2023

Regulatory Update for Ambulatory Medical Practices

Regulation of healthcare continues to expand

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Introduction

Regulations that govern how you run your medical practice continue to expand and become increasingly complex. This guide will help you stay informed about recent regulatory initiatives that can impact how you conduct business operations and deliver patient care.

ABBREVIATIONS AND ACRONYMS

ACO	accountable care organization	**HIE**	health information exchange
AEOB	advanced explanation of benefits	**HIPAA**	Health Insurance Portability and Accountability Act
API	application programming interface	**HHS**	the U.S. Department of Health and Human Services
APM	alternative payment model	**ICD**	International Classification of Diseases
CAHPS	Consumer Assessment of Healthcare Providers & Systems survey	**MIPS**	Merit-based Incentive Payment System
CEHRT	certified EHR technology	**MSSP**	Medicare Shared Savings Program
CHIP	the Children's Health Insurance Program	**MVP**	MIPS Value Pathway
CMS	Centers for Medicare and Medicaid Services	**NDC**	National Drug Code
CPT	Current Procedural Terminology	**NPI**	National Provider Identifier
CQMs	clinical quality measures	**ONC**	Office of the National Coordinator for Health IT
DRG	Diagnosis Related Group	**PAYGO**	pay-as-you-go
eCQMs	electronic clinical quality measures	**PDMP**	Prescription Drug Monitoring Program
EPCS	electronic prescribing of controlled substances	**TEFCA**	Trusted Exchange Framework and Common Agreement
HCPCS	Healthcare Common Procedure Coding System	**TIN**	Tax Identification Number

CHAPTER 1

CMS PAYMENT AND POLICY CHANGES

The Centers for Medicare and Medicaid Services (CMS) issued the Calendar Year 2023 Medicare Physician Fee Schedule final rule in November 2022, as the agency is required to do each year. Effective on January 1, 2023, the regulations include policy updates to Medicare payment rates, telehealth services, and value-based programs, such as the Merit-based Incentive Payment System (MIPS) and MIPS Value Pathways (MVPs) program. Overall, the final rule isn't a major departure from the policies of the current or previous administrations.

Mitigation of CMS's Medicare payment cuts

CMS was on track to reduce Medicare payments by 8.5 percent starting on January 1, 2023. However, at the end of December 2022, President Biden signed into law a $1.7 trillion spending bill that includes several important healthcare policy provisions. **These provisions allow for mitigation of CMS's planned 8.5 percent payment reduction, decreasing it to a 2 percent cut.**

Four percent of the planned payment reduction was a result of pay-as-you-go (PAYGO) sequester rules. An additional 4.5 percent was a result of a reduction in Medicare's conversion factor, as finalized in the 2023 Medicare Physician Fee Schedule issued in November.

The spending bill signed into law:

- Prevents the 4 percent PAYGO sequester cuts from occurring in both 2023 and 2024
- Adds 2.5 percent back to the conversion factor in 2023
- Adds 1.25 percent back to the conversion factor in 2024

As a result, the Medicare payment reduction is reduced to a 2 percent cut.

Although this is an overall advocacy win for physician groups, most stakeholders are disappointed that Congress did not override the entire 8.5 percent cut for 2023. Looking ahead, physicians now face a 3.25 percent cut in 2024 and the return of an 8.5 percent cut in 2025.

