Goodbye measures of data quantity, hello data quality measures of MACRA

Meaningful Use, MACRA, eCQMs, and EHRs: Practice and payment survival in a data-centric world

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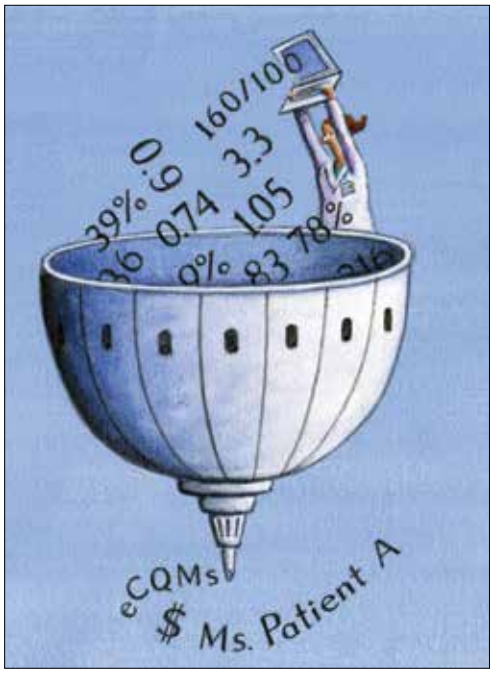

ILLUSTRATION: PAUL ZWOLAK FOR OBG MANAGEMENT

Practicing clinical medicine is increasingly challenging. Besides the onslaught of new clinical information, we have credentialing, accreditation, certification, team-based care, and patient satisfaction that contribute to the complexity of current medical practice. At the heart of many of these challenges is the issue of accountability. Never has our work product as physicians been under such intense scrutiny as it is today.

To demonstrate proof of the care we have provided, we have enlisted a host of administrators, assistants, abstractors, and other helpers to decipher our work and demonstrate its value to professional organizations, boards, hospitals, insurers, and the government. They comb through our charts, decipher our handwriting and dictations, guesstimate our intentions, and sometimes devalue our care because we have not adequately documented what we have done. To solve this accountability problem, our government and the payer community have promoted the electronic health record (EHR) as the "single source of truth" for the care we provide.

This effort received a huge boost in 2009 with the Health Information Technology for Economic and Clinical Health (HITECH) Act. HITECH authorized incentive payments through Medicare and Medicaid to health care providers that could demonstrate Meaningful Use (MU) of a certified EHR. This resulted in a boom in EHR purchases and installations.

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TABLE 1 The current progression of Meaningful Use stages[2]

	Stage of Meaningful Use										
First payment year	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
2011	1	1	1	*1 or 2	2	2	3	3	TBD	TBD	TBD
2012		1	1	*1 or 2	2	2	3	3	TBD	TBD	TBD
2013			1	*1 or 2	2	2	3	3	TBD	TBD	TBD
2014				*1 or 2	1	2	2	3	3	TBD	TBD
2015**					1	1	2	2	3	3	TBD
2016						1	1	2	2	3	3
2017							1	1	2	2	3

*3-month quarter electronic health record (EHR) reporting period for Medicare and continuous 90-day EHR reporting period (or 3 months at Stage option) for Medicaid eligible providers. All providers in the first year in 2014 use any continuous 90-day EHR reporting period.

**Data collected for 2015 affects 2017 payments. The date for application for hardship exemption is July 1, 2016. Forms can be downloaded at http://www.cms.gov.

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The deadline to apply for hardship exemption for Meaningful Use is July 1. This affects 2015 data for 2017 payments.

By 2012, 71.8% of office-based physicians reported using some type of EHR system, up from 34.8% in 2007.[1] In many respects this action was designed as a stimulus for the slow economy, but Congress also wanted some type of accountability that the money spent to subsidize EHR purchases was going to be well spent, and would hopefully have an impact on some of the serious health issues we face.

The initial stage of this MU program seemed to work out reasonably well. So, if a little is good, more must be better, right? Unfortunately, no. But, where did MU go wrong, and how is it being fixed? Contrary to popular belief, MU is not going away, it is being transformed. To help you navigate the tethered landscape of MU past and, more importantly, bring you up to speed on MU future (the Medicare Access and CHIP Reauthorization Act of 2015 [MACRA]) and your payment incentives in this data-centric world, we address MU transformation in this article.

Where Meaningful Use stage 2 went wrong

MU stage 2 turned out to significantly increase the documentation burden on health care professionals. In addition, one of the tragic unintended consequences was that all available EHR development resources by vendors went toward meeting MU data capture requirements rather than to improving the usability and efficiency of the EHRs. Neither result has been well received by health care professionals.

Stage 3 of MU is now in place. It is an attempt to simplify the requirements and focus on quality, safety, interoperability, and patient engagement. See "Meaningful Use stage 3 specifications" on page 28. The current progression of MU stages is depicted in **TABLE 1**.[2]

Our new paradigm

Now that EHR implementation is fairly widespread, attention is focused on streamlining the reporting and documentation required for accountability, both from the data entry standpoint and the data analysis standpoint. Discrete data elements, entered by clinicians at the point of care, and downloaded directly from the EHR increasingly will be the way our patient care is assessed. Understanding this new paradigm is critical for both practice and professional viability.

