Taking Meaningful Use to the Next Level:
What You Need to Know about the MACRA Advancing Care Information Component
Taking Meaningful Use to the Next Level: What You Need to Know about the MACRA Advancing Care Information Component

Table of Contents

Introduction  1

1. ACI Versus Meaningful Use  2
   EHR Certification  2
   Reporting Periods  2
   Reporting Methods  3
   Group Reporting  3
   Scoring  3

2. ACI Scoring  4
   Base and Performance Scoring  4
   ACI Bonus Related to MIPS Clinical Improvement  6

3. The Importance of Protecting Patient Health Information  6

4. What You Should Be Doing Now  7
   Patient Privacy  7
   Technology Review  7
   Know the Score  7

Summary  8
About Hayes  8
Sources  9
Introduction
The CMS EHR incentive program – better known as Meaningful Use – has been maligned in many corners of the healthcare industry, but it’s hard to argue with the results. Since the beginning of Stage 1 Meaningful Use in 2011, EHR adoption has grown to 83% of basic systems and 96% for certified EHR technology, according to the Office of the National Coordinator for Health Information Technology (ONC). A study published in Health Affairs in November 2015 concluded that nearly 100 percent adoption of basic EHR’s “is possible in the near future.”

The implementation of MACRA promises to take the integration of electronic records to another level. The Advancing Care Information (ACI) component of the MIPS track of MACRA replaces Meaningful Use and expands to include MIPS eligible clinicians who were not previously eligible for Meaningful Use incentive payments such as physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists and hospital-based EP’s.

ACI continues to support the foundational objectives of the HITECH Act of 2009 and Meaningful Use, and aims to encourage ongoing progress on key uses such as health information exchange and patient engagement. CMS feels these more challenging objectives are “essential to leveraging certified EHR technology to improve care coordination and represent the greatest potential for improvement and significant impact on delivery system reform.”

CMS has outlined several major goals in designing the requirements for ACI:

- Increase clinician and patient engagement
- Encourage the use of certified EHR technology (CEHRT)
- Place emphasis on performance
- Promote innovation and interoperability
- Improve physician and patient access to data

ACI represents 25 percent of your composite MIPS score – the measurement that determines incentive and penalty payments under MACRA - so it’s critical to understand what it involves.

There has been concern over what additional changes may be coming to MACRA post election. However much of the discussion has focused on the Affordable Care Act. MACRA was overwhelming approved with bipartisan support by Congress, 392-27 in the House of Representatives and 92-8 in
Taking Meaningful Use to the Next Level: What You Need to Know about the MACRA Advancing Care Information Component

the Senate, so it is likely here to stay. It’s a safe bet that regardless of what changes may be coming, increased use of technology will be an ongoing focus.

This paper will provide an in depth review of the ACI component of MACRA and its scoring methodology as well as offering guidance on what you need to do to be ready for implementation.

I. ACI Versus Meaningful Use

In designing the ACI category, CMS sought to improve and encourage the use of certified EHR technology (CEHRT) over time by adopting a new, more flexible scoring methodology than Meaningful Use. The goal is to allow MIPS eligible clinicians to use EHR technology in a way that is more relevant to their practice. The new scoring system puts a greater focus on Patient Electronic Access, Coordination of Care Through Patient Engagement and Health Information Exchange to improve care and further interoperability.

CMS also felt that de-emphasizing some of the objectives of meaningful use which clinicians have historically achieved high performance would reduce burden, encourage greater participation, and direct attention to other objectives and measures that have significant room for continued improvement.

In an effort to streamline and simplify MIPS reporting requirements, CMS will not require reporting of two Meaningful Use measures - Clinical Decision Support (CDS) and Computerized Provider Order Entry (CPOE) - in the ACI category. Given the consistently high performance on these two objectives in Meaningful Use, accomplishing a median score over 90 percent for the last three years, CMS believes these objectives and measures are no longer an effective measure of EHR performance and use.

The following measures are still required as part of ONC’s functionality standards for CEHRT, however.

EHR Certification

Under Meaningful Use, clinicians were required to use CEHRT in 2017 for the Medicare and Medicaid EHR Incentive programs. For 2017 under MIPS, clinicians can use CEHRT certified to either the 2014 or 2015 edition criteria. For 2018, clinicians must use CEHRT certified to the 2015 edition criteria only.

Reporting Periods

Clinicians were required to report using a 90-day period under Meaningful Use. To lower reporting burden, focus clinicians’ quality
improvement efforts and consolidate administrative actions, ACI eliminates that requirement and establishes a one, full calendar year reporting period. This aligns with the reporting requirements of the other three MIPS categories.

However, as part of the Pick Your Pace option to accommodate the ramp up of MIPS, CMS has reduced the reporting period to 90 days for CY 2017. To account for the mandated switch from 2014 certified CEHRT to 2015 certified CHERT, CMS is allowing a 90-day reporting period for CY 2018 as well.

Reporting Methods
Clinicians were able to submit Meaningful Use measures through a CMS website. Under ACI, MIPS eligible clinicians can submit data through qualified registry, EHR, QCDR, attestation and CMS Web Interface submission methods. Regardless of methods, all clinicians must follow the reporting requirements of the ACI performance category.

Group Reporting
Under Meaningful Use, CMS adopted a reporting mechanism for clinicians who are part of a group to attest using one common form, or a batch reporting process. To determine whether those clinicians meaningfully used CEHRT under that batch reporting process, CMS assessed the individual performance of the clinicians that made up the group, not the group as a whole.

MIPS allows clinicians to submit data as a group and the ACI measures will be aggregated and assessed at the group level. CMS believes this approach better reflects the team dynamics of the group and reduces the overall reporting burden for clinicians who practice in groups. The agency also feels it provides an incentive for practice wide data submission and provides enterprise-level continuous improvement strategies for submitting data.

There are no restrictions on group reporting for 2017, but CMS may consider imposing a threshold in future years such as limiting aggregate reporting to groups with 50 percent or more of their eligible patient encounters captured in CEHRT.

Scoring
Scoring for ACI is designed to be more flexible that the overall all-or-nothing approach of Meaningful Use. It also eliminates the requirement to meet certain measure thresholds. The scoring methodology developed for ACI is meant to promote the use of CEHRT reporting requirements in an efficient, effective and flexible way.
2. ACI Scoring

CMS has taken into consideration that the MIPS eligible clinicians who were not eligible for Meaningful Use likely do not have prior experience with CEHRT objectives and measures. To help ease the transition for these clinicians, CMS developed a scoring methodology within ACI that provides flexibility from early adoption of CEHRT through advanced use of health IT. Ultimately, CMS designed a flexible framework that provides multiple paths to achievement while recognizing clinicians’ efforts at all levels.

Developing this framework meant moving away from the concept of requiring a single threshold for a measure, and instead providing incentives for continuous improvement and recognizing onboarding efforts among late adopters.

One of the key lessons CMS learned from Meaningful Use and one that has been incorporated in their thinking surrounding MACRA is that updating software, training staff and changing practice workflows to accommodate new technology takes time. This also means clinicians need time and flexibility to focus on the health IT activities that are most relevant to their patient population. Clinicians also want consistent timelines and reporting requirements to simplify and streamline the reporting process.

To meet the dual goals of incentivizing participation and reporting while recognizing exceptional performance, CMS has established a scoring methodology for ACI broken into a “base score” and a “performance score” that provides an opportunity for bonus points at varying levels above the base score requirements.

The total possible score for ACI is 155 percent, capped at 100 percent when applied to the 25 possible points for the ACI category in the MIPS final score.

Base and Performance Scoring

Under the final policy, clinicians must report on required measures in each of five objectives to earn any base score, and thus to earn any score in the ACI category. Reporting on the optional measures allows the clinician to earn a higher score.

