Operating EHR Under MACRA

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Understanding MACRA & MIPS

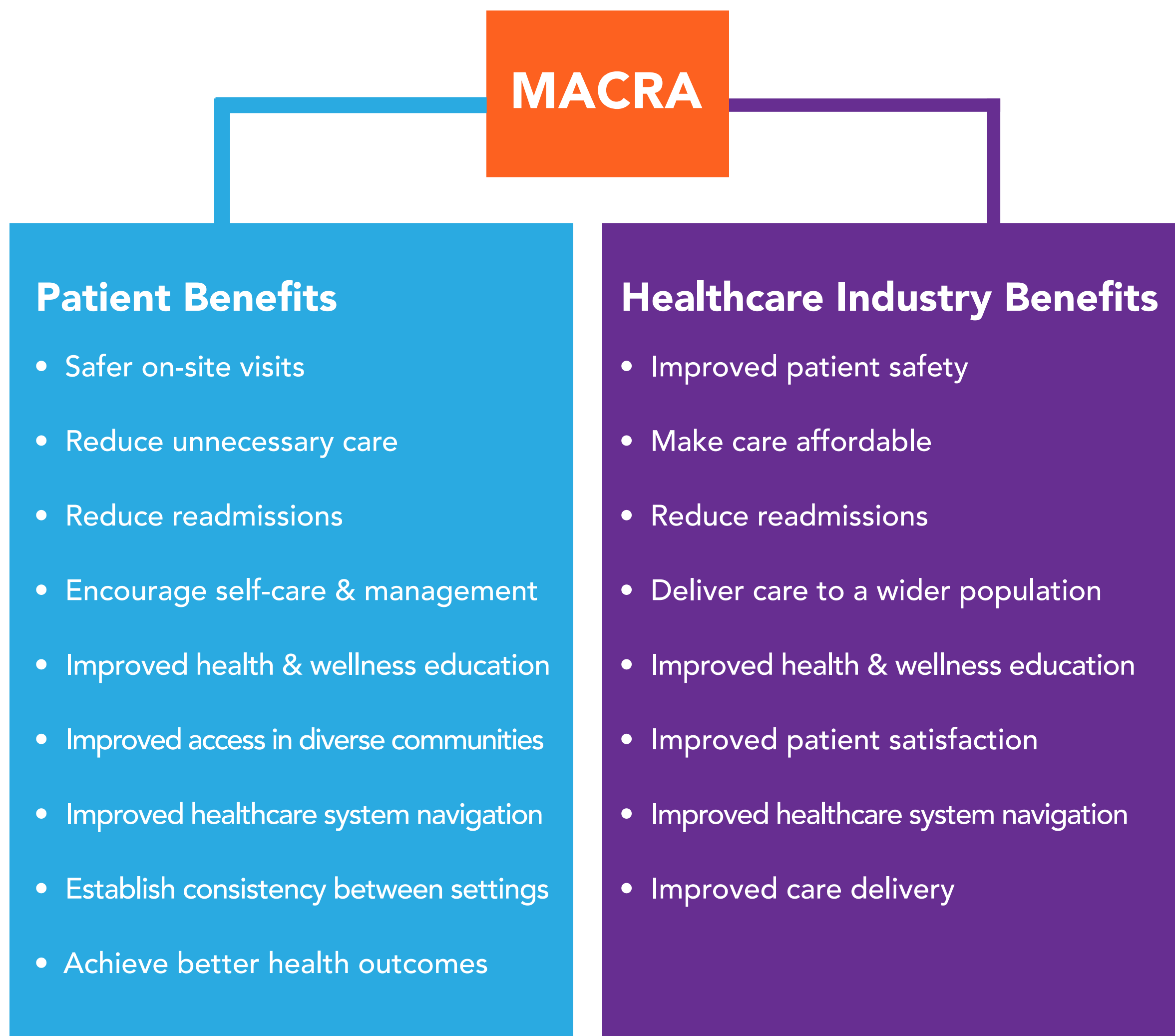
The Medicare Access & CHIP Reauthorization Act (MACRA) and its associated payment programs, the Merit-Based Incentive Payment System (MIPS) and the Advanced Alternative Payment Models (APMs), were passed by the U.S. Congress in 2015. With the final rule published as of October 2016, the payment programs are slated to be fully implemented in 2019. Because these payment programs are replacing Meaningful Use, reporting practices are being rolled out gradually, starting with 2017 as the first full reporting year.

