Health Information Compliance Alert

Compliance: Enjoy More Flexibility & Eased Burdens For EHR Incentive Programs

Certification criteria also gets a makeover for 2015 Edition.

The Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs have created a lot of headaches for providers but that is now changing, with newly revised requirements that allow more time to meet critical objectives that affect your reimbursement.

On Oct. 6, the **Centers for Medicare & Medicaid Services** (CMS) and the **Office of the National Coordinator for Health Information Technology** (ONC) released two final rules on electronic health information: the final rule for the 2015 Edition Health IT Certification Criteria, and the final rule with a 60-day comment period for the Medicare and Medicaid EHR Incentive Programs.

Pay Attention to Substantial Changes

According to an Oct. 6 CMS announcement, the new final rules make significant changes to the current requirements, and aim to ease providers' reporting burdens, support interoperability, and improve patient outcomes. The final rules allow providers to choose the measures of progress that are most meaningful to their practice and provide more time to implement changes to program requirements.

The final rules also encourage providers to apply for hardship exceptions if they need to switch EHRs or have other technology difficulties with their vendors, and the rules give developers more time to create user-friendly technologies. CMS is planning to use the feedback on the EHRs Incentive Programs final rule to provide insights for future policy developments and rulemaking to implement the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which it expects to release in the spring of 2016.

Important: For the EHR Incentive Programs in 2015 through 2017, the final rule's major provisions include:

- Reducing objectives for eligible professionals (EPs) from 18 total objectives to just 10 objectives including one public health reporting objective;
- Reducing objectives for critical access hospitals (CAHs) and eligible hospitals (EHs) from 20 total objectives to only nine objectives including one public health reporting objective; and
- Preserving the previously finalized Clinical Quality Measures (CQM) reporting for both EPs and EHs/CAHs.

What CMS Now Expects from You

CMS also modified and restructured the EHR Incentive Programs' objectives and measures in 2015 through 2017 to align with Stage 3, as well as modified the "patient action" measures in the Stage 2 objectives. The major provisions for Stage 3 in 2017 and subsequent years include:

- Eight objectives for EPs, EHs and CAHs (in Stage 3, more than 60 percent of the proposed measures require interoperability, increased from 33 percent in Stage 2);
- Public health reporting with flexible options for measure selection;
- CQM reporting aligned with the CMS quality reporting programs;
- Finalize the use of application program interfaces (APIs) that allow for developing new functionalities to build bridges across systems and provide increased data access for patients;
- A 90-day reporting period for providers who choose to begin Stage 3 in 2017 (Stage 3 requirements are optional in 2017);

- A 90-day reporting period for all providers in 2015, as well as for new participants in 2016 and 2017;
- All providers must comply with Stage 3 requirements beginning in 2018 using EHR technology certified to the 2015 Edition;
- Increased thresholds, advanced use of health information exchange functionality, and an overall focus on continuous quality improvement included in the Stage 3 objectives and measures; and
- Flexible reporting periods that are aligned with other programs to reduce burden, including moving from a fiscal year to calendar year reporting for all providers beginning in 2015.

CMS Feels Your Pain

These final rules are largely the result of a massive shift to EHRs and providers voicing their difficulties in doing so while remaining compliant. More than 70 percent of EPs and other clinicians, along with more than 95 percent of EHs, are using EHRs and received incentive payments, according to CMS.

"We have heard from physicians and other providers about the challenges they face making this technology work well for their individual practices and for their patients," CMS states. "Doctors in particular have expressed ongoing concern over increasing requirements for the use of EHR technology and frustration at competing reporting requirements among programs."

If you're facing challenges in planning for and reporting on complex and numerous meaningful use requirements, you're not alone. "We recognize we have more to do," CMS notes. CMS is hoping that the new final rules will make significant enough changes to ease providers' burdens. In response to providers' comments, the regulations:

Remove many of the "check box" process measures, so that the program focuses on better patient care such as clinical decision support, electronic prescribing, and information exchange.

Reduce the burden and duplicative reporting, including reporting on measures relevant to providers' specialties.

Give providers and states more time (27 months, until Jan. 1, 2018) to comply with the new requirements and prepare for the next set of system improvements. CMS extended this start date from 2017 and made the program optional for providers in 2017.

Modify the measures so that one-third more measures rely on the exchange of health information, to address health information blocking and interoperability between providers and with patients.

What Final Rules Mean for You

These regulations make a myriad of changes, but here are the key takeaways on what this means for providers:

1. By Feb. 29, 2016, you must report on your use of EHRs for any continuous 90 days within Calendar Year 2015 (or within the period Oct. 1, 2014 to Dec. 31, 2015 for EHs/CAHs). You may extend the Feb. 29, 2016 deadline to the end of March if you need more time.

2. For 2016 and 2017 for both Medicare and Medicaid providers (and 2018 for Medicaid providers), you can report on any 90 days if you're new to the EHR Incentive Programs.

3. If you are ready to move forward, you can transition to the next phase in 2017. But most of the changes aren't required until 2018.

4. For Medicare providers experiencing difficulty, you should apply for hardship exceptions, which CMS will review on a case-by-case basis.

Resources: For a fact sheet on the ONC 2015 Edition final rule, go to www.healthit.gov/sites/default/files/factsheet_draft_2015-10-06.pdf. The CMS fact sheet on the EHR Incentive Programs final rule is available at www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-06.html. To access more

information on the EHR Incentive Programs, visit www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/EHRIncentivePrograms.