Public Health Reporting Under Meaningful Use: Delayed—or Dead?

written by Theresa Hush | March 30, 2016

Of all the requirements in the EHR Incentive Program, the Modified Stage 2 provisions for public health reporting were among the most controversial when finalized—and remain the most muddled. Amended by a series of CMS FAQs since Final Rules, the 2016 requirements have been significantly eased.

Providers now question whether Specialized Registry reporting will become a reality, and some have put off active engagement with Registries until CMS clarifies its direction. What should *your* path be, and how secure is your exclusion from reporting?

Public Health Reporting: Who Is "Public Health"?

Public health reporting under Meaningful Use falls into three areas: Immunization registries, syndromic surveillance registries and Specialized Registries.

The first two types of reporting are the territory of public health agencies. Public health reporting for immunizations and communicable diseases are more broadly accepted. Yet, public health agency registries are not universally operational. There is uneven capability among state and local public health agencies collecting immunization data for accepting electronic data feeds on the scale that required reporting would demand.

Syndromic surveillance registries have issues, too. They are at a relatively early stage and non-existent in many areas. Many areas are dependent on Centers for Disease Control (CDC) systems for tracking incidence of symptoms and disease.

If these two types comprised the full public health reporting requirements in Meaningful Use, however, there would be less controversy. That's because the requirements would also fall on fewer providers—mostly primary care physician practices and hospital emergency departments.

It's the third public health reporting arena that is the locus of concern. Let's focus on the Specialized Registry to clarify what all the confusion is about.

Specialized Registry: Who Is Involved?

The Specialized Registry doesn't yet have a core constituency, and its goal is less understood. Most importantly, it is also not firmly in the "public" arena like immunizations and syndromic surveillance, but comprised of various physician specialty registries and private registries. These attributes make the Specialized Registry unusual and also variable. For public health reporting, this also means uncertain. In a time of tremendous change in health care, uncertainty and new requirements are not welcomed by providers.

Complicating matters, there is no list of Specialized Registries or a common classification system. There are only proxy rules based on other programs—the Qualified Clinical Data Registry, the Clinical Data Registry designated in future Meaningful Use, and PQRS Reporting Registries. So, even under the best scenario, no one knows where to look to find the entity to which data should be sent. That, to put it mildly, is a big problem.

Despite those issues with implementation, the Specialized Registry may be the sole public health reporting option for many providers. Under the new MU rules, the largest number of eligible providers and hospitals will not likely be able to report to meet requirements by reporting to immunization or syndromic surveillance. That's because they don't do immunizations or manage communicable diseases. Therefore, if everyone must complete public health reporting or face penalties under Meaningful Use, the most significant volume of providers' public health reporting may well be to Specialized Registries. But if it's not clear who those entities are, then what can a provider do?

The CMS Backwalk and What it (Probably) Means

According to the final rules released in October 2015 for Modified Stage 2, all Eligible Providers and Eligible Hospitals are required to report to one or more of the three public health reporting options. Initially these can be blended, but later (likely under MIPS), these will be distinct

reporting requirements.

But then . . .

Soon after the release of rules, CMS produced its first set of FAQs, indicating that it did not intend to penalize providers for inability to meet new measures, nor engage in new activities during 2015. CMS also clarified providers' ability to claim an exclusion to public health reporting initiatives.

Days before the February 29 deadline for meeting the "active engagement" with a registry under public health reporting, CMS released a series of FAQs that weakened the public health reporting requirements and, particularly, the Specialized Registry requirements:

> Stated that providers could determine the availability of Specialized Registries by simply asking their State Public Health agency and/or affiliated specialty societies. Since the Specialized Registry is, by definition, not limited to these arenas, this took the oomph out of providers' needs to get in active engagement;
> Defined possible exclusions from public health reporting;
> Extended the period for the provider to get in "active engagement" as long as the Specialized Registry was ready to accept reporting within the first 60 days of the year; and
> Gave broad definition to the term "Specialized Registry," including QCDRs that meet a public health role.

If you're completely dizzy, you're not alone. In large part, CMS provided an easier out for providers who were agonizing over the need to find a Registry for reporting within a too-tight timeframe. This is a good thing, because more clarification about the goals is needed, and certainly more time for providers to understand and select their options.

But the current delay appears to be an extension, rather than an elimination of the Specialized Registry under MU. The Rules remain intact, and, furthermore, there is a clearer commitment to the central position of the Clinical Data Registry in improving outcomes. In addition, the release of more information on MIPS, expected soon, will most certainly begin to tie together the loose ends of the various reporting efforts.

This breather has another advantage. As technology continues to advance—with better data, more sophisticated coding and higher adoption rates by providers—EHR technology will be recognized as the basic foundation upon which all health care walks. Nonetheless, because it is subject to variations in implementation and use, differences in vendor coding and mapping of

data, EHR technology will never be a “magic” solution for universally improving the quality and economics of health care. The health care industry must come to a mutual understanding that data is the fuel of progress, not the engine. Rather, the engine is the hard work of getting providers and patients involved in better processes and programs to improve outcomes—applying that data to effect lasting change.

In for the Long Haul: How to Turn Public Health Reporting to Your Benefit

There is little doubt that the universal force of the Budget—from government spending to consumers’ pocketbook decisions—will push health care providers to achieve real savings and better outcomes. The data from the rapid EHR adoption will be put to use. Public health reporting should go beyond “check the box” and be a positive force for change, and the value of that reporting needs to be clearer to all the stakeholders.

For that to happen, we need to ask what constitutes the best stewardship, validation and use of patients’ data to achieve the goal of improved health care:

> How can we best evaluate outcomes over time and examine the interventions that are most effective in prevention, deterring progression or improving poor outcomes? Who fulfills this role most effectively?
> How do we protect patients (and providers) from actions based on inaccurate or incomplete data? With EHRs still in early adoption and data coding structures not well ingrained, how do we ensure that results shown by EHR data are correct?
> How can our research, performance improvement and outcomes activities based on patient data steer clear of financial, business or other protective interests that may negatively impact patients?
> How do we enable patients to gain greater access to and involvement in their health care—and their data?

The Specialized Registry as a public health reporting vehicle may have a longer launch trajectory than originally assumed. But its central concept, evolving into the Clinical Data Registry, remains solid: There must be auditors and stewards of data for benchmarking, evaluating the real data that generate outcomes analyses, and laying the groundwork for improving health care.

Download your free copy of our new eBook, *ICLOPS Value-Based Payment Modifier Primer: How NOT to Forfeit Your Medicare Revenues.*

Founded in 2002, ICLOPS has pioneered data registry solutions for improving patient health. Our industry experts provide comprehensive ICLOPS Clinical Data Registry and Performance

Improvement Technology and Services Solutions that help you both report and improve your performance. ICLOPS is a CMS Qualified Clinical Data Registry.

Contact ICLOPS for a Discovery Session.

Image Credit: Karl Mooney