

## Part 3: EHR – A better way?

### The Government Recognizes its Mistakes

In January 2016, Andy Slavitt, acting administrator of CMS, which controls MU, gave a broad policy speech in San Francisco. He said:

*“Now that we effectively have technology into virtually every place care is provided, we are now in the process of ending Meaningful Use and moving to a new regime culminating with the MACRA implementation...For one, the focus will move away from rewarding providers for the use of technology and towards the outcome they achieve with their patients.*

*Second, providers will be able to customize their goals so tech companies can build around the individual practice needs, not the needs of the government. Technology must be user-centered and support physicians, not distract them.”*

Mr. Slavitt implicitly acknowledged many physician complaints, such as that MU-compliant EHRs are bureaucrat-centered rather than physician centered and are more of a distraction than a value-added support system. Slavitt promised that the EHR requirements in MACRA, which is Medicare’s policy going forward, would address many of the MU issues.

### MACRA – The New Federal Policy

Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA) in 2015. MACRA is the most important federal healthcare legislation since the ACA; and, while we can’t discuss all ramifications in this short pamphlet, we can tell you the important things to know about MACRA as it relates to MU.

When it comes to MU, MACRA includes something called the “ Merit-Based Incentive Payment System,” or MIPS. This system calculates provider “scores,” which directly impact their Medicare reimbursement rates. “Advancing Care Information” is 25% of that score, and replaces the old MU rules.



CMS compares this new regime favorably to MU in the following figure:

Meaningful Use	Advancing Care Information
Must report on all objective and measure requirements	<b>Advancing Care Information streamlines measures and emphasizes Interoperability, Information exchange, and security measures. Clinical Decision Support and Computerized Provider Order Entry are no longer required</b>
One-size-fits-all – every measure reported and weight equally	<b>Customizable – Physicians or clinicians can choose which best measures fit their practice</b>
All-or-nothing EHR measurement and quality reporting	<b>Flexible – multiple paths to success</b>
Misaligned with other Medicare reporting programs	<b>Aligned with other Medicare reporting programs. No need to report quality measures as part of this category</b>

Figure 3. Principal Changes from the Medicare EHR Incentive Program to Advancing Care Information Performance Category.<sup>23</sup>

MIPS also only applies to office-based physicians who are reimbursed by Medicare. It does not apply to hospitals, facilities, or Medicaid. To receive full credit for the Advancing Care Information score, providers must achieve 100 points. Fifty points can be attained from the base score, which involves protecting patient health information, and public health and clinical data registry reporting. Providers must report information regarding e-prescribing, patient electronic access, care coordination through patient engagement, and health information exchange. There is then the performance score, which allows for up to 80 points. This means that the total score can go all the way up to 130, but a score of 100 receives full credit. The performance score allows physicians to select certain measures from a list and fulfill those measures for credit.

If collecting and evaluating all this information sounds like an enormous task, that's because it is. According to a Docs 4 Patient Care Foundation white paper, it "is widely recognized that, with rare exceptions, such quality measures have never been shown to improve outcomes. Under the MU program such quality measures have generated huge amounts of data reported to CMS that have never been read or analyzed. Continuing such a practice ensures that the \$15 billion a year that is currently spent on quality reporting will continue to be wasted."<sup>24</sup> The final rules for MACRA will not be set forth until the fall of 2016, but it looks like many of the same problems that plagued MU may plague MACRA as well.





## Comparing the Outcome of Meaningful Use to its Intentions

The Center for Medicare & Medicaid Services's PowerPoint presentation explaining MU to physicians is quite revealing. Per CMS, MU goals intended to: "Improve quality, safety, efficiency, and reduce health disparities; Engage patients and families in their healthcare; Improve care coordination; Improve population and public health; All the while maintaining privacy and security."<sup>25</sup> As of now, there is no strong evidence that the MU goals improved either healthcare quality or safety, and the idea that MU would reduce healthcare disparities comes across as downright fantastical.

Similarly, MU has resulted in less patient-doctor engagement, not more. There hasn't been any discernible improvement in either care coordination or public health. MU's security and privacy features were certainly very stringent, but there doesn't seem to be any evidence that a lack of security in healthcare information was even a substantial problem in 2009, when the HITECH Act was enacted.

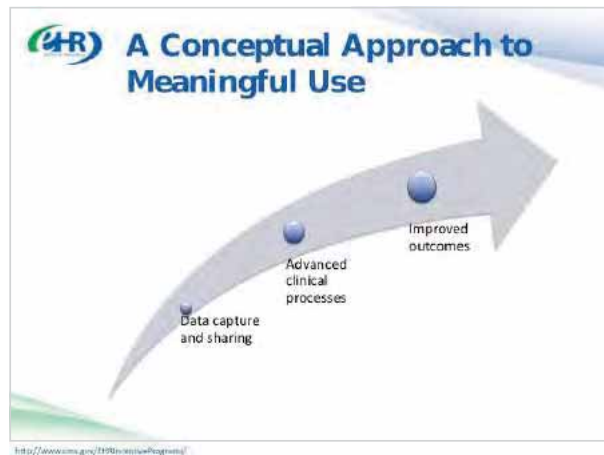


Figure 4. A Conceptual Approach to Meaningful Use.