Appropriate use criteria for advanced diagnostic imaging

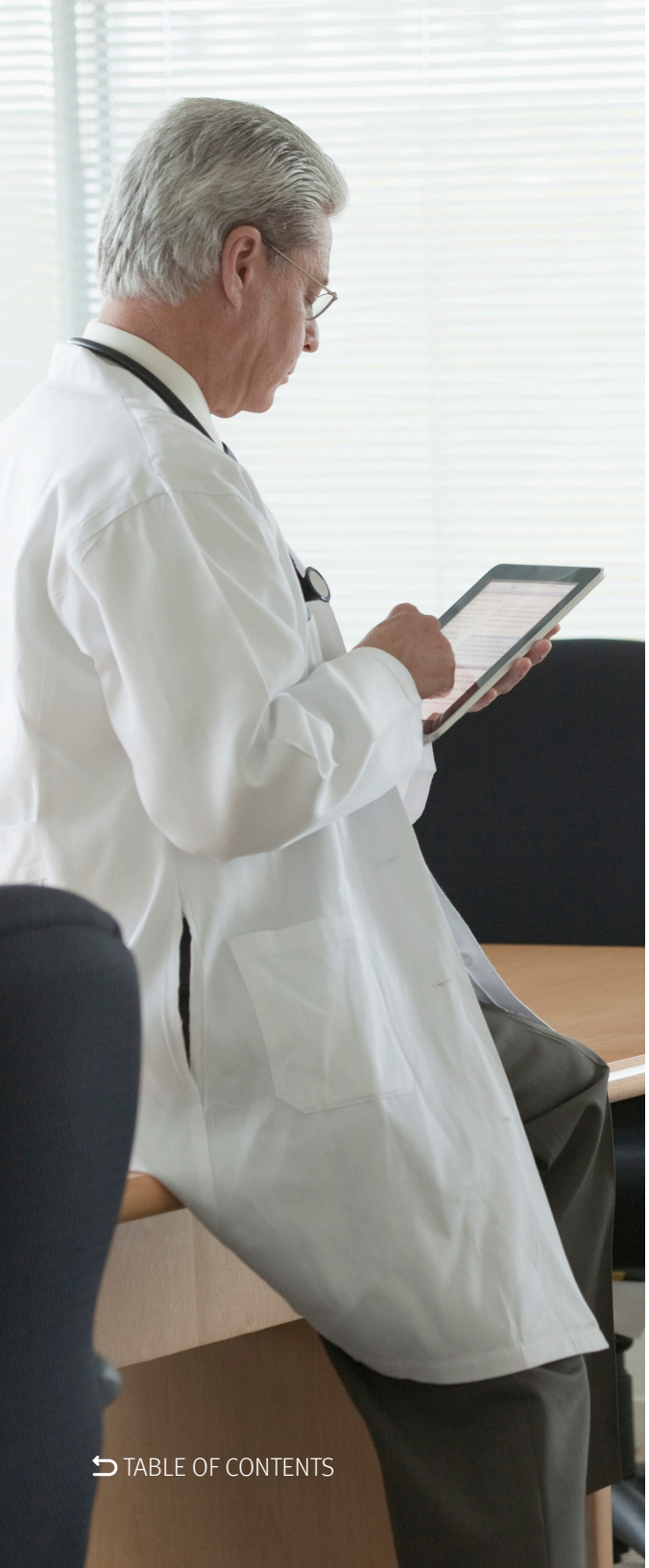
For the first time in several years, the 2023 Physician Fee Schedule final rule did not address the **appropriate use criteria** program. This program is designed to help ensure that advanced diagnostic imaging services are only provided to Medicare beneficiaries when medically necessary. Several months before the rule took effect, CMS posted a message to its appropriate use criteria website stating that enforcement of the requirement would be delayed until further notice.

Because of the considerable changes required for CMS to implement the program, this delay is likely to continue beyond the 2023 calendar year. However, keep an eye open for future announcements, given the significant impact on providers who order or perform diagnostic tests and the statutory requirement on CMS to eventually implement this program.

E-prescribing of controlled substances

The Medicare Physician Fee Schedule established 2023 as the first measurement year for compliance with the electronic prescribing of controlled substances (EPCS) program. The program requires most prescribers who issue controlled substance prescriptions under Medicare Part D to electronically transmit at least 70% of controlled substances (Schedule II-V) prescribed to Medicare Part D beneficiaries.

For 2023, a letter of non-compliance from CMS is the only consequence for failure to comply with this regulation. Actual financial penalties will be addressed in future rulemaking. More information about the EPCS program, including requirements and exceptions, can be found **here**.



Changes to the MIPS scoring system

The Merit-Based Incentive Payment System (MIPS) continues to function as the main tool in CMS's initiative to transform healthcare delivery from fee-for-service to fee-for-value. For 2023, be aware of the following:

- The performance threshold—the score that providers must exceed to earn an incentive payment or avoid a penalty—remains 75 out of 100, according to plan.
- Scores above threshold result in positive adjustments; scores below this threshold result in negative adjustments.
- Under MIPS, eligible clinicians will receive positive or negative payment adjustments of up to 9% in 2025 based on 2023 performance.
- CMS will not apply an exceptional performance threshold in 2023 or distribute the corresponding $500 million in incentive payments in 2025.

