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CMS Releases Final Rule for Promoting Interoperability Program

Article By:

Daniel L. Walbright

The Centers for Medicare and Medicaid Services (CMS) recently released their Final Rule for the Promoting Interoperability Program formerly known as the Medicare and Medicaid Electronic Health Record Incentive Programs.

CMS had previously published a Proposed Rule and a request for feedback from the public related to improving interoperability and the sharing of electronic medical records between providers, and between providers and patients, which we covered in a May blog post. CMS has stated that the purpose of the Final Rule is to "advance the agency's priority of creating a patient-centered health care system by achieving greater price transparency, interoperability, and significant burden reduction so that hospitals can operate with better flexibility and patients have what they need to be active healthcare consumers."

Price transparency

The Final Rule requires hospitals to make their list of standard charges publicly available via the Internet in a machine readable format and to make updates to this information at least annually or more often, as appropriate. According to CMS, the hospital chargemaster itself may be posted on the Internet for patient-consumers to access and review, as desired, to make more informed health care decisions.

Before the Final Rule, CMS only required hospitals to make the list publicly available, with no requirement that it be published via the Internet unless state law required otherwise. According to the Final Rule, compliance with this new requirement will promote price transparency and improve health care decision-making. CMS encourages hospital providers to deliver additional context to its patient-consumers beyond the mere disclosure of price information, to the extent that additional information would improve transparency and alleviate confusion to those patient-consumers.

CMS announced that it would continue to work with stakeholders to determine the best approach to making price transparency information available to consumers. Please note that the Final Rule does not require any information to be published in a payor-specific manner.

Meaningful Measures and Patients Over Paperwork

In October 2017, CMS launched the Meaningful Measures Initiative as one component of its Patients Over Paperwork Initiative. The Meaningful Measures Initiative is aimed at identifying the highest priority areas for quality measurement and quality improvement in order to assess quality of care issues. In the Final Rule, CMS removes a total of 39 measures from the Hospital Inpatient Quality Reporting Program in order to implement a much smaller set of what CMS considers the most meaningful measures for patients and clinicians in its quality programs and the Patients Over Paperwork Initiative.

According to the Final Rule, CMS's motivation behind these changes is to ensure quality measurements are simultaneously useful and impactful for patients and not overly burdensome on providers such that it takes time and resources away from providing quality care to patients.

Burden reduction

The Final Rule strips back certain documentation requirements related to submitting acceptable Medicare claims. For example, the Final Rule removes the current requirement that a written inpatient admission order be present in the EMR as a specific condition of Medicare Part A payment. CMS has stated that the Final Rule should reduce the amount of time spent by hospitals on paperwork by approximately 2 million hours, which translates to approximately $75 million in saved expenses.

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