Interoperability and Innovation: A CMS Update

Ashby Wolfe, MD, MPP, MPH
Regional Chief Medical Officer, San Francisco, Seattle & Denver
Centers for Medicare & Medicaid Services

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Objectives

- **Update on CMS priorities**
  - CMS National Quality Strategy
  - Strategic Pillars and Health Equity (with examples)
- **Regulations Update**
  - Telehealth provisions within the Physician Fee Schedule and CAA 2022
  - Promoting Interoperability 2022 and proposed regulations for 2023
- **Brief Update on Information Blocking**
- **Questions**

CMS National Quality Strategy: Goals

Embed Quality across the Care Journey

Advance Health Equity

Foster Engagement with Stakeholders Focused on Person & Family-Centered Care

Promote Safety to Achieve Zero Preventable Harm

Strengthen Resiliency in the Healthcare System

Embrace the Digital Age

Incentivize Scientific Innovation & Technology

Increase Alignment to Promote Seamless and Coordinated Healthcare

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Legacy-Quality-Strategy

CMS Strategic Pillars

ADVANCE EQUITY

Advance health equity by addressing the health disparities that underlie our health system

EXPAND ACCESS

Build on the Affordable Care Act and expand access to quality, affordable health coverage and care

ENGAGE PARTNERS

Engage our partners and the communities we serve throughout the policymaking and implementation process

DRIVE INNOVATION

Drive Innovation to tackle our health system challenges and promote value-based, person-centered care

PROTECT PROGRAMS

Protect our programs' sustainability for future generations by serving as a responsible steward of public funds

FOSTER EXCELLENCE

Foster a positive and inclusive workplace and workforce, and promote excellence in all aspects of CMS's operations

https://www.cms.gov/cms-strategic-plan

https://www.cms.gov/sites/default/files/2022-04/13_CCI%20Fact_sheet_4_12%20Final-508.pdf

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PILLAR: HEALTH EQUITY

CMS defines health equity as the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, and other factors that affect access to care and health outcomes.

CMS is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all people served by our programs by incorporating the perspective of lived experiences and integrate safety net providers and community-based organizations into our programs. Together this work will eliminate avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing the care and support that people need to thrive.

https://www.cms.gov/sites/default/files/2022-04/Health%20Equity%20Pillar%20Fact%20Sheet_1.pdf

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The Centers for Medicare & Medicaid Services Health Equity Goals

✓ Close the gaps in health care access, quality, and outcomes for underserved populations

✓ Promote culturally and linguistically appropriate services to ensure understandable and respectful care and services that are responsive to preferred languages, health literacy, and other diverse communication needs.

✓ Incorporate screening for and promote broader access to health-related social needs, including greater adoption of related quality measures, coordination with community-based organizations, and collection of social needs data in standardized formats across CMS programs and activities.

✓ Expand and standardize the collection and use of data, including on race, ethnicity, preferred language, sexual orientation, gender identity, disability, income, geography, and other factors across CMS programs.

https://www.cms.gov/sites/default/files/2022-04/Health%20Equity%20Pillar%20Fact%20Sheet_1.pdf

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The Centers for Medicare & Medicaid Services Health Equity Goals (2)

✓ Evaluate policies to determine how CMS can support safety net providers, partner with providers caring in underserved communities, and ensure care is accessible to those who need it.

✓ Build on outreach efforts to enroll eligible people across Medicare, Medicaid/CHIP and the Marketplace.

✓ Ensure engagement with and accountability to the communities CMS serves in policy development and the implementation of CMS programs.

✓ Ensure CMS programs serve as a model and catalyst to advance health equity through our nation's health care system, including with states, providers, plans, and other stakeholders.

https://www.cms.gov/sites/default/files/2022-04/Health%20Equity%20Pillar%20Fact%20Sheet_1.pdf

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Innovation Center (CMMI) Strategy Refresh

https://innovation.cms.gov/strategic-direction-whitepaper

ACO Reach

https://innovation.cms.gov/innovation-models/aco-reach

"Reaching" Beyond GPDC: ACO REACH Model Goals

GPDC	*ACO REACH*
 Empower beneficiaries to personally engage in their own care delivery.	**Promote health equity** and address healthcare disparities for underserved communities
 Transform risk-sharing arrangements in Medicare fee-for-service (FFS).	**Continue the momentum of provider-led organizations** participating in risk-based models
 Reduce provider burden to meet health care needs effectively.	**Protect beneficiaries and the model** with more participant vetting and monitoring and greater transparency

Inpatient Prospective Payment System proposed rule

CMS is proposing three health equity-focused measures for adoption in the Hospital Inpatient Quality Reporting (IQR) Program.

