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Certified Electronic Health Record Technology Under the Quality Payment Program

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Key Findings

- The quality payment program (QPP) is a value-based care reimbursement system for Medicare providers.
- For full reimbursement and performance success, the QPP requires practices to fully adopt certified electronic health record technology (CEHRT). CEHRT adoption is a requirement on its own, and related to other QPP requirements such as practice improvement activities and the reporting of quality measures.
- Small and rural practices have historically faced barriers in the adoption of CEHRT, and consequently, if practices are unable to participate and succeed in value-based care systems going forward, they may be at risk of monetary penalties.
- In this article, the authors make four recommendations for assisting small and rural practices in adopting CEHRT for QPP participation:
- Provide adequate incentive funds for small and rural practices
  1. Help clinicians adopt and fully incorporate CEHRT
  2. Ensure CEHRT is designed to ease the burden of reporting
  3. Encourage virtual reporting and collaborations with APMs.

The Quality Payment Program (QPP) is a Medicare Part B reimbursement system designed to incentivize value-based care over volume-based care. The QPP has two tracks for clinicians: the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (Advanced APMs). Both QPP tracks require clinicians to adopt and use certified electronic health record technology (CEHRT) for full reimbursement.

Not only is CEHRT central to one of the four MIPS scoring categories and a requirement of Advanced APMs, but integrated technology also plays a vital role in a practice's ability to function in a value-based care system. CEHRT can facilitate communication and data sharing between clinicians, which is usually necessary in value-based care models; and CEHRT can ease the burden of reporting, a central component of value-based care models.

Some practices, especially those that are small or in rural areas, may lack the resources (financial, staffing, or otherwise) to implement or upgrade health information technology (IT) systems. The QPP provides practices with incentives and penalties to adopt CEHRT; those unable to do so may be uncompetitive under this new reimbursement system. In this issue brief, we discuss the role of CEHRT in the QPP in more detail and offer policy recommendations to help small and rural practices adopt CEHRT, improve health IT capabilities, and participate in value-based care.

The QPP and CEHRT

Under the MIPS track of the QPP, Medicare reimbursement is tied to performance on the MIPS score, which has four main components, each carrying a different weight with regard to the total overall score. The four components represent

developments in (1) quality; (2) cost or resource use; (3) clinical practice improvements (called "Improvement Activities"); and (4) interoperable, electronic health records (EHRs) and information exchange. This last MIPS category, Advancing Care Information (ACI), replaced the EHR Incentive Program when the QPP was implemented in 2017 (Table 1).

Table 1. MIPS performance score components

MIPS component	Existing program being replaced	CEHRT in the component
Quality	Physician Quality Reporting Program—with an emphasis on outcome measures	CEHRT is central to monitoring and reporting MIPS quality measures
Cost/Resource Use	Value-Based Payment Modifier program	
Improvement Activities	New performance category for the Medicare program designed to account for efforts to improve service delivery that had not been previously reimbursed	Bonus points for reporting through CEHRT
Advancing Care Information	Medicare Electronic Health Records Incentive program	Based on ability to use an increasingly sophisticated health IT

MIPS = Merit-Based Incentive Payment System; CEHRT = certified electronic health record technology; IT = information technology.

Stage 1 of the EHR Incentive Program, a program to encourage adoption and meaningful use of CEHRT, began in 2011 and focused on the collection and sharing of data. Stage 2 was introduced in 2014, with the goal of advancing clinical processes, and Stage 3 was slated to start in 2017, with the goal of improved outcomes.[1] Stage 3 was replaced with the ACI component of MIPS for Medicare clinicians. Although the stages of the EHR Incentive Program were designed to be completed sequentially, practices had the option to begin Stage 1 in different years. Likely, practices with more advanced health IT capabilities were more disposed to attest to the EHR Incentive Program, whereas practices that did not have advanced health IT capabilities opted to never participate in the EHR Incentive Program. Consequently, as of the start of the QPP in 2017, not all practices had reached the same standard of CEHRT adoption.