Changes to performance categories and measures

Changes to MIPS measure reporting this year are mostly minor, with some measures added, modified, or removed. In 2022, the Electronic Case Reporting measure became and remains required under the MIPS Promoting Interoperability measure. Providers and practices will need to focus time and effort on adopting workflow and technology to support this underutilized measure.

For more information, see the chart on the following page.

Measure	Changes for 2023
Quality These measures now account for 30% of a practice's MIPS score.	• Eliminates exceptional performance bonus and 3-point floor • Nine quality measures, including three electronic clinical quality measures (eCQMs) • Removes 11 quality measures (pneumococcal and Influenza immunization measures retained for MVPs only) • Substantive changes to 76 quality measures
Cost Measures in this category account for 30% of your MIPS score.	• No notable changes
Improvement activities These measures now account for 15% of your MIPS score.	• Updates improvement-activities inventory – four activities added, six removed, and five modified
Promoting interoperability Measures in this category now account for 25% of your MIPS score.	• Eliminates the electronic case reporting exception for clinicians using EHR technology that is not certified for electronic case reporting; this exception only applied in 2022 • Modifies the levels of active engagement for the Public Health and Clinical Data Exchange Objective measures • Makes the Query of Prescription Drug Monitoring Program (PDMP) measure mandatory—rather than optional as it was in 2022 • Adds Participation in the Trusted Exchange Framework and Common Agreement (TEFCA) as a voluntary third option for satisfying the Health Information Exchange (HIE) Objective • Finalizes previously proposed revisions to the promoting interoperability category scoring system

Changes to the framework for MIPS reporting—MIPS Value Pathways

Last year, CMS established 2023 as the start of the transition of MIPS to the MIPS Value Pathways (MVPs) participation framework. This framework organizes the reporting requirements for each MIPS category around specific medical conditions, specialties, or episodes of care.

Practices will still have to report on the four performance areas currently used in MIPS; however, they now have the option to use a value pathway—a specialty or condition-based framework for reporting. MVPs will only be used for three of the performance areas—quality, cost, and improvement activities. Reporting on promoting interoperability will remain unchanged.

Twelve MVPs are available for voluntary implementation in 2023:

- Advancing Rheumatology Patient Care
- Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes
- Advancing Care for Heart Disease
- Optimizing Chronic Disease Management
- Adopting Best Practices and Promoting Patient Safety within Emergency Medicine
- Improving Care for Lower Extremity Joint Repair
- Patient Safety and Support of Positive Experiences with Anesthesia
- Advancing Cancer Care
- Optimal Care for Kidney Health
- Optimal Care for Patients with Episodic Neurological Conditions
- Supportive Care for Neurodegenerative Conditions
- Promoting Wellness

Last year, CMS floated the idea of completing the transition from traditional MIPS to MVPs before the 2028 performance period. CMS has yet to finalize a date to complete this transition.

ACO reforms

Last year, CMS finalized several key changes to regulations governing the Medicare Shared Savings Program (MSSP)—Medicare's largest accountable care organization (ACO) program. The changes were made to increase program participation.

CMS will offer new and existing ACOs additional time in the program before being forced to take on downside risk. In addition, the agency will offer risk-free advance shared savings payments to certain types of new ACOs.

CMS envisioned these polices as "the most significant reforms since the program was established in 2011." During the 2023 application cycle—which begins in June—we will see whether these changes deliver the boost in physician participation that CMS envisioned. These new regulations could also spur physician groups to reevaluate their ACO strategy, consider new partnerships or models, or pursue opportunities with payers outside of Medicare.

ACO quality measures

For the 2023 and 2024 performance years, ACOs have the option to:

- Report the full list of 13 quality measures:
  - 10 CMS web interface measures
  - Two administrative claims measures
  - The Consumer Assessment of Healthcare Providers & Systems (CAHPS) survey
- Report six measures (required in 2025):
  - Three electronic clinical quality measures (eCQMs) or MIPS clinical quality measures (MIPS CQMs)
  - Two administrative claims measures
  - The CAHPS survey
- Starting with the 2025 performance year, ACOs will be required to:
  - Report three eCQMs or MIPS CQMs
  - Conduct the CAHPS survey
- CMS will calculate the two administrative claims measures
- All six measures will be included in an ACO's quality score

See the chart on the following page.