- The first measure assesses a hospital's commitment to establishing a culture of equity and delivering more equitable health care by capturing concrete activities across five key domains, including strategic planning, data collection, data analysis, quality improvement, and leadership engagement.
- The second and third measures capture screening and identification of patient-level, health-related social needs—such as food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety

Additionally, **CMS seeks public input on how to optimally measure health care quality disparities**, including what to prioritize in data collection and reporting as well as approaches to consider in driving provider accountability across hospital quality programs.

CMS is also **seeking stakeholder input through a Request for Information (RFI) on social determinants of health, particularly related to homelessness**, reported by hospitals on Medicare claims. With this RFI, CMS seeks to better understand the perspectives of people who are experiencing or have experienced homelessness, advocates representing people experiencing homelessness, hospitals and other key stakeholders for consideration in future payment policies.

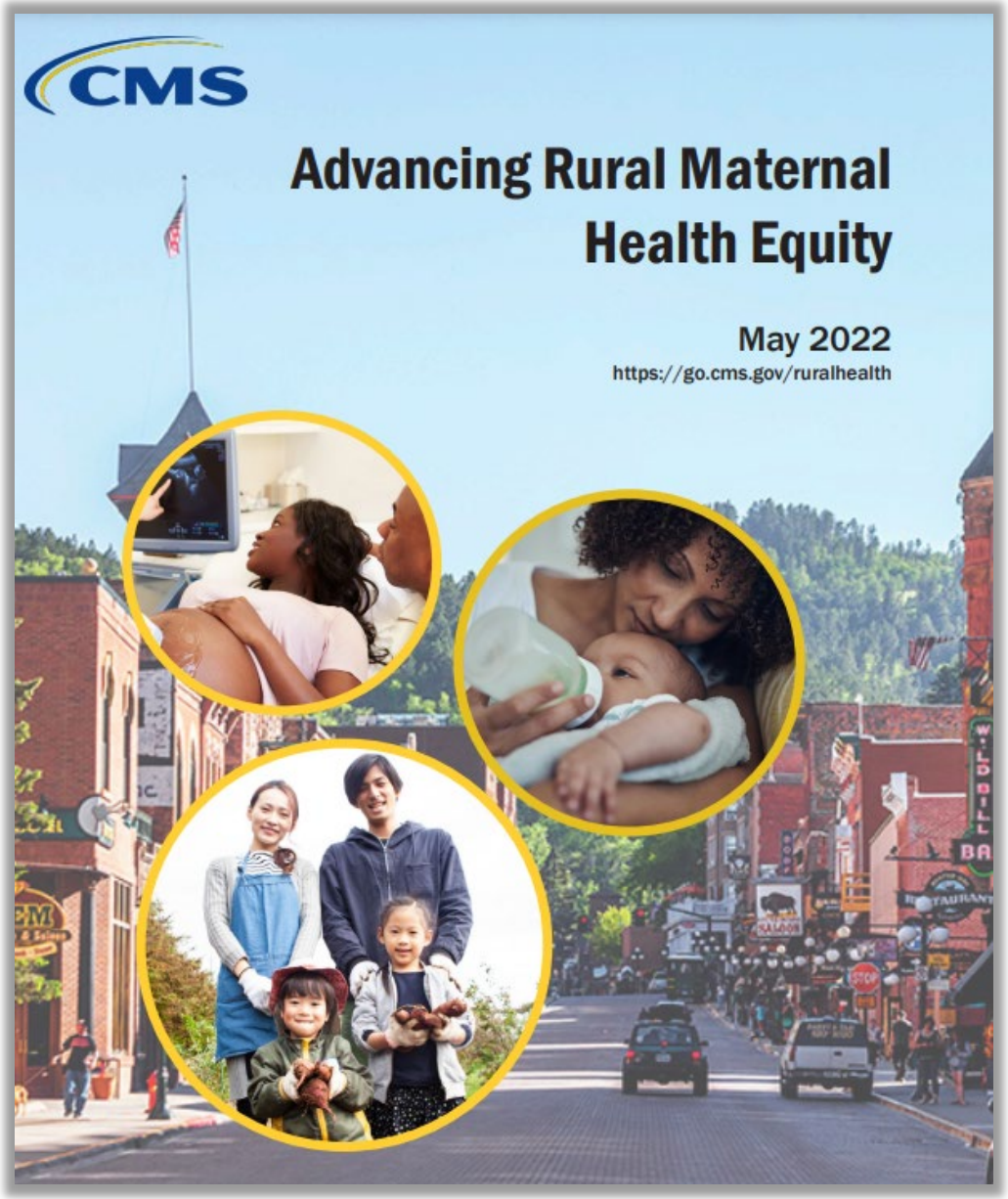
https://www.cms.gov/newsroom/fact-sheets/fy-2023-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-hospitals-ltch-pps