Let's push away the timeline for a moment. What can healthcare providers actually take away from the implementation of MACRA?

Emphasis is being placed on patient care quality over cut and dry fee-for-service compensation.

Why is MACRA Compliance Important?

MACRA applies to Medicare-covered individuals, which means providers are compensated for treating those individuals based on claims filed to the governmental agency, the Centers for Medicare & Medicaid Services (CMS). Instead of treating a higher volume of patients to recover the most revenue (which was the old model), physicians and practices are encouraged to treat patients more carefully and in an interactive manner. The idea is that doing so will yield a number of benefits for both patients and the healthcare industry.



These goals are admirable, but progress needs to be tracked. In order to ensure providers are taking unified steps toward improving care delivery, the CMS requires data. That's where MIPS comes in.

Merit-Based Incentive Payment System (MIPS)

To encourage healthcare providers and facilities to take part in the MACRA initiative, the plan describes the use of Quality Payment Programs (QPP). These programs include MIPS and Advanced ABMs. Only certain eligible professionals can take part in Advanced ABMs if they meet certain criteria, and the measures involve "taking on some risk related to their patients' outcomes." The appeal for these programs is that providers have the potential to receive a higher incentive payment. The CMS expects the majority of healthcare providers to take part in MIPS, however.

Under MIPS, there are three categories of data, called measures, that can be reported on in order to receive appropriate incentives. Those categories are listed as Quality, Improvement Activities, and Advancing Care Information.

Quality

Most providers will be familiar with Quality measures, as they replace the Physician Quality Reporting System (PQRS) that was implemented previously. Quality measures include data collected from patient treatment cases and describe care outcomes. There are 271 Quality measures that apply to various diagnoses and treatment plans. The measures generally take the form of statistical information about percentages of the provider's care population that meet certain criteria. This can include the diagnosis of certain ailments, administration of specific treatments, or prescriptions made for a given ailment.

Improvement Activities

Improvement Activities do not replace or update a previous initiative. Reports in this category help the CMS verify that providers are able to transition effectively into the MACRA program. Providers can submit information about process improvements, enrollment in data collection and care monitoring programs, and other categories that contribute to quality control within the practice.

Spotlight on EHR: Advancing Care Information

The final category that healthcare providers need to report on involves the integration of appropriate Healthcare Information Technology (HIT) for ongoing data collection and transmittal. More specifically, it relates to the implementation of Electronic Health Records (EHR) software. Although Quality measures are weighted the most heavily for providers participating in MIPS, the Advancing Care Information category is vital. Without the implementation of EHR systems, providers are forced to rely on traditional methods, like submittal to a healthcare registry. EHR is preferred because it's considered expedient, secure, and minimizes the risk of data collection errors.

A provider can often cover Advancing Care Information measures at the same time as submitting Quality measures simply by using their EHR to make the submission.

Key Data to Maintain

A diverse range of quality measures can be collected with the use of EHR. The following list describes some of the measure objectives included under the Advancing Care Information category of MIPS.

ELECTRONIC PRESCRIBING

Electronic Prescribing, or e-Prescribing, is a common tool in most well-known EHR systems. Providers can use their EHR to reference a drug formulary and subsequently submit prescription orders directly to the patient's pharmacist.

HEALTH INFORMATION EXCHANGE (HIE)

HIE gives providers a way to transmit or request health records electronically for a given patient. This is especially important with the arrival of new patients, where the receiving physician needs to verify prior conditions, treatments, allergies, etc.

PUBLIC HEALTH REPORTING

Healthcare providers may need to report care information or new diagnoses to public health agencies to as mandated by local, state, or federal government. Data can be exported from the EHR and submitted to these appropriate organizations.

