

RFI & Questions – Quality, Timeliness, and Completeness of Public Health Reporting

The Medicare PI Program's requirement that eligible hospitals and CAHs report their level of "active engagement" between the eligible hospital or CAH, and a PHA, as well as the recently established one-year limitation in how long an eligible hospital or CAH may spend in Pre-Production and Validation, has provided a basis that could broadly incentivize the exchange of EHR data. However, because active engagement reporting only requires an attestation of whether an eligible hospital or CAH is reporting production data or still in the process of validation, this approach does not allow CMS to assess eligible hospitals and CAHs on the comprehensiveness, quality, or timeliness of the data they provide to PHAs. Therefore, CMS is considering whether alternatives to the "active engagement" approach could better allow them to assess eligible hospital and CAH performance, meet the data needs of PHAs, and ultimately allow CMS to incentivize increased performance in these areas. CMS is interested in how they could think about alternatives to the "active engagement" approach described above.

CMS is also interested in the increasing focus on leveraging FHIR-based data exchange for public health needs. Finally, CMS is interested in ensuring that any changes to the active engagement approach are implemented in a way that takes advantage of opportunities to further automate reporting and minimize administrative burden for eligible hospitals and CAHs. Therefore, CMS is seeking public comment and feedback on these questions and other topic areas listed in the proposed rule.