EHR Report

Restoring the promise of (really) meaningful use

By Chris Notte, MD, and Neil Skolnik, MD

When we started publishing the EHR Report several years ago, our very first column was a brief overview of a new federal incentive program known as Meaningful Use. At that time, the prospect of receiving thousands of dollars to adopt an electronic health record seemed exciting, and our dream of health care's digital future appeared to be coming true.

Best of all, we as physicians would be paid to simply embrace it!

Unfortunately, it wasn't long before that dream (for many at least) devolved into a nightmare. Electronic health records hadn't been designed to fit into physicians' long-established work flows, and just weren't up to the challenge of increasing efficiency. In fact, EHRs quickly became virtual taskmasters, leaving physicians mired in a sea of clicks and slow-moving screens.

Frankly speaking, Meaningful Use hasn't lived up to its promises. With measures obligating users to fill in a myriad of check-boxes and document often irrelevant information, the program has seemed less like an incentive and more like a penance.

To top it off, the all-or-nothing requirement has meant that—after a year of hard work—providers missing even one goal receive no payments at all, and instead are assessed financial penalties!

All of this has appropriately led physicians to become jaded—not excited—about the digital future.

Thankfully, there is reason for hope: 2017 marks the end of Meaningful Use under Medicare

What's new for 2017?

In spite of great initial intentions and several revisions, the EHR Incentive Program has never made the use of electronic records "meaningful," but it will soon disappear. Along with two other incentive payment programs (the Physician Quality Reporting System and the Value-Based Payment Modifier), it is being consolidated under the Quality Payment Program, established as part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

MACRA has a much grander scope and sets an even loftier goal: transforming care delivery to achieve better value and ultimately healthier patients.

Now, in case you're not already confused by the number of programs cited above, there is one more we need to mention to explain the future of EHR incentives: the Merit-Based Incentive Payment System, or MIPS, one of two tracks in the Quality Payment Program.

The majority of Medicare providers will choose this track, which focuses on four major components to determine reimbursement incentives: quality, improvement activities, advancing care information, and cost.

Depending on performance in each of these areas, participants will see a variable payment adjustment (upward or downward) in subsequent years (this is a percentage of Medicare payments that increases annually, beginning with a possible + / ~ 4% in 2019, to a maximum of + /- 9% in 2022).

Providers under MIPS who choose to attest for this year might select from three levels of participation:

1. Test: submission of only a minimal amount of 2017 data (such as one or two measures) to avoid penalty.
2. Partial: submission of 90 days' worth of data, which may result in a neutral or positive payment adjustment (and may even earn the max adjustment).
3. Full: submission of a full year of data.

Here's an example of how this will work: A provider who attests in March 2018 for the full 2017 year and does really well could see up to a 4% incentive bonus on Medicare payments in

2019. A provider who chooses not to attest would receive a penalty of 4%.

It's worth noting here that MIPS expands upon the inclusion criteria set for Meaningful Use under Medicare. Medicare Part B clinicians are eligible to participate if they bill $30,000 in charges and see at least 100 Medicare patients annually. MIPS also broadens the list of eligible provider types. Physicians, nurse practitioners, physician assistants, clinical nurse specialists, and certified registered nurse anesthetists are all able to attest.

Advancing Care Information

Under MIPS, Meaningful Use is replaced by an initiative called Advancing Care Information, or ACL In this new incarnation, there are fewer re- quired measures, and they are much less oner- ous than they were under the former program.

Also, there are a number of optional measures. A provider may choose to attest to these nonrequired metrics to improve his or her chances of achieving the maximum incentive, but it isn't necessary.

There are also bonus measures involving public health registry reporting. These are optional but a sure bet to increase incentives. In all, the ACI component composes 25% of a provider's final MIPS score.

For 2017, participants are able to choose one of two tracks in the ACI program, depending on their EHR's certification year.

(If you are confused by this or don't know the status of your product, check with your vendor or go to https://chpl.healthit.gov to figure it out.)

Providers with technology certified to the 2015 edition (or a combination of technologies from the 2014 and 2015 editions) can fully at- test to the ACI objectives and measures or elect to use the transition objectives and measures. Those with 2014 edition software must choose the transition measures.

We will cover the specific measures in a future column, but for now we'll note that both tracks are very similar and focus on protecting patient data, encouraging patient access to their own records, and sharing information electronically with other providers.

Rekindling the dream

We are certain that changing legislation won't solve all of the problems inherent in current EHR systems, but we are always encouraged by any attempt to reduce the documentation burden on physicians. By eschewing thresholds, eliminating the all-or-nothing requirement, and reducing the number of required measures, the ACI program does seem to shift the focus away from volume and toward value.

That alone has the potential to restore our hope of a brighter future, and make our use of electronic health records significantly more meaningful.

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Note: To learn more about the Quality Payment Program and MIPS, we highly recommend an online resource published by the Centers for Medicare & Medicaid Services that is easy to follow and is full of useful information. It can be found at https://qpp.cms.gov.

Ref: Notee, Chirs, Neil Skolnik, Internal Medicine News, June 1, 2017, page 27.