Many of the ACI measures are like those in Modified Stage 2 of the EHR Incentive Program; individuals' scores are based on their capacity to protect patient health information, provide patient access to electronic health information, and exchange health information among clinicians and facilities.[2] Although CEHRT adoption and use is central to a high score on the ACI, CEHRT use is also relevant for high performance in the other three MIPS score components as well.

ACI bonus points are available if clinicians use CEHRT to attest to the Improvement Activities component, and many of the activities in that component require CEHRT and health IT capabilities. For example, Improvement Activities include expanding practice access using e-visits and telehealth, improving care coordination through electronic capture, and sharing specialist reports or consults with referring clinicians. Patient portals, secure messaging, health information exchange, and interoperability are the most frequently cited forms of health IT that earn clinicians points toward their MIPS score in the Improvement Activities category.

CEHRT also facilitates reporting of the MIPS quality category. Specifically, CEHRT enables clinicians to capture, track, and report electronic clinical quality measures (eCQMs) and electronic quality data. The QPP final rule, for the first year of the program, allows clinicians—either as individuals or groups—to submit MIPS quality data through multiple methods. Some of these, such as EHR-based reporting and the CMS Web Interface (a quality data reporting mechanism used by accountable care organizations and many group practices), rely on CEHRT capabilities to capture the numerator, denominator, and exception and exclusion data needed for electronic quality measure reporting. Small and rural practices without these submission capabilities may be limited to other, more labor-intensive reporting methods during the 8-week submission period.

In addition to MIPS, the Advanced APM track is available to clinicians participating in Medicare APMs that meet certain requirements. To qualify as "advanced," a MIPS APM must tie payments to quality measures, engage participating clinicians in two-way risk sharing, and meet CEHRT criteria. Adoption of CEHRT is a core component of the QPP and provides opportunities to earn MIPS bonus points toward full reimbursement. Eligible clinicians who cannot comply with the QPP are at risk of monetary penalties; there are some exemptions for clinicians in small or rural practices.

Recommendations

Several recommendations follow for assisting clinicians, especially those in small practices and rural areas, in implementing CEHRT and facilitating compliance with the QPP requirements. Our recommendations echo concerns cited in a 2016 US Government Accountability Office (GAO) report on value-based payment model participation challenges for small and rural practices[3]; however, our recommendations are specific to the QPP. Key concerns listed in the GAO report were resources for setting up health IT (including time, knowledge, and capital) and the ability to use the technology to improve patient care, practice flow, and quality reporting.

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Recommendation 1: Provide Adequate Incentive Funds for Small and Rural Practices

CEHRT is considered a central component in the transition to payment for quality (value-based care), and health IT systems are expensive. Although large practices can distribute expenses across multiple clinicians and subunits, the total price tag associated with transitioning to CEHRT may be a barrier for small and rural practices. In the past, the EHR Incentive Program provided funds to aid with implementation for first time users; however, this program was replaced by the QPP. Clinicians who did not take advantage of the EHR Incentive Program funds and are now looking to adopt CEHRT to participate in the QPP may still face financial barriers. An incentive program targeted at supporting the implementation of EHR systems could help first-time adopters looking to participate in the QPP with initial capital expenditures.

Recommendation 2: Help Clinicians Adopt and Fully Incorporate CEHRT

CMS has pledged additional resources to help small or rural practices develop the technological capabilities to comply with the CEHRT requirements of the QPP through the creation of the MACRA [Medicare Access and CHIP Reauthorization Act of 2015] Quality Improvement Direct Technical Assistance (MQIDTA) program.[4] Modeled after the Regional Extension Center (REC) program, the MQIDTA program will provide education and training programs targeting practices with 15 or fewer clinicians.[5] Although the REC program was positively associated with adoption of EHRs in small and rural practices, barriers—such as training staff to use EHRs and designing and implementing workflow changes to accommodate EHRs—remained.[6]

The MQIDTA program will need to do more than the REC to help practices incorporate technology as a routine aspect of practice procedures. This could include building EHR templates to be used as a framework or establishing a best practices toolkit to help with staff training. Also, CMS should provide practice transformation funds targeted to practices that have adopted CEHRT but are having difficulties integrating health IT in their clinic processes.