ACO quality measure	Collection type
CAHPS for MIPS survey (10 measures)	• CAHPS survey
Hospital-wide, 30-day, all-cause unplanned readmission rate for MIPS eligible clinician groups	• Administrative claims
Risk standardized, all-cause unplanned admissions for multiple chronic conditions for ACOs	
Diabetes: Hemoglobin A1c (Hba1c) poor control	• CMS web interface or eCQM or MIPS CQM
Preventive care and screening: screening for depression and follow-up plan	
Controlling high blood pressure	• CMS web interface • Starting with the 2025 performance year, these measures will no longer be in use
Falls: Screening for future fall risk	
Preventive care and screening: Influenza immunization	
Preventive care and screening: Tobacco use screening and cessation intervention	
Colorectal cancer screening	
Breast cancer screening	
Statin therapy for the prevention and treatment of cardiovascular disease	
Depression remission at twelve months	

Application deadlines for ACOs in the MSSP

In February 2023, CMS released the application dates for ACOs that want to participate the MSSP starting on January 1, 2024. The first phase of the annual application cycle will begin May 18 and last through June 15. ACOs interested in applying to the program must meet this June 15 deadline.

Following this initial phase, the application process includes several subsequent phases where ACOs will need to submit additional or updated information. For providers and physician groups, the most important of those deadlines is August 1, which is the final date that prospective ACOs that submitted the first phase of the application will be able to add ACO participants to their participant lists.

Increase in participation expected

In November 2022, CMS finalized several key reforms to the MSSP that are set to take effect for the first time in 2024. As noted by CMS in a January 2023 press release, “the policies finalized in the CY 2023 Medicare Physician Fee Schedule final rule are expected to grow participation in the program for 2024 and beyond, when many of the new policies are set to go into effect.”

CMS and industry stakeholders expect to see a significant increase in 2024 MSSP participation as a result of these regulatory reforms. These 2024 application deadlines align with dates established by CMS in previous years. Key dates to keep in mind are a June 15 initial deadline for ACOs and an August 1 final deadline for physicians to join those ACOs.

CHAPTER 2

TELEHEALTH REGULATORY WAIVERS

Regulations governing telehealth were initially relaxed as part of the U.S. government's Public Health Emergency Declaration concerning the COVID-19 outbreak which was first issued January 24, 2020. This gave providers flexibility to meet the sudden increase in demand for virtual care during the lockdown phase.

Most significantly, regulatory waivers allowed practices to offer telehealth services to patients located anywhere geographically—not just remote rural areas—with the patient at home or any other location. They also established payment parity for video and audio visits with in-person visits. For medical practices, this removed financial concerns from the equation when determining whether to see a patient in-person or virtually.

The Department of Health and Human Services (HHS) more recently announced its plan to allow the COVID-19 Public Health Emergency to expire on May 11, 2023. Fortunately for many providers, Congress previously voted to extend a number of the telehealth flexibilities through the end of 2024, regardless of the status of the Public Health Emergency. Congress has the option to make these flexibilities permanent but has yet to do so.[1]

One telehealth flexibility that HHS and Congress have not extended is the regulatory waiver pertaining to enforcement of the Health Insurance Portability and Accountability Act (HIPAA) privacy rule. This means that after May 11, providers offering telehealth services and transmitting personal health information—including names, phone numbers, birth dates, IP addresses, email addresses, device identifiers, and photos—using non-HIPAA-compliant applications risk being subject to HIPAA enforcement.

CHAPTER 3

CURES ACT REGULATIONS

The 21st Century Cures Act, known more simply as the Cures Act, became law in 2016. This bipartisan legislation sought to increase choice and access for patients and providers. To achieve these goals, the law authorizes funding to help address the opioid epidemic and improve mental health services. It also streamlines approval for new drugs, devices, and treatments.

Also included in this law are provisions to prevent *information blocking* and update requirements for health IT certification. These provisions have major regulatory impact on medical practices.