Most measures are calculated using a numerator and denominator. Clinicians are required to submit the numerator and denominator for each required measure to earn the base score. Submitting similar data for the optional measures earns higher scores. Measures which require a Yes/No response each carry their own specific scoring value.
The objectives and required measures are:

<table>
<thead>
<tr>
<th>ACI Objective</th>
<th>ACI Measure</th>
<th>Required/not Required for base score (50%)</th>
<th>Performance score (up to 90%)</th>
<th>Report Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protect Patient Health Information</td>
<td>Security Risk Analysis</td>
<td>Required</td>
<td>0</td>
<td>Yes/No Statement*</td>
</tr>
<tr>
<td>Electronic Prescribing</td>
<td>e-Prescribing</td>
<td>Required</td>
<td>0</td>
<td>Numerator/Denominator</td>
</tr>
<tr>
<td>Patient Electronic Access</td>
<td>Provide Patient Access</td>
<td>Required</td>
<td>Numerator/Denominator</td>
<td></td>
</tr>
<tr>
<td>Patient Electronic Access</td>
<td>Patient-Specific Education</td>
<td>Not Required</td>
<td>Up to 10 added % points</td>
<td>Numerator/Denominator</td>
</tr>
<tr>
<td>Coordination of Care through Patient Engagement</td>
<td>View, download, or Transmit (VDT)</td>
<td>Not Required</td>
<td>Up to 10 added % points</td>
<td>Numerator/Denominator</td>
</tr>
<tr>
<td>Coordination of Care through Patient Engagement</td>
<td>Secure Messaging</td>
<td>Not Required</td>
<td>Up to 10 added % points</td>
<td>Numerator/Denominator</td>
</tr>
<tr>
<td>Coordination of Care through Patient Engagement</td>
<td>Patient-Generated Health Data</td>
<td>Not Required</td>
<td>Up to 10 added % points</td>
<td>Numerator/Denominator</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>Send a Summary of Care</td>
<td>Required</td>
<td>Up to 10 added % points</td>
<td>Numerator/Denominator</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>Request/Accept Summary of Care</td>
<td>Required</td>
<td>Up to 10 added % points</td>
<td>Numerator/Denominator</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>Clinical Information Reconciliation</td>
<td>Not Required</td>
<td>Up to 10 added % points</td>
<td>Numerator/Denominator</td>
</tr>
<tr>
<td>Public Health and Clinical Data Registry Reporting</td>
<td>Immunization Registry Reporting</td>
<td>Not Required</td>
<td>10 points for Yes; 0 points for No</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Public Health and Clinical Data Registry Reporting</td>
<td>Syndromic Surveillance Reporting</td>
<td>Not Required</td>
<td>Bonus**</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Public Health and Clinical Data Registry Reporting</td>
<td>Electronic Case Reporting</td>
<td>Not Required</td>
<td>Bonus**</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Public Health and Clinical Data Registry Reporting</td>
<td>Public Health Registry Reporting</td>
<td>Not Required</td>
<td>Bonus**</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Public Health and Clinical Data Registry Reporting</td>
<td>Clinical Data Registry Reporting</td>
<td>Not Required</td>
<td>Bonus**</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Additional Bonus</td>
<td>Report improvement activities using CEHRT</td>
<td>Not Required</td>
<td>10 points for Yes; 0 points for No</td>
<td>Yes/No</td>
</tr>
</tbody>
</table>

*This objective requires a Yes/No response. Failure to answer “yes” to being able to protect patient health information results in a base score of zero, a performance score of zero and a total ACI category score of zero.

**Reporting to one or more of these public health and clinical registries beyond the Immunization Registry Reporting measure earns 5 additional percentage points:

The performance score is based on a clinician’s performance rate for each reported optional measure (calculated using the numerator/denominator). A performance rate of 1-10 percent would earn one percentage point, 11-20 percent earns two points, and so on. For example, if a clinician
reports a numerator/denominator of 85/100 in a particular measure, he or she would earn nine percentage points toward the performance score of ACI. By reporting on all nine measures available for the performance bonus, a clinician is able to earn up to 90 additional percentage points.

**ACI Bonus Related to MIPS Clinical Improvement Activities Category**

Clinicians can receive a 10 percent bonus score in the ACI category if they can attest to completing at least one of the specified activities from the following list of clinical improvement areas using CEHRT functionality.