Maternal Health Equity

https://www.cms.gov/files/document/maternal-health-may-2022.pdf

Next Steps and Recommendations:

- Implement recommendations related to disseminating best practices for quality improvement related to rural maternal health outcomes before, during, and after pregnancy; leveraging existing policy levers (e.g., building on the Affordable Care Act to expand access to quality, affordable health coverage and care, USPSTF Recommendations, American Rescue Plan Act) for improved engagement and payment of rural advanced practice and other professionals; and applying lessons learned during the PHE to promote innovative telehealth payment and service delivery models for maternal health in rural and underserved areas.
- Promote flexibilities for rural providers to address obstetric readiness challenges and improve rural maternal health outcomes for women of color in their communities related to care disparities; financial challenges; workforce, training, and equipment inadequacies; and regional relationships.
- Amplify opportunities to reduce maternal morbidity and mortality in the United States by aligning rural maternal health priorities with broader HHS and Administration initiatives (e.g., HHS Rural Health Action Plan).
- Continue to engage and partner with rural stakeholders and federal partners to explore opportunities to reduce rural maternal health equity by addressing key areas, including social determinants of health



CMS Behavioral Health Strategy

- **Consists of five bold and Interrelated goals**:

✓ Strengthen quality and equity in behavioral health care
✓ Improve access to substance use disorder (SUD) prevention, treatment and recovery services
✓ Ensure effective pain treatment and management
✓ Improve access to and quality of mental health care and services
✓ Utilize data to inform effective actions and measure impact on behavioral health

- Aims to reduce disparities in health and health care among individuals CMS serves

- Focuses on improving quality measurement in behavioral health and pain management across CMS programs

- Seeks to identify and address barriers that impede access by people with or at risk of substance use disorders to evidence-based treatment and recovery services for better detection, diagnosis and management of such conditions

https://www.cms.gov/About-CMS/Story-Page/behaviorial-health
https://www.cms.gov/files/document/cms-behavioral-health-stategy.pdf

CY 2022 Physician Fee Schedule (PFS) Final Rule

https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2022-medicare-physician-fee-schedule-final-rule

Current Telehealth Flexibilities Under the Public Health Emergency

- **Eligible Practitioners**
  - All health care practitioners who are authorized to bill Medicare for their professional services may also furnish and bill for telehealth services
  - Healthcare professionals who were not previously authorized under the statute to furnish and bill for Medicare telehealth services—including physical therapists, occupational therapists, speech language pathologists, and others—may receive payment for Medicare telehealth services.

- **Audio-only Telehealth for Certain Services**
  - Beginning on March 1, 2020, telephone evaluation and management and certain behavioral health care and educational services may be furnished via telehealth using audio-only telephones.

PFS 2022: Telehealth and Other Services Involving Communications Technology

- **Mental Health (Consolidated Appropriations Act 2021)**
  - Section 123 of the CAA **removed the geographic restrictions and added the home of the beneficiary as a permissible originating site for telehealth services when used for the purposes of diagnosis, evaluation, or treatment of a mental health disorder**
    - Also requires that there be an in-person, non-telehealth service with the physician or practitioner within six months prior to the initial telehealth service, and thereafter, at intervals as specified by the Secretary.

