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An introduction to information blocking

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Healthcare doesn't take place in one location. Health information takes many forms and receives contributions from several sources and actors. In today's healthcare industry, the patient and their electronic medical record is a major connecting point and that connection is largely enabled using Health Information Technology (HIT). If the HIT is not designed, implemented, or used to allow the flow of electronic health information or if barriers to exchange of that information are present, it may hinder information flow, which may implicate a case of information blocking. The topic of information blocking is evolving, but at its heart is the idea that electronic healthcare information should be allowed to flow from provider to provider, provider to payer, from provider to patient, and so on to all those authorized to be able to access, exchange, or use the information. This article will provide an introduction to the topic of information blocking as a key compliance focus.

Over the past few years, the topic of information blocking has been a focus in two areas of rulemaking. First, the Centers for Medicare & Medicare Services (CMS) issued rulemaking under authority of the Medicare and CHIP Reauthorization Act (MACRA), creating mandatory attestation statements tied to the implementation and use of Certified Electronic Health Record Technology (CEHRT) for participation in the Promoting Interoperability (PI) programs.[1] Second, the Office of the National Coordinator (ONC) has taken the framework of information blocking outlined in the 21st Century Cures Act and carries it forward with definitions and exceptions in its 21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program proposed rule (Cures Act Proposed Rulemaking).[2]

MACRA impact on information blocking

On February 17, 2009, the Health Information Technology for Economic and Clinical Health Act (HITECH) was enacted as part of the American Recovery and Reinvestment Act of 2009 and signed into law. HITECH created the Electronic Health Record (EHR) Incentive Program (now known as the PI program) to both encourage adoption and use of EHRs and to stimulate the economy. HITECH created ONC as an office of the Department of Health and Human Services (HHS). ONC was tasked with outlining creation of the CEHRT program, ensuring base functionality was available. Correspondingly, CMS outlined requirements for providers in the Medicare and Medicaid PI programs to use CEHRT to satisfy certain programmatic requirements. Subsequently, CMS incorporated CEHRT requirements into the Merit-based Incentive Payment System (MIPS) program, and the Advanced Alternative Payment Models (A-APMs) and Other Payer (non-Medicare) A-APMs under the Quality Payment Program (QPP). The PI program has provided over $35 billion in incentives to participating healthcare providers with the idea of enabling electronic exchange of standardized health information using CEHRT.[3]

In April 2015, MACRA was enacted and contained a section on the topics of interoperability and information blocking.[4] This section of MACRA grants authority to CMS to ensure that participants in the Medicare PI, Medicaid PI, and MIPS PI programs are implementing and using CEHRT as intended. CMS achieves this using

three attestation statements required for any PI program (i.e., Medicare, Medicaid, or MIPS). These three attestation statements relate to implementation of CEHRT and CEHRT's required standards as well as the use of CEHRT to provide authorized access to electronic healthcare information. CMS outlines guidance on understanding these attestation statements in its 2018 PI Information Blocking Factsheet[5] as well as in the MIPS and A-APM Final Rule for 2017.[6]

CMS titles these as the information blocking attestation statements, which certify that the attester complied with the CEHRT implementation and use requirements and cooperated with requests for information by certifying bodies to assure the viability of CEHRT in use. If the attester doesn't respond affirmatively to these attestation statements, the PI attestation will not be accepted, and the provider will fail the PI program for that year. Inability to attest may lead to loss of incentives under the Medicaid PI program, negative payment adjustment under the Medicare hospital PI program, and/or a score of zero for the PI category in the MIPS program. CMS has also proposed to begin publishing in late 2020 a list of hospitals, critical access hospitals (CAHs), eligible professionals, and eligible clinicians (ECs) that do not affirmatively attest to these three attestation statements. The list would be published on Hospital Compare or Physician Compare sites, respectively, based on 2019 attestation to PI programs.[7] These statements were first required with the 2017 PI attestations.