Challenges in this new era

To understand the challenges ahead, we must first take a critical look at how physicians think about documentation, and what changes these models of documentation will have to undergo. Physicians are taught to think in complex models that we document

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Meaningful Use stage 3 specifications

Objective 1: Protect patient health information. Protect electronic health information created or maintained by the Certified Electronic Health Record Technology (CEHRT) through the implementation of appropriate technical, administrative, and physical safeguards.

Objective 2: Electronic prescribing. Eligible providers (EPs) must generate and transmit permissible prescriptions electronically, and eligible hospitals must generate and transmit permissible discharge prescriptions electronically.

Objective 3: Clinical decision support. Implement clinical decision support interventions focused on improving performance on high-priority health conditions.

Objective 4: Computerized provider order entry. Use computerized provider order entry for medication, laboratory, and diagnostic imaging orders directly entered by any licensed health care professional, credentialed medical assistant, or a medical staff member credentialed and performing the equivalent duties of a credentialed medical assistant, who can enter orders into the medical record per state, local, and professional guidelines.

Objective 5: Patient electronic access to health information. The EP provides patients (or patient-authorized representatives) with timely electronic access to their health information and patient-specific education.

Objective 6: Coordination of care through patient engagement. Use the CEHRT to engage with patients or their authorized representatives about the patient's care.

Objective 7: Health information exchange. The EP provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their EHR using the functions of CEHRT.

Objective 8: Public health and clinical data registry reporting. The EP is in active engagement with a public health agency or clinical data registry to submit electronic public health data in a meaningful way using certified EHR technology, except where prohibited, and in accordance with applicable law and practice.

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Meaningful Use is not going away; stage 3 is now in place, focusing not on data quantity but on patient safety and engagement and EHR interoperability

as narratives or stories. While these models are composed of individual "elements" (patient age, due date, hemoglobin value, systolic blood pressure), the real information is in how these elements are related. Understanding a patient, a disease process, or a clinical workflow involves elements that must have context and relationships to be meaningful. Isolated hemoglobin or systolic blood pressure values tell us little, and may in fact obscure the forest for the trees. Physicians want to tell, and understand, the story.

However, an EHR is much more than a collection of narrative text documents. Entering data as discrete elements will allow each data element to be standardized, delegated, automated, analyzed, and monetized. In fact, these processes cannot be accomplished without the data being in this discrete form. While a common complaint about EHRs is that the "story" is hard to decipher, discrete elements are here to stay. Algorithms that can "read" a story and automatically populate these elements (known as natural language processing, or NLP) may someday allow us to go back to our dictations, but that day is frustratingly still far off.

TABLE 2 Proposed eCQM reporting timelines for Medicare and Medicaid EHR Incentive Program[2]

	2017 only	2018 and subsequent years	
Reporting method available	Attestation and electronic reporting	Attestation	Electronic reporting
Provider type who may use method*	All Medicare providers	Medicare providers with circumstances rendering them unable to eReport	All Medicare providers
CQM reporting period	• 1 CY for Medicare • 1 CY for returning Medicaid • 90 days for first time meaningful user Medicaid	• 1 CY for Medicare • 1 CY for returning Medicaid • 90 days for first time meaningful user Medicaid	
eCQM version required (CQM electronic specifications update)	2016 Annual Update	2016 Annual Update or more recent version	2017 Annual Update
CEHRT edition required	2014 or 2015 edition	2015 edition	

Abbreviations: CEHRT, certified electronic health record technology; CY, calendar year; eCQM, electronic clinical quality measures.
*Medicaid providers must refer to state requirements for reporting.

Hello eCQMs

Up to now, physicians have relied on an army of abstractors, coders, billers, quality and safety helpers, and the like to read our notes and supply discrete data to the many clients who want to see accountability for our work. This process of course adds considerable cost to the health care system, and the data collected may not always supply accurate information. The gap between administrative data (gathered from the *International Classification of Diseases Ninth* and *Tenth* revisions and *Current Procedural Terminology* [copyright American Medical Association] codes) and clinical reality is well documented.[3–5]

In an attempt to simplify this process, and to create a stronger connection to actual clinical data, the Centers for Medicare and Medicaid Services (CMS)[6] is moving toward direct extraction of discrete data that have been entered by health care providers themselves.[7] Using clinical data to report on quality metrics allows for improvement in risk adjustment as well as accuracy. Specific measures of this type have been designated eCQMs.