  - We are implementing these statutory amendments, and finalizing that **an in-person, non-telehealth visit must be furnished at least every 12 months for these services**, that exceptions to the in-person visit requirement may be made based on beneficiary circumstances (with the reason documented in the patient's medical record), and that more frequent visits are also allowed under our policy, as driven by clinical needs on a case-by-case basis.

PFS 2022: Telehealth and Other Services Involving Communications Technology (2)

- **CMS is amending the current definition of interactive telecommunications** system for telehealth services – which is defined as multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner – **to include audio-only communications technology when used for telehealth services for the diagnosis, evaluation, or treatment of mental health disorders furnished to established patients in their homes** under certain circumstances.

- CMS is **limiting the use of an audio-only interactive telecommunications system to mental health services furnished by practitioners who have the capability to furnish two-way, audio/video communications, but where the beneficiary is not capable of, or does not consent to, the use of two-way, audio/video technology**.

- CMS also **finalized a requirement for the use of a new modifier for services furnished using audio-only communications**, which would serve to verify that the practitioner had the capability to provide two-way, audio/video technology, but instead, used audio-only technology due to beneficiary choice or limitations. We are also clarifying that mental health services can include services for treatment of substance use disorders (SUDs).

PFS 2022: Telehealth and Other Services Involving Communications Technology (3)

- We finalized that **we will extend, through the end of CY 2023, the inclusion on the Medicare telehealth services list of certain services added temporarily to the telehealth services list that would otherwise have been removed from the list as of the later of the end of the COVID-19 PHE** or December 31, 2021.
  - This will allow CMS additional time for us to evaluate whether the services should be permanently added to the Medicare telehealth services list.

- We also have extended inclusion of certain cardiac and intensive cardiac rehabilitation codes through the end of CY 2023.

- Additionally, we are adopting coding and payment for a longer virtual check-in service on a permanent basis.

Consolidated Appropriations Act of 2022

CONGRESS.GOV

https://www.congress.gov/bill/117th-congress/house-bill/2471

Consolidated Appropriations Act of 2022

Title III - Medicare

Subtitle A – Telehealth Flexibility Extensions

Medicare Promoting Interoperability Program Overview

Requires eligible hospitals and CAHs to report on objectives and measures to be considered a meaningful EHR user and avoid a downward payment adjustment

Focuses on:

- Advancement of CEHRT functionality
- Burden reduction
- Advancing interoperability
- Improving patient access to health information

CHANGES TO THE MEDICARE PROMOTING INTEROPERABILITY PROGRAM IN CY 2022

Changes to the Medicare Promoting Interoperability Program in CY 2022

EHR Reporting Period:

A minimum of any continuous 90-days for eligible hospitals and CAHs*

Electronic Prescribing Objective:

Available bonus points for PDMP will increase from 5 points to 10 points

Health Information Exchange Objective:

Health Information Exchange Bi-Directional Exchange measure (worth 40 points) added as an alternative to the 2 existing measures

Public Health and Clinical Data Exchange Objective:

Requiring reporting a **"yes"** on 4 of the Public Health and Clinical Data Exchange Objective measures, worth up to 10 points;

Public Health Registry Reporting and Clinical Data Registry Reporting measures will remain **optional** and available for a total of 5 bonus points.

**No change from the 2021 EHR Reporting Period*

Changes to the Medicare Promoting Interoperability program in cy 2022 *(continued)*

Scoring Threshold:

Increasing the minimum scoring threshold from **50 points to 60 points**

Attestation:

Requiring eligible hospitals and CAHs to attest to having completed an annual self-assessment of the SAFER Guides measure, under the Protect Patient Health Information objective, beginning with the CY 2022 EHR reporting period

- Removing attestation statements 2 and 3 from the Medicare Promoting Interoperability Program's prevention of information blocking requirement

eCQMs:

Safe Use of Opioids eCQM is now mandatory for CY 2022 reporting (was optional in CY 2021)

CY 2022 EHR Reporting Period Timeline

2022

Begins January 1, 2022
Ends December 31, 2022

February 28, 2023

- Final day to attest using QualityNet

2023

- Eligible hospitals and CAHs who did not demonstrate meaningful use can submit a Hardship Exception Application no later than September 1