Information blocking

As part of its implementation of the Cures Act, the Office of the National Coordinator for Health IT (ONC) released 21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program (ONC's Cures Act Final Rule) in May 2020. One important goal of the Cures Act and the ONC final rule is to prevent information blocking.[2]

ONC's Cures Act final rule:

- Defines information blocking as any action likely to interfere with access, exchange, or use of electronic health information
- Outlines exceptions to the definition of information blocking, which may be allowed to prevent harm, protect privacy, or other reasons
- Calls on healthcare providers to adopt standardized application programming interfaces (APIs), which enable people to securely access their electronic health information at no cost; for example, by using apps on their smartphone

ONC's Cures Act Final Rule applies to healthcare providers, developers of certified health IT, health information exchanges (HIEs), and health information networks—described by ONC as "information blocking actors." The rule includes a **knowledge requirement** that applies differently to healthcare providers compared to other actors. If a healthcare provider *knowingly* interferes with access, exchange, or use of healthcare information, they are subject to penalties, unless the interference falls under a regulatory exception.

Exactly how regulatory enforcement agencies will interpret and apply the knowledge requirement remains uncertain.

That's not the only uncertainty. Monetary penalties for providers who violate the rules have not yet been established.

This means that even though these rules went into effect in April 2021, regulatory agencies still aren't enforcing them. However, healthcare providers are urged by the American Medical Association (AMA) and other stakeholder groups to adopt policies and conduct training within their organizations well in advance of the anticipated release of a rule to enforce information blocking regulations.

Health IT certification

While the information blocking rule does not require clinicians to use any specific technology, clinicians participating in CMS quality programs such as MIPS still need to demonstrate meaningful use of certified EHR technology (CEHRT). The Cures Act and the ONC final rule made several changes to ONC's existing 2015 Edition Health IT Certification program. These changes are known as the 2015 Edition Cures Update. CEHRT developers had a deadline of December 31, 2022, to make these updates available to their customers.

Clinicians who participate in CMS quality programs requiring CEHRT must adopt and use technology that meets 2015 Edition Cures Update criteria by the established program deadlines to receive incentives and avoid penalties. These deadlines vary by program.

MIPS participants won't need to upgrade until the beginning of their 90-day Promoting Interoperability performance period in 2023. Note that clinicians and groups select this 90-day period—reporting on 90 consecutive days of their choice. Clinicians and groups participating in advanced alternative payment models (advanced APMs)—for examples, an ACO – may have different deadlines.

NextGen Enterprise EHR

NextGen® Enterprise EHR has been granted 2015 Edition Cures Update certification from an authorized certification body, the Drummond Group LLC, and was the first EHR developer to offer a fully certified, complete EHR solution that meets 2015 Edition Cures Update criteria.

This approval designates that NextGen Enterprise EHR delivers the required functionality to meet federal government regulations related to use of certified EHR technology.

CHAPTER 4

THE TRUSTED EXCHANGE FRAMEWORK AND COMMON AGREEMENT

On January 18, 2022, HHS and ONC announced the publication of the Trusted Exchange Framework and Common Agreement (TEFCA). The goals of this agreement are to:

- Establish a floor for interoperability across the United States
- Establish an infrastructure model and governing approach for users in different networks to securely share basic clinical information
- Enable people to access their healthcare information more easily

TEFCA outlines a common set of principles, terms, and conditions to support the development of exchange of electronic health information across disparate health information networks nationwide. It describes a common set of non-binding, foundational principles for policies and practices that can help facilitate communication across these networks.

The announcement of this publication brings us closer to achieving the goals of the 21st Century Cures Act—establishing a national framework to support data sharing between providers, health plans, patients, HIEs, and public health organizations. More about TEFCA **here**.

CHAPTER 5

SURPRISE BILLING REGULATIONS

In 2022, regulations implementing provisions of the No Surprises Act went into effect. This law includes a provision that requires healthcare providers to offer patients detailed pre-visit cost estimates. Specific requirements for these estimates vary by payer and visit type and are at different stages of implementation. **The good faith estimate requirement which applies to providers who treat uninsured and self-pay patient went into effect in January 2022.**

Good faith cost estimate requirements

The cost estimate provision requires providers and facilities to inquire about an individual's health insurance status at the time a service appointment is scheduled. Then, for services scheduled for uninsured or self-pay individuals, a provider or facility must provide a good faith estimate of all expected charges.

The estimate must be delivered to the patient within three business days if a service is scheduled at least ten business days in advance, and within one business day if a service is scheduled at least three business days in advance. There is no requirement if a service is scheduled less than three business days in advance.

The good faith estimate requirement for self-pay and uninsured patients remains in effect in 2023. Physician groups that have not already done so should take steps now to ensure they have the necessary technology infrastructure, personnel, and processes in place to deliver pre-visit cost estimates to all patients. Doing so will help ensure compliance with the No Surprises Act, especially as its provisions expand over time. The ability to deliver pre-visit cost estimates will also help position medical practices for success in the world of consumer-focused healthcare.