An eCQM is a format for a quality measure, utilizing data entered directly by health care professionals, and extracted directly from the EHR, without the need for additional personnel to review and abstract the chart. eCQMs rapidly are being phased into use for Medicare reimbursement; it is assumed that Medicaid and private payers soon will follow. Instead of payment solely for the quantity of documentation and intervention, we will soon also be paid for the quality of the care we provide (and document). **TABLE 2** includes the proposed eCQM reporting timelines for Medicare and Medicaid.[2]

MACRA

eCQMs are a part of a larger federal effort to reform physician payments—MACRA. Over the past few years, there have been numerous federal programs to measure the quality and appropriateness of care. The Evaluation and Management (E&M) coding guidelines have been supplemented with factors for quality (Physician Quality Reporting System [PQRS]), resource use (the Value-based Payment Modifier), and EHR engagement (MU stages 1, 2, and 3). All of these programs are now being rolled up into a single program under MACRA.

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MACRA has 2 distinct parts, known as the Merit-based Incentive Payment System (MIPS) and the Alternative Payment Model. MIPS keeps the underlying fee-for-service model but adds in a factor based on the following metrics:

- clinical quality (which will be based on eCQMs)
- resource use (a gauge of how many economic resources you use in comparison to your peers)
- clinical practice improvement (a measure of how well you are engaged in quality improvement, which includes capturing patient satisfaction data, and being part of a qualified clinical data registry is one way to demonstrate that engagement)
- meaningful use of EHR.

It is important to understand this last bulleted metric: MU is not going away (although that is a popular belief), it is just being transformed into MACRA, with the MU criteria simplified to emphasize a patient-centered medical record. Getting your patients involved through a portal and being able yourself to download, transmit, and accept patients' data in electronic form are significant parts of MU. Vendors will continue to bear some of this burden, as their requirement to produce systems capable of these functions also increases their accountability.

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Under the Alternative Payment Model, qualified physician practices receive a pool of money for care delivery, with unused funds profiting the practices

Measurement and payment incentive

In the MIPS part of MACRA, the 4 factors of clinical quality, resource use, clinical practice improvement, and meaningful use of EHR will be combined in a formula to determine where each practitioner lies in comparison to his or her peers.

Now the bad news: Instead of receiving a bonus by meeting a benchmark, the bonus funds will be subtracted from those providers on the low end of the curve, and given to those at the top end. No matter how well the group does as a whole, no additional money will be available, and the bottom tier will be paying the bonuses of the top tier. The total pool of money to be distributed by CMS in the MIPS program will only grow by 0.5% per year for the foreseeable future. But MACRA does provide an alternative model for reimbursement, the Alternative Payment Model.

Alternative Payment Model

The Alternative Payment Model is basically an Accountable Care Organization—a group of providers agree to meet a certain standard of care (eCQMs again) and, in turn, receive a lump sum of money to deliver that care to a population. If there is some money left over at the end of a year, the group runs a profit. If not, they run a loss. One advantage of this model is that, under MACRA, the pool of money paid to "qualified" groups will increase at 5% per year for the next 5 years. This is certainly a better deal than the 0.5% increase of MIPS.

For specialists in general obstetrics and gynecology it may very well be that the volume of Medicare patients we see will be insufficient to participate meaningfully in either MIPS or the Alternative Payment Model. Regulations are still being crafted to exempt low-volume providers from the burdens associated with MACRA, and the American Congress of Obstetricians and Gynecologists (ACOG) is working diligently to advocate for systems that will allow members to see Medicare patients without requiring the substantial investments these programs likely will require.

The EHR: The single source of truth

The push to make the EHR the single source of truth will streamline many peripheral activities on the health care delivery side as well as the payer side. These requirements will present a new challenge to health care professionals, however. No one went to medical school to become a data entry clerk. Still, EHRs show the promise to transform many aspects of health care delivery. They speed communication,[8] reduce errors,[9] and may well improve the safety and quality of care. There also is some evidence developing that they may slow the rising cost of health care.[10]

But they are also quickly becoming a major source of physician dissatisfaction,[11] with an apparent dose-response relationship.[12] Authors of a recent RAND study note, "the current state of EHR technology significantly worsened professional satisfaction in multiple ways, due to poor usability, time-consuming data entry, interference with face-to-face patient care, inefficient and less fulfilling work content, insufficient health information exchange, and degradation of clinical documentation."[13]

This pushback against EHRs has been heard all the way to Congress. The Senate recently has introduced the "Improving Health Information Technology Act."[14] This bill includes proposals for rating EHR systems, decreasing "unnecessary" documentation, prohibiting "information blocking," and increasing interoperability. It remains to be seen what specific actions will be included, and how this bill will fare in an election year.

So the practice of medicine continues to evolve, and our accountability obligations show no sign of slowing down. The vision of the EHR as a single source of truth—the tool to streamline both the data entry and the data analysis—is being pushed hard by the folks who control the purse strings. This certainly will change the way we conduct our work as physicians and health care professionals. There are innovative efforts being developed to ease this burden. Cloud-based object-oriented data models, independent "apps," open Application Programming Interfaces, or other technologies may supplant the transactional billing platforms[15] we now rely upon.

ACOG is engaged at many levels with these issues, and we will continue to keep the interests of our members and the health of our patients at the center of our efforts. But it seems that, at least for now, a move to capturing discrete data elements and relying on eCQMs for quality measurements will shape the foreseeable payment incentive future.

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Future technologies may replace our current billing platforms but, for now, eCQMs will determine our payments

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