2022- 2024

- Eligible hospital FY 2024
- CAHs 2022

CY 2022 Medicare Promoting Interoperability Program Scoring Methodology

OBJECTIVES	Electronic Prescribing	Health Information Exchange	Provider to Patient Exchange	Public Health and Clinical Data Exchange
MEASURES	e-Prescribing **(10 points)**	Support Electronic Referral Loops by Sending Health Information **(20 points)**	Provide Patients Electronic Access to Their Health Information **(40 points)**	**Report on the following:** • Syndromic Surveillance Reporting • Immunization Registry Reporting • Electronic Case Reporting • Electronic Reportable Laboratory Result Reporting **(10 points)**
	Bonus: Query of Prescription Drug Monitoring Program (PDMP) **(10 bonus points)**	Support Electronic Referral Loops by Receiving and Reconciling Health Information **(20 points)** **OR** Health Information Exchange Bi-Directional Exchange **(40 points)**		***Bonus***: Report on one: • Public Health Registry Reporting • Clinical Data Registry Reporting **(5 bonus points)**

CEHRT Requirements

CEHRT Requirements

- Must utilize 2015 Edition certification criteria, 2015 Edition Cures Update criteria, or a combination of the two
- CEHRT functionality must be in place by the first day of the EHR reporting period and the product must be certified by the last day of the EHR reporting period
- The eligible hospital or CAH must be using their selected version's functionality during the entire EHR reporting period

eCQM Requirements

9 available eCQMS for CY 2022

Beginning in CY 2022: Must **report** on **3** self-selected eCQMs and the Safe Use of Opioids – Concurrent Prescribing measure using **3** self-selected quarters of data

Added the following **2** eCQMs for CY 2023:

- Hospital Harm - Severe Hypoglycemia (NQF #3503e)
- Hospital Harm - Severe Hyperglycemia (NQF #3533e)

Removed the following **3** eCQMs for CY 2024:

- STK-06 (Discharged on Statin Medication)
- PC-05 (Exclusive Breast Milk Feeding)
- ED-2 (Admit Decision Time to ED Departure Time for Admitted Patients)

Required use of the 2015 Edition Cures Update beginning in CY 2023 for all available eCQMs

eCQM Requirements

eCQMs for Eligible Hospitals and CAHs for CY 2022

Short Name	Measure Name	NQF No.
ED-2	Admit Decision Time to ED Departure Time for Admitted Patients	0497
PC-05	Exclusive Breast Milk Feeding	0480
STK-02	Discharged on Antithrombotic Therapy	0435
STK-03	Anticoagulation Therapy for Atrial Fibrillation/Flutter	0436
STK-05	Antithrombotic Therapy by the End of Hospital Day Two	0438
STK-06	Discharged on Statin Medication	0439
VTE-1	Venous Thromboembolism Prophylaxis	0371
VTE-2	Intensive Care Unit Venous Thromboembolism Prophylaxis	0372
Safe Use of Opioids	Safe Use of Opioids – Concurrent Prescribing	3316e

Security Risk Analysis Measure

Eligible hospitals and CAHs must conduct or review a security risk analysis of CEHRT including addressing encryption/security of data, and implement updates as necessary at least once each calendar year and attest to conducting the analysis or review.

It is acceptable for the security risk analysis to be conducted outside the EHR reporting period; however, the analysis must be conducted within the calendar year of the EHR reporting period.	It remains a requirement of the Medicare Promoting Interoperability Program, but is not scored.	A Yes/No attestation is required.

Safer Guides

ONC developed and released the 9 Safety Assurance Factors for EHR Resilience Guides (SAFER Guides) to help hospitals conduct self-assessments to optimize the safety and safe use of EHRs. Beginning with CY 2022 EHR reporting period, CMS is adding a new SAFER Guides measure to the Protect Patient Health Information objective.

Eligible hospital or CAH must attest to having conducted an annual self-assessment of all 9 SAFER Guides at any point during the calendar year in which the EHR reporting period occurs.