- Expanded Practice Access
- Population Management
- Care Coordination
- Beneficiary Engagement
- Safety and Practice Assessment
- Achieving Health Equity
- Integrated Behavioral and Mental Health

Future changes could include establishing benchmark thresholds for future reporting and scoring for performance improvement to gauge the value of certain measures, comparisons to prior years performance of that of peer groups.

The goal of the scoring methodology is to encourage clinicians to use CEHRT products not only for patient documentation, but also to improve clinical practices.

**3. The Importance of Protecting Patient Health Information**

With breaches a real and present danger in the healthcare industry, MACRA understandably focuses heavily on protecting patient privacy. That is the main reason the Protect Patient Health Information objective and measure is an overarching requirement and compliance is mandatory to achieving any score in the ACI category.

CMS believes that there are many benefits to safeguarding ePHI. Unintended and/or unlawful disclosures of ePHI put EHR’s, interoperability and health information exchange at risk. The agency believes it is paramount to properly protect and secure ePHI.

They also recognize that compliance with the measure may not be enough to protect data as breaches become more sophisticated. That’s why CMS stresses that security risk analyses on a regular basis remain an important component of protecting ePHI.
Some of the commenters on the proposed rule suggested that the Protect Patient Health Information objective and measure requirements would be a burden to small group practices, practices in rural settings, new adopters of CEHRT and some clinicians who experience varying hardships. CMS responded that HIPAA rules are more comprehensive than ACI and have been effective for over a decade. The agency also noted that HHS offers a risk assessment tool designed for use by small and medium sized providers and clinicians.

Finally, CMS believes it is important to address the unique risks and challenges that EHR’s may represent and that maintaining a focus on protection of ePHI is necessary for all clinicians.

4. What You Should Be Doing Now

ACI is focused on finding the most effective ways to use technology to improve patient care and protect patient privacy. To that end, there are a number of things you should already have on your project list.

Patient Privacy
If you aren’t able to answer “yes” to Protecting Patient Health Information, you will get zero points for the ACI category and lose 25 percent of your composite MIPS score. Ensuring that you can answer “yes” on this crucial measure should be your highest priority.

Technology Review
To align with the goals set forth in the ACI category, you should conduct a full evaluation of your technology infrastructure. For the transition year 2017 you can use 2014 CEHRT certified systems. Beginning in 2018, you will need to be using 2015 CEHRT technology so now is the time to begin planning for that upgrade if you haven’t already done so.

Know the Score
Study the ACI section of the final rule to gain a full understanding of the scoring parameters. Make sure you are able to report on the five required measures in the base scoring so you will be assured of getting the first 50 percent of the score. Review the optional measures to see which ones you can easily incorporate into your reporting program so you can add valuable bonus points and increase your overall score.

One particular objective to consider is Public Health and Clinical Registries. Reporting on Immunization Registry Reporting and one of the other listed registries is a good way to pick up 15 bonus points.
Summary

CMS says the restructuring of the ACI category requirements as described in the final rule is geared toward increasing participating and EHR adoption. The agency believes adherence to the requirements of the ACI component is the most effective way to encourage the adoption of CEHRT and to introduce new MIPS eligible clinicians to the use of certified EHR technology and health IT overall.

CMS promises to continue reviewing and evaluating the ACI performance category and will take into consideration the ongoing evolution in the health IT industry. Based on technology changes, CMS expects to adapt the scoring methodology of ACI to strengthen the efficacy of the program and to ensure increased value for MIPS eligible clinicians and the Medicare Program.

About Hayes

Hayes Management Consulting is a leading, national healthcare consulting firm and software developer that partners with healthcare organizations to streamline operations, improve revenue and enhance technology to drive success in an evolving healthcare landscape. To learn how Hayes Management Consulting can help support your initiatives, call 617-559-0404 or requestconsultant@hayesmanagement.com.

www.hayesmanagement.com
617-559-0404
Sources


2. Proposed MACRA Rule, Center for Medicare & Medicaid Services, April 2016