MACRA Targets Meaningful in Meaningful Use

By Barry P. Chaiken, MD, MPH

The 2015 Medicare Access and CHIP Reauthorization Act (MACRA) opened the way for the U.S. Department of Health and Human Services (DHHS) to streamline the quality improvement and healthcare information technology programs it built over the past several years.

Since the passage of the 2009 HITECH Act, the quality reporting and meaningful use criteria have grown in complexity and breadth, making their program guidelines difficult to follow. The proposed MACRA rule attempts to lessen the burden for physicians (a rule for provider organizations is under development) while working to better achieve goals of improved quality of care and effective use of information technology.

Currently, Medicare physicians submit data to a variety of uncoordinated quality reporting programs: accountable care organizations, the Comprehensive Primary Care Initiative, Medicare Shared Savings Program, the Physician Quality Reporting System, the Value Modifier Program, and the electronic health record (EHR) incentive program (i.e., meaningful use).

The proposed MACRA rule attempts to aggregate current reporting programs into a more manageable form by offering two distinct reporting options and reducing the number of metrics required overall. The new Quality Payment Program offers two paths: the Merit-Based Incentive Payment System (or MIPS) and the advanced Alternative Payment Models (or APMs).

The proposed rule targets only eligible clinicians who receive payment from CMS and includes a long list of providers in addition to physicians. The reporting period for quality measures begins in calendar year 2017, with the results impacting CMS payments in calendar year 2019.

DHHS expects most program clinicians to participate in the MIPS program. As outlined, the MIPS program adjusts reimbursement based on four areas:

1. **Quality**—from a broader list, clinicians choose six key measures, with results accounting for 50% of the overall incentive score
2. **Cost**—using claims, DHHS assigns a value equal to 10% of the overall incentive score
3. **Advancing Care Information**—with emphasis on interoperability and information exchange, clinicians choose to report on their use of information technology, with this measure impacting 25% of the overall incentive score
4. **Clinical Practice Improvement Activities**—from a list of 90 options, clinicians choose activities that match their practice, with results impacting 15% of the overall incentive score

Clinicians who participate to a "sufficient extent" in various advanced APMs may be exempt from the MIPS reporting requirements and qualify for incentive payments. Advanced APMs must meet three proposed requirements to earn these payments: 1) use of EHRs, 2) payment for professional services based on acceptable quality measures, and 3) existing as an enhanced medical home or bearing more than nominal risk for financial losses. Such APMs include the Comprehensive Primary Care Plus (CPC+) model, Next Generation ACOs, and other types of programs where clinicians accept both risk and reward for delivering high-quality, patient-centered, coordinated care.

DHHS expects to distribute $500 million in incentive payments in 2019 to eligible clinicians as a consequence of the MIPS program. In addition, the agency estimates the APM incentive program will disburse $200 million in incentive payments.

Impact on health IT

Although the HITECH Act and the meaningful use program delivered on their promise to increase the availability of EHRs to clinicians, the impact of these programs remains controversial. With more than $30 billion spent on incentives, little evidence exists that quality of care improved or costs were reduced. In addition, many physicians report that the use of EHRs reduced their productivity, and patients continue to complain about their struggles to obtain complete medical records.

While some consider the meaningful use program a failure, that viewpoint has overtones of Monday morning quarterbacking. Although the HITECH Act focused on facilitating implementation of EHRs, its inclusion in the broader American Recovery and Reinvestment Act (ARRA) signifies its general purpose: to serve as part of an economic stimulus program focused on helping the U.S. emerge from the deepest recession since the Great Depression.

In addition to improving healthcare delivery through the use of information technology, DHHS needed its meaningful use program to incentivize provider organizations to rapidly deploy EHRs so that the funds devoted to the program would be part of the overall ARRA stimulus effort. This probably explains why meaningful use stage 1 criteria contained relatively simple usage metrics.

As the Office of the National Coordinator for Healthcare Information Technology's committees worked on meaningful use stage 2, they also scrutinized more valuable metrics focused on quality, safety, and cost savings. Unfortunately, those

metrics required much more comprehensive and difficult-to-obtain data elements that greatly increased in complexity when applied across a diverse and disparate delivery system. For example, the data elements, processes, and performance metrics vary widely among internal medicine, obstetrics, and ophthalmology practices.

Focus on interoperability

In retrospect, the meaningful use program should have focused on interoperability and the simple, seamless exchange of clinical information among providers and disciplines. This is a critique of the program as executed, not of the intent of the participants, who represented all stakeholders in the healthcare information technology universe. They put forth their best efforts, irrespective of the current results.

That said, now is the time to correct the program, and MACRA offers that opportunity. By completely refocusing the CMS payment incentives on quality, cost, advancing care information, and clinical practice improvement activities, DHHS targets a less prescriptive and more flexible set of objectives that allows for innovation and flexibility among practices.

To achieve proper reporting of quality and process metrics requires a robust exchange of medical information, regardless of care setting. Only through actual, reliable, and complete interoperability can providers generate the reports necessary to satisfy MACRA reporting requirements and obtain incentive payments.

MACRA offers an opportunity to reboot the meaningful use program and allow it to facilitate what it should have incentivized back in 2009: comprehensive clinical information interoperability. With the value of 20-20 hindsight, let's hope providers, EHR vendors, and government agencies agree that MACRA offers them a do-over to get the problem of interoperability fixed once and for all. This time, patients are watching carefully.

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SUGGESTED READING

Miliard, M. (2016, April 27). MACRA proposed rule published by HHS, streamlining federal programs including meaningful use. Retrieved from http://www.healthcareitnews.com/news/macra-proposed-rule-published-hhs-streamlining-federal-programs-including-meaningful-use

Wynne, B., Pahner, K., & Zatorski, D. (2016, April 29). Breaking down the MACRA proposed rule [Blog post]. Retrieved from http://healthaffairs.org/blog/2016/04/29/breaking-down-the-macra-proposed-rule/