A Yes/No attestation statement is required, accounting for having completed an annual self-assessment on all 9 SAFER guides. For CY 2022, this measure is **required**, will not be scored, and an attestation of yes/no is acceptable and will not affect the total score or status.

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Actions to Limit or Restrict the Compatibility or Interoperability of CEHRT

There are currently 3 attestation statements which support **the "prevention of information blocking,"** allowing eligible hospitals and CAHs to attest to their information blocking practices.

Beginning with CY 2022:

- We will no longer require statements 2 and 3;
- Statement 1 will remain without modification;

We are **modifying** the heading of the regulation text and **the definition of "meaningful EHR user"** from "support for health information exchange and the prevention of information blocking" **to "actions to limit or restrict the compatibility or interoperability of CEHRT."**

Additional Resources

For more information on final changes to the Medicare Promoting Interoperability Program in CY 2022:

- Review fact sheet on final rule (CMS-1752-F)
- View final rule (CMS-1752-F) on Federal Register
- Visit CMS website
- Subscribe to CMS Promoting Interoperability Programs listserv

The slides, transcript, and recording of the PI overview webinar is posted to the Promoting Interoperability Programs Events webpage: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/EventsPI

Quality Net Help Desk: Medicare Promoting Interoperability Program participants may contact the QualityNet help desk for assistance at qnetsupport@hcqis.org or 1-866-288-8912.

Proposed Changes to the Electronic Prescribing Objective

Query of Prescription Drug Monitoring Program (PDMP) measure:

- Require submission of the Query of Prescription Drug Monitoring Program (PDMP) measure
- Worth 10 points, beginning with the CY 2023 electronic health record (EHR) reporting period
- Expand the Query of PDMP measure description to include Schedule II opioids and Schedule III, and IV drugs beginning with the CY 2023 EHR reporting period
- Adopt measure exclusions

https://www.cms.gov/newsroom/fact-sheets/fy-2023-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-hospitals-ltch-pps

Proposed Changes to the Health Information Exchange Objective

Enabling Exchange under the Trusted Exchange Framework and Common Agreement (TEFCA) measure

Add the Enabling Exchange under TEFCA measure as an alternative to reporting on the two existing Health Information Exchange Objective options, beginning with the CY 2023 EHR reporting period.

To fulfill the Health Information Exchange (HIE) objective, eligible hospitals and critical access hospitals must choose one of the following options:

1. Report on both the Support Electronic Referral Loops by Sending Health Information measure and the Support Electronic Referral Loops by Receiving and Reconciling Health Information measure.
2. Report on the HIE Bi-Directional Exchange measure.
3. Report on the proposed Enabling Exchange Under TEFCA measure.

https://www.cms.gov/newsroom/fact-sheets/fy-2023-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-hospitals-ltch-pps

Proposed Changes to the Public Health and Data Exchange Objective

- Consolidate the existing three levels of active engagement into two, beginning with the CY 2023 EHR reporting period.
- Eligible hospitals and critical access hospitals must demonstrate their level of active engagement as either proposed Option 1 (pre-production and validation) or proposed Option 2 (validated data production) to fulfill each measure.
- Requiring submission of the option chosen as well as a time limit for Option 1:
  - Proposed Option 1: Pre-production and Validation (a combination of current Option 1, completed registration to submit data, and current Option 2, testing and validation);
  - Proposed Option 2: Validated Data Production (current Option 3, production).

https://www.cms.gov/newsroom/fact-sheets/fy-2023-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-hospitals-ltch-pps

Antimicrobial Use and Resistance (AUR) Surveillance Measure

Add the AUR measure as a fifth required measure (Syndromic Surveillance Reporting, Immunization Registry Reporting, Electronic Case Reporting, Electronic Reportable Laboratory Result Reporting, and the Antimicrobial Use and Resistance [AUR] Surveillance Measure), beginning with the CY 2023 EHR reporting period.

https://www.cms.gov/newsroom/fact-sheets/fy-2023-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-hospitals-ltch-pps

Medicare Promoting Interoperability Program for Eligible Hospitals and Critical Access Hospitals