Recommendation 3: Ensure CEHRT Is Designed to Ease the Burden of Reporting

Like most value-based care programs, the QPP requires multiple types of reporting. Clinicians often cite reporting fatigue and smaller practices have noted difficulties in entering, managing, analyzing, and reporting data to federal agencies.[6] CEHRT adoption may ease the burden of MIPS reporting by automating certain aspects of quality reporting, freeing up administrative time within a practice.

The Application Access (Application Program Interface, or API) certification criteria in the CEHRT 2015 Edition should help health IT vendors develop applications that more easily capture and share EHR data, thereby simplifying these tasks. CMS should work with the Office of the National Coordinator for Health IT to ensure robust testing and certification of CEHRT, which is adopted more frequently by small and rural practices relative to 2015 Edition criteria, especially in relation to APIs and eCQMs.

In addition, the MQIDTA should track which health IT vendors are serving small and rural practices, review the capabilities of these vendors to report certified eCQMs in the MIPS measure set, and work with practices adopting these systems to ensure their vendors are able to report the specific eCQMs the practices have selected. Additional communication about what clinicians, especially those in small and rural practices, need for MIPS reporting would allow applications to be tailored to the program, further automating the MIPS reporting process. As Recommendations 1 and 2 mention, targeted funds and technical support will make it easier for small and rural practices (who are more frequently not up-to-date in their health IT capabilities) adopt and use CEHRT.

Recommendation 4: Encourage Virtual Reporting and Collaborations with APMs

Economies of scale are relevant when it comes to reporting. Clinicians reporting through larger groups can use a centralized reporting entity, whereas clinicians reporting in smaller groups or solo will have to use their own staff and time for reporting. Although large groups make reporting easier, joining a large group may be unattractive (because it is often associated with the loss of autonomy) or infeasible (some practices do not have a nearby large practice to join) for some small or rural practices. Clinicians in small or rural practices may want to join virtual groups to share resources for MIPS reporting while leaving their autonomy and physical location unchanged.

The QPP allows practices with fewer than 10 clinicians to band together with other solo and small practices to form virtual groups that allow practices to retain their autonomy but take advantage of economies of scale in reporting. Alternatively, small practices can join regional Advanced APMs to avoid MIPS reporting, but only if they can share information with other entities (they will still have to report to the APM entity according to the APM rules).[6] Clinicians share risk when they report in groups or join an APM, and because small or rural practices may not know which clinicians to partner with or which APMs to join, guidance and support is needed to facilitate group reporting and selection of APMs. The MQIDTA should provide practices with access to resources that can help small or rural practices assess the benefits and

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risks of joining either these entities or a new virtual group that will preserve their independence while providing important economies of scale related to reporting.

Conclusion

Small and rural practices provide unique benefits in our health care system, such as coordinating care for individuals who would otherwise be marginalized and responding directly and more personally to the individual needs of their patient populations. However, some aspects of the modern health care system, including the shift to a value-based payment system, lend themselves to economies of scale.

QPP exemptions for clinicians in small or rural practices and a graduated program roll out ("pick-your-pace") in Performance Year 1 may delay penalties related to noncompliance with CEHRT. However, in future years, QPP bonuses and penalties become larger and practices that are unable to successfully participate in the program will incur financial losses. Lower revenue will impact a practice's ability to implement and integrate CEHRT capabilities, creating a steeper uphill challenge to participation in value-based care programs and success in the QPP. Support for CEHRT should be meaningful and occur in a timely fashion to avoid preventing clinicians in small and rural practices from fully participating in a value-based care system.

The value-based care movement is likely here to stay and with it comes attestation to quality measurement and improvement activities, areas in which CEHRT continues to play an important role. CEHRT is essential to participation in a value-based payment system. To move practices with less health IT infrastructure to adopting CEHRT, we recommend

1. Targeted financial support for adopting CEHRT
2. Educational support and ongoing, adaptive training for CEHRT adoption and integration
3. A commitment to ensuring that health IT vendors provide necessary functional capabilities and support to small and rural practices
4. Guidance in developing economies of scale through virtual groups and regional APMs.[7,8]

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