Uninsured or self-pay patients who receive a final bill that exceeds the good faith estimate by $400 or more can dispute the final charges through a new federal dispute resolution arbitration process.

Components of a good faith cost estimate

A good faith cost estimate for uninsured or self-pay patients must include the following information:

- Patient name and date of birth
- Description of the primary item or service
- Itemized list of items or services
- Applicable diagnosis codes (ICD), expected service codes (CPT, HCPCS, DRG, or NDC), and expected charges for each listed item or service
- Name, NPI, and TIN of each provider or facility represented in the estimate
- State(s) and office or facility location(s) where the items or services are expected to be furnished
- List of items or services that the provider or facility anticipates will require separate scheduling and that are expected to occur before or following the expected period of care for the primary item or service
- Disclaimer that there may be additional items or services the provider or facility recommends as part of the course of care that must be scheduled or requested separately
- Disclaimer that informs the individual of their right to initiate the patient-provider dispute resolution process if the actual billed charges are substantially in excess of the expected charges included in the good faith estimate
- Disclaimer that the good faith estimate is not a contract and does not require the individual to obtain the items or services

Enforcement delays

CMS has indefinitely delayed enforcement of certain provisions of the No Surprises Act—co-provider and co-facility requirements for uninsured and self-pay individuals. To meet these requirements, providers will eventually have to include cost estimates for all items and services reasonably expected to occur during a scheduled visit, including items and services from other providers, facilities, and labs.

CMS has also indefinitely delayed the requirements for providers to share data with payers. Payers will be required to use this data to furnish advanced explanation of benefits (AEOB) documents to insured patients before submission of a claim. The payer will be required to provide an AEOB if a healthcare service is scheduled at least 72 hours in advance or at the patient's request.

In a fall 2022 Request for Information, CMS explained reasons for these delays—lack of data standards and interoperability among healthcare providers and between payers and providers. In 2023, CMS will likely issue rules to implement these outstanding No Surprise Act requirements.

These rules may establish new financial data sharing standards and processes which will be significant for providers, insurers, and developers of healthcare technology.

CHAPTER 6

PRIOR AUTHORIZATION REFORMS

Physicians consistently identify payer prior authorization requirements as a top reason for professional burnout and job dissatisfaction. In response, the federal government wants to issue new regulations to limit those burdens and further digitize the prior authorization process.

In December 2022, CMS released a proposed rule focused on electronic prior authorization that includes several new application programming interface (API) requirements applicable to payers operating in government sponsored programs, including Medicare Advantage, Medicaid, the Children's Health Insurance Program (CHIP), and individual market exchanges. Provisions included in this rule would automate the prior authorization process and facilitate the exchange of requests and decisions from a provider's EHR or PM system. The rule would also add a new Electronic Prior Authorization measure to the MIPS Promoting Interoperability category that providers would be required to report starting in 2026.

CMS could issue a final rule in late 2023. Meanwhile, the U.S. Department of Health and Human Services' (HHS) Office of the National Coordinator for Health IT (ONC) is expected to soon release its own proposed rule with new EHR certification requirements related to this new prior authorization process. Once finalized, this would have important implications for both healthcare practices and developers of certified EHR software.

CHAPTER 7

STRATEGY THAT WILL DRIVE FUTURE REGULATION

The Biden administration provided insights into strategic direction for regulatory initiatives with the release of a white paper, **CMS Innovation Center Strategy Refresh**, in October 2021. The strategy outlined in the white paper does not end any current payment models, such as ACOs, MIPS, or APMs, nor does the white paper propose any new models. However, it reveals general principles which will more than likely become manifest in future CMS regulations.

Its top two strategic objectives are to drive accountable care and advance health equity.

Accountable care

CMS plans to increase the number of patients in downside risk payment models. This indicates a continued move toward models such as ACOs where providers take on increasing responsibility for the cost of care and assume greater downside risk.

Health equity

A major focus of healthcare policy will be to address inequities in the healthcare system. Initially, expect regulations in this area to focus on data collection. Practices will be asked to report demographic data about underserved populations, including information on social needs and social determinants of health. The goal of gathering this information is to enable regulators to set standards for measuring inequities in the healthcare system..