Objective	Measure	Maximum Points	Required/Optional
Electronic Prescribing	e-Prescribing	10 points	Required
	Query of Prescription Drug Monitoring Program (PDMP)*	10 points*	Required
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	15 points*	Required (eligible hospital or critical access hospital choice of one of the three reporting options)
	Support Electronic Referral Loops by Receiving and Reconciling Health Information	15 points*	
	-OR-		
	Health Information Exchange Bi-Directional Exchange	30 points*	
	-OR-		
	Enabling Exchange under Trusted Exchange Framework and Common Agreement (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 five measures*: • Syndromic Surveillance Reporting • Immunization Registry Reporting • Electronic Case Reporting • Electronic Reportable Laboratory Result Reporting • Antimicrobial Use and Resistance Surveillance Reporting*	25 points*	Required
	Report one of the following measures: Public Health Registry Reporting or Clinical Data Registry Reporting	5 points (bonus)*	Optional

The Security Risk Analysis measure, Safety Assurance Factors for EHR Resilience (SAFER) Guides measure, and attestations required by section 106(b)(2)(B) of Medicare Access and CHIP Reauthorization Act (MACRA) are required, but they will not be scored. eCQM measures are required, but they will not be scored. *Signifies proposal made in FY 2023 IPPS/LTCH PPS Proposed Rule.

https://www.cms.gov/newsroom/fact-sheets/fy-2023-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-hospitals-ltch-pps

Information Blocking

https://www.healthit.gov/topic/information-blocking

Information Blocking

https://www.healthit.gov/topic/information-blocking

Information Blocking Portal

Report information blocking

Additional Considerations:

- If you believe that a HIPAA covered entity or business associate violated your (or someone else's) health information privacy rights or committed another violation of the HIPAA Privacy, Security or Breach Notification Rules, please file your complaint directly with The HHS Office for Civil Rights
- As specified by the Cures Act, information blocking claims and information received by ONC in connection with a claim or suggestion of information blocking are generally protected from disclosure under the Freedom of Information Act

You are NOT required to submit any personally identifying information to submit concerns, complaints, feedback, or inquires. If you want to remain anonymous to ONC, please click the "yes" button below.

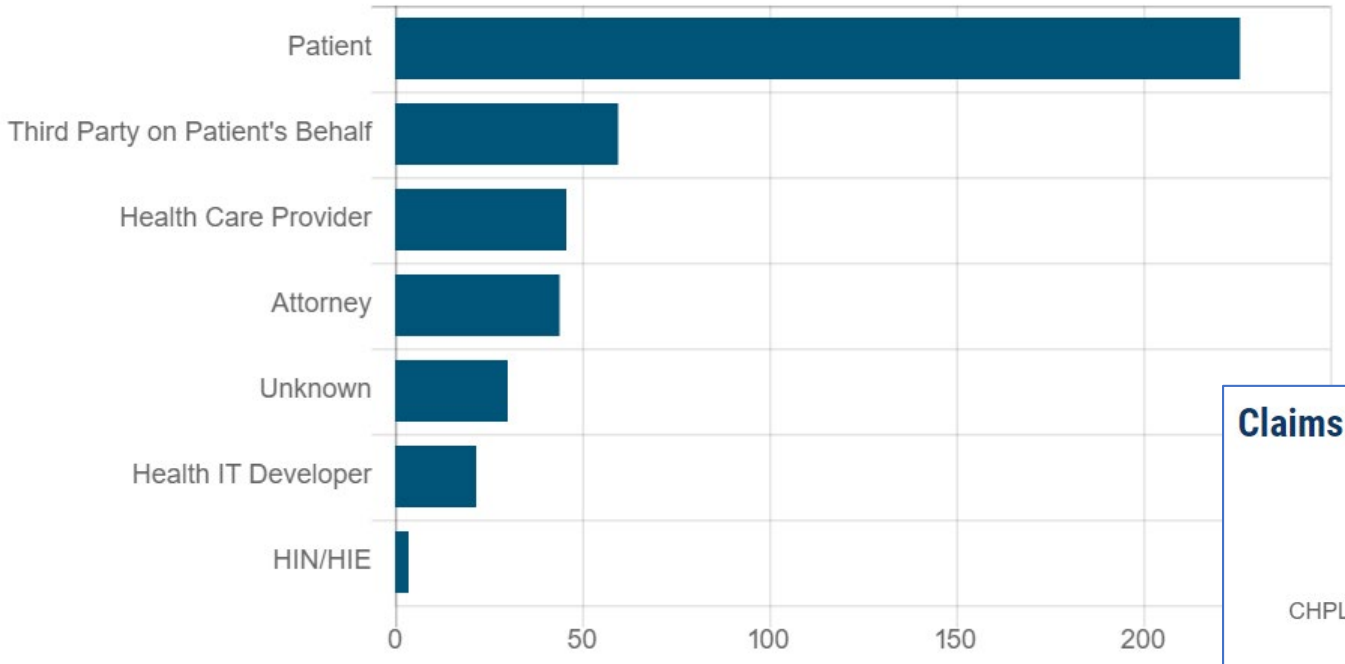
Information on submissions received through the Report Information Blocking Portal[2]