PATIENT-SPECIFIC EDUCATION

Certified EHR technology can be used to access educational materials and in turn deliver them to patients for review. In addition to transparency between the provider and patient, this reinforces the self-management goal of MACRA.

PATIENT ELECTRONIC ACCESS

A digital version of the patient's health record can be accessed online and reviewed by the patient from any device. Certified EHR products feature built-in Application Programming Interfaces (APIs) that allow for this access.

SECURE MESSAGING

The provider can show that they have communicated directly with their patient using a secure messaging tool. This is not a required measure, as not all certified EHR products feature these tools.

PROTECT PATIENT HEALTH INFORMATION

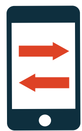
Included in MACRA are instructions for security risk analysis, security system updates, and specifications for the encryption of patient health records. Certified EHR vendors put the infrastructure in place, but it is the clinician's responsibility to take proper steps toward ongoing risk reduction.

Using EHR for Data Submission

Exchange-Ready Systems

Certified EHR (CEHR) technology is equipped with reporting functions that meet standards set forth on a national level by the CMS. There are currently just under 3,700 active CEHR systems listed on the national Certified Health IT Product List (CHPL). An EHR system is deemed "certified" when it can transfer information securely, by electronic means, and in the appropriate file format.

Because all CEHR systems follow the same standards for interoperability, most widely-used CEHR software is packaged with Health Information Exchange (HIE) functionality. Providers can send or receive patient data directly from their system using these built-in tools. There are three operations that fall under HIE. As defined by HealthIT.gov, they are:



Directed Exchange: "The ability to send and receive secure information electronically between care providers to support coordinated care."

Query-Based Exchange: "The ability for providers to find and/or request information on a patient from other providers, often used for unplanned care."

Consumer Mediated Exchange: "The ability for patients to aggregate and control the use of their health information among providers."

Submitting Measures

While these exchange methods are used to pass patient information between facilities, providers, and patients, submitting MIPS or APM measures is a little different. Providers can only submit some of their measures through their CEHR. For example, there are 271 approved quality measures to choose from, but only 53 of those measures can be reported directly through the CEHR. It's also worth noting that different CEHR systems may only be able to some of those 53 measures. It will depend on what APIs the software developer has built for.

Although they cannot be submitted directly, the other measures can still be collected from CEHRs, however. Providers can export the data from their system and deliver it to a qualified data submission vendor (DSV). After the data has been handed off, the DSV is responsible for submitting the measures to the CMS for the program year. Because of the interoperability standards previously stated, the data exported from the CEHR will almost always be in an appropriate format by default. If there are any special submission steps, the DSV usually provides providers with instructions.

Compliance with MACRA can be overwhelming. So much emphasis is put on using CEHR systems, which, although functional, are often difficult to use. When the ultimate goal of MACRA is to improve physician and patient interactions and deliver higher quality care, having a distracting computer screen in the exam room is counter-productive. In order to ditch the screens and clicks without sacrificing vital data-gathering, many hospitals, clinics, and small practices have implemented mobile EHR apps in their process.

Mobile EHR apps like iScribe are changing the pay that patients experience - and physicians deliver - quality care. Where CEHR systems are often difficult to navigate and log data, mobile EHR apps boast intuitive and easily navigable interfaces. By combining touch, voice-to-text, and predictive terminology functionality, doctors can gather the information they need for their MIPS measures about 33% faster than through the base CEHR. Operating a tablet or smartphone in the exam room also adds the qualitative benefit of a more intimate, conversational interaction with patients. In short, mobile EHR apps allow care providers to simultaneously improve patient satisfaction while meeting MACRA requirements.

Implementing a mobile EHR app is a simple process, too, and doesn't require a rip-and-replace of a practice's existing CEHR system. Instead, the mobile EHR app relies on an API integration with the underlying software. Setup can be performed in minutes, and providers don't need to worry about adjusting their planned measures to comply with new system functionality. It's the same CEHR, just with a functional facelift.

To learn more about the iScribe mobile EHR app, visit www.iscribehealth.com

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