Once CMS sets these standards, policy makers can begin to develop initiatives to address inequities. More than likely, new regulations will emerge from this effort. Expect also that CMS will adjust payment levels according to how well medical practices adhere to these new regulations.

CHAPTER 8

FINAL THOUGHTS

Expect efforts by the federal government to regulate and reform healthcare to continue. Through Medicare, the federal government is the largest single purchaser of healthcare in the United States. The government's share of the healthcare pie is growing. In 2021:

- **Medicare spending** was $900.8 billion—21 percent of total national health expenditures.[3]
- **Medicaid spending** was $734 billion—17 percent of total national health expenditures.[4]
- **34 percent** of total healthcare spending was sponsored by the federal government.[5]

The greater the portion of the healthcare bill paid by the government, the more the government will use its influence to shape the delivery of care. Even if there are no major new legislative initiatives by Congress in the weeks and months ahead, regulatory initiatives from CMS and other federal agencies continue to expand and move forward at full speed.

Complying with complex, ever-changing regulations places a lot of demands on your practice's health IT infrastructure. You need a platform that can facilitate meeting requirements of value-based payment programs like MIPS and APMs, new surprise billing rules, and other regulatory initiatives. You need a vendor who can ensure your EHR is fully certified and meets the requirements of the 2015 Edition Cures Update by the deadline established by CMS quality programs.

At NextGen Healthcare, we have both technology and professional expertise that can help you meet this challenge.

We have a long history of success ensuring that our clients understand and meet their compliance obligations. NextGen Healthcare has also invested heavily in development of solutions to help medical practices address focus areas of government policy and regulation, such as value-based care, health equity, access to electronic health information, and good faith cost estimates. Contact us to learn more about the following solutions:

- NextGen® Population Health
- The NextGen® Patient Experience Platform
- NextGen® API Solutions
- Enhanced interoperability
- Integrated cost estimation

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More about the Cures Act and NextGen Healthcare

NextGen Enterprise EHR 6.2021.1 Cures is 2015 Edition Cures compliant and has been certified by an ONC-authorized certification body in accordance with applicable certification criteria adopted by the Secretary of Health and Human Services. This certification does not represent an endorsement by the U.S. Department of Health and Human Services

Certificate No: 15.04.04.2054.Next.60.10.1.220318
Certification Date: March 18, 2022
Program: 2015 Edition Cures Update

For additional information about this certification, please visit:
nextgen.com/certifications

Mirth Connect Receives ONC Health IT Cures Update Certification

Mirth® Connect by NextGen Healthcare is an integration engine used by domestic and international hospitals, health systems, clinics, provider groups, labs and testing facilities, public health agencies, government entities, health IT organizations, pharmacies, and more. These organizations rely on Mirth Connect to deliver compliant data with speed and accuracy.

Mirth Connect (version 4.2) is 2015 Edition Cures Update compliant and has been certified by an ONC-Authorized Certification Body in accordance with criteria adopted by the Secretary of Health and Human Services. Mirth Connect met the rigorous standards for the security of healthcare data required to receive certification by SLI Compliance®, an ONC Authorized Certification Body. This certification signifies that Mirth Connect complies with all applicable certification requirements in support of the 21st Century Cures Act. With this certification, users have greater assurance of data integrity and optimal security when exchanging patient data.

HOW CAN WE HELP YOU?

Contact us at 855-510-6398 or results@nextgen.com

We are committed to making sure your medical practice can meet the complex regulatory demands of care delivery, today and tomorrow.

If you use NextGen® solutions, reach out to your account manager. If you are new to NextGen Healthcare, contact us at **855-510-6398** or **email results@nextgen.com**.

BELIEVE IN BETTER.®

1 "CMS Waivers, Flexibilities, and the Transition Forward from the COVID-19 Public Health Emergency," Centers for Medicare & Medicaid Services, February 27, 2023, https://www.cms.gov/newsroom/fact-sheets/cms-waivers-flexibilities-and-transition-forward-covid-19-public-health-emergency. **2** "Information Blocking," Official Website of The Office of the National Coordinator for Health Information Technology (ONC), Last reviewed October 31, 2022, https://www.healthit.gov/topic/information-blocking. **3** "NHE Fact Sheet," Centers for Medicare & Medicaid Services, last modified February 17, 2023. https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet. **4** Ibid. **5** Ibid.

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