Total number of information blocking portal submissions received	413
Total number of possible claims of information blocking	381
Total number of submissions received that did not appear to be claims of potential information blocking[3]	32

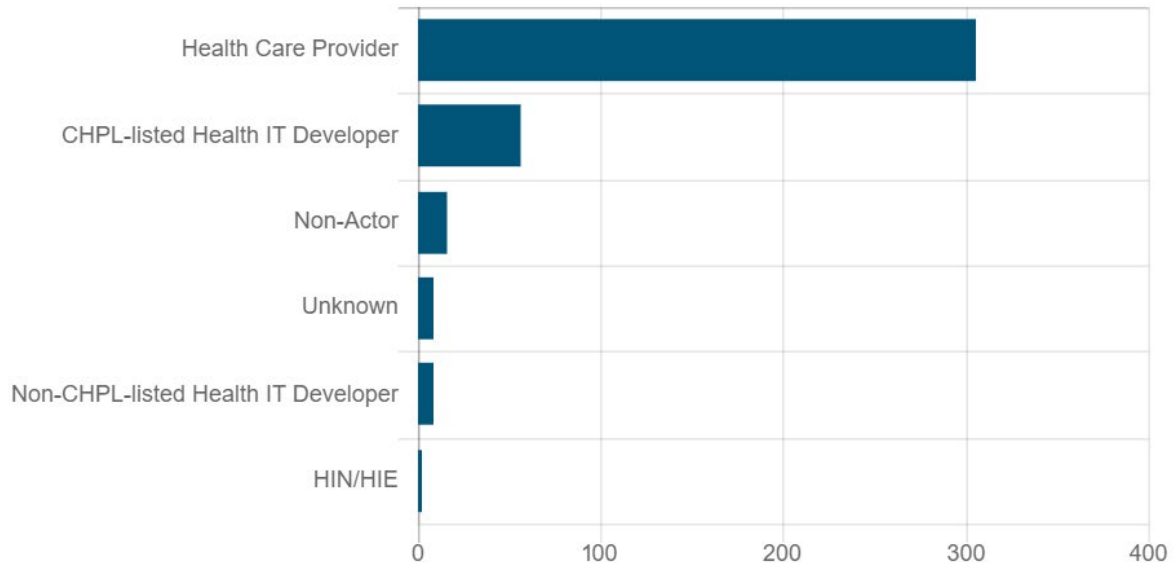
https://www.healthit.gov/data/quickstats/information-blocking-claims-numbers

Current as of 6/10/22

Claims Counts by Types of Claimant



Claims Counts by Potential Actor



https://www.healthit.gov/data/quickstats/information-blocking-claims-numbers

Information Blocking Resources

Information Blocking FAQs
https://www.healthit.gov/curesrule/resources/information-blocking-faqs

What happens when a claim is submitted to the Information Blocking Portal?
https://www.healthit.gov/cures/sites/default/files/cures/2021-11/Information-Blocking-Portal-Process.pdf

Information Blocking Claims: By the Numbers
https://www.healthit.gov/buzz-blog/21st-century-cures-act/information-blocking-claims-by-the-numbers

Total number of portal submissions received
https://www.healthit.gov/data/quickstats/information-blocking-claims-numbers

Ashby Wolfe, MD, MPP, MPH
Centers for Medicare & Medicaid Services
CMS San Francisco, Seattle & Denver

ashby.wolfe1@cms.hhs.gov
415-744-3501