## Suggestions of Journal of Informatics Study

- **First**, design EHR documentation tools to take into account “note-intensive tasks” that support the collaborative nature of medical work.
- **Second**, clearly define roles and responsibilities.
- **Third**, provide a balance between flexibility and interruption to be compatible with medical work’s complex nature, and facilitate necessary interactions among ED staff and patients in the medical environment.

## Is Meaningful Use necessary?

Spending taxpayer money requires accountability on how the money is spent. Incentive pay for adopting and using EHR is the perfect example of how well intended attempts at accountability can go awry. EHRs were meant to save time and money, but due to the bureaucratic oversight required to assure the money is appropriately spent, neither goal was achieved. This is not a fixable glitch in government funding; it is an intrinsic part of it.


Why has computer technology not been adopted in healthcare with the same enthusiasm and productivity success of other economic sectors? A significant part of the answer to this question requires recognizing the pre-existing legal and regulatory obstacles, which made implementing EHRs difficult and excessively expensive, even before HITECH and MU. If we are to construct effective, cost-efficient policies going forward, the harmful effects of government-created obstacles must be acknowledged.

While this paper only addresses two pieces of legislation, the HITECH Act and HIPAA, looking at these laws’ pernicious effects proves a cautionary tale. Government policies often do more harm than good, despite the best of intentions. An ideal federal policy would strive to leave as many decisions as possible to doctors and patients. A practicing physician knows better than a distant bureaucrat which health records system would best suit her. Going forward, the federal healthcare policies should be much more restrained in its attempts to manipulate behavior through incentives or mandates.

## Possible Solutions

There's no magic policy that the federal government can enact right now to fix all that is wrong with MU and EHR. It was the very existence of MU rules in the first place that poisoned the well. According to Dr. Michael Koriwchak, a practicing otolaryngologist and vice president of the Docs 4 Patient Care Foundation, as soon as the federal government set forth MU requirements, it took "all of the oxygen out of the room" when it came to developing EHRs that physicians actually liked. "Before Meaningful Use, only 4% of doctors had EHRs, but the satisfaction rate was astronomical – more than 90%," said Dr. Koriwchak. He argued that this was because doctors only used EHRs that made their job easier, rather than more frustrating. At the time, the only way EHR vendors could sell their product was to make something that providers wanted to buy. However, once MU came along, the vendors only cared about making software that was compliant with government requirements, thus eligible for incentive pay. Software manufacturers completely lost interest in winning doctors over with a user friendly and efficient product.

**The solution, then, is to slowly unwind the MU regime and return to some semblance of a free market system in which software manufacturers are aiming to please doctors and patients, not the federal government. This means that if MACRA is even retained, "Advancing Care Information" should not be a part of it, and that the federal government should not be in the business of assessing "meaningfulness" of various EHRs going forward.**



## Direct Primary Care – A Case Study in Patient-Centered, Doctor-Friendly EHR Development

The rapidly growing Direct Primary Care (DPC) movement offers all-access primary care paid for entirely by a monthly fee comparable in price to a cellphone plan. The movement shuns all insurance reimbursement and emphasizes a personalized doctor-patient relationship.

Its removal from the third party payer system makes the DPC movement a unique market space for EHRs. Free from the usual insurer and government stipulations, DPC doctors only adopt EHRs when it serves their needs and demonstrably improves the doctor-patient relationship.

The result has been a marketplace with a wide variety of EHR platforms and add-ons that range in price from completely free to a few hundred dollars a month. These EHRs are markedly more simple and doctor-friendly with their documentation. They also often come with additional value-adding features including management of on-site medication dispensing, monthly billing of patient credit cards, seamless integration of secure digital communication, and built-in telemedicine.

With a variety of options, DPC doctors can pick the platforms and add-ons that work best for their practice, their patients, and their budget. Since DPC doctors are free from third parties and are the sole customers for the EHRs, the vibrant marketplace is constantly innovating and adapting to meet the changing needs of DPC doctors.

While not completely comparable to the practice of hospital medicine, the DPC movement does offer a sense of what market-based, doctor-oriented, and patient-centered EHR adoption could be. Any reforms to the existing hospital EHR marketplace would do well to learn from the success of DPC EHRs. Specifically, structural protections should be considered so that doctors, and not third party payers, are the customers of the EHR. And there should also be marketplace protections so that competition and innovation can ensure that EHRs adapt to changing physician needs.



## Discussion and Conclusion

When Congress passed legislation that gave rise to MU, it did so with the best of intentions. The disadvantages of paper records are obvious: handwriting can be illegible, organization can be less than ideal, and sharing information can be quite difficult. Furthermore, the advantages of physicians being able to share patient health information easily are quite clear. Doctors don't have an excess of free time, and the time that they spend consulting each other about challenging cases is efficient when each doctor has the patient's health information readily available.

As the facts in this pamphlet show, however, MU in practice has been far different than what was envisioned. Instead of physicians having more time to devote to patient care, they have less. Rather than streamlining things, EHRs typically leave physicians bogged down and discouraged.

After reviewing studies on the effects of MU, we conclude that both physician satisfaction and patient care would have been better off without the HITECH Act. While the pace of EHR adoption would have been slower, the implemented EHRs would have been more efficient and better designed to meet both doctors' and patients' needs.



## Appendix A: Insights from a practicing physician

Dr. Josh Umbehr's Perspective

Josh Umbehr, AtlasMD founder, has a theory about physical reluctance to convert to digital medical records and patient communication. “Ninety percent of the problems with doctors adopting healthcare technology stems from the combination of providing healthcare based on insurance rules and government regulation. If you look at any other example of a start-up company from Silicon Valley, you’ll see that they grow, change, and adapt at a lightning speed.”<sup>1</sup>

Dr. Umbehr additionally points out that MU compliant EHRs cause major frustration because they are disconnected from what doctors and patients want. Instead, they are geared to meet the agenda of federal bureaucrats. According to Umbehr, HIPAA and MU security requirements are at odds with what patients really want. Patients care more about quickly and easily navigating a system than about security. There is a trade-off between information security and a user-friendly interface. As one writer, put it: “...fewer restrictions on information allow insurance markets to operate efficiently, reduce transaction costs among privacy providers, facilitate education and research, and lower overall costs for consumers. These and other advantages benefit society in the aggregate and should not be easily discounted. The effect of any given privacy policy is to create a tradeoff between these benefits and those gained from limiting access to information.”<sup>26</sup>

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<sup>1</sup>From a personal communication with Dr. Umbehr, August 2016.



## In Summary ...

We have highlighted that most government policy interventions bring with them unintended, harmful consequences. It is only through maximizing doctor and patient choice and giving ultimate authority to the patient-doctor relationship that we gain both control and flexibility in healthcare cost and delivery. Lastly, we encourage lawmakers and healthcare professionals to work together to repeal harmful regulations and policies that cause these serious problems, instead of piling on more regulations and penalties in the hopes of finding a fix.



## Appendix B: Glossary

**American Reinvestment and Recovery Act:** Commonly known as the “Stimulus,” it was passed in 2009 as a response to the 2008 financial crisis and ensuing recession. The Congressional Budget Office estimates its approximate cost at \$837 billion.<sup>27</sup>

**Center for Medicare and Medicaid Services (CMS):** A federal agency within the Department of Health and Human Services. It administers Medicare and Medicaid in conjunction with state governments. These two programs comprise 36% of every healthcare dollar spent in the United States.<sup>28</sup>

**Competitive Advantage:** A circumstance that puts one business in a better position over another.

**CPOE:** Computerized Physician Order Entry. Refers to the process of a provider entering instructions electronically instead of via a paper chart.

**Department of Health and Human Services (HHS):** This is the federal department that is responsible for protecting the health of all Americans. The Center for Medicare and Medicaid Services is a part of this department.

**Electronic Health Record (EHR):** Instead of recording patient information into paper charts by hand, providers record it electronically, usually using a computer. Also known as EMR, or electronic medical record.

**E-Prescribing:** Instead of handing patients a prescription to take to a pharmacy, providers send the prescription electronically to a patient’s chosen pharmacy.

**Interoperability:** The ability to transfer patient information from one EHR software to another. So far, this has proved elusive and difficult.

**Health Insurance Portability and Accountability Act (HIPAA):** A 1996 law that spelled out strict privacy and security requirements for transmitting patient healthcare information.



**Health Information Technology for Economic and Clinical Health Act (HITECH):** A law passed in 2009 along with the stimulus act. It instituted a regime to incentivize providers financially to adopt EHRs.

**Market Failure:** A situation in which there is an inefficient distribution of goods and services. It is difficult to know whether a market failure results from intrinsic factors in the market, or from external (e.g. government) interference. Examples of market failure from an intrinsic feature would be pollution that is harmful to third parties that have nothing to do with a transaction. Economists often call this a “negative externality” since pollution costs are not included in production costs absent some form of government agency- or court- imposed regulation. An example of market failure due to government intervention is housing shortages due to rent control laws.

**Meaningful Use (MU):** A series of rules and criteria that govern whether EHRs are being used in a “meaningful” way. In order to qualify for incentive payments and avoid reimbursement cuts, providers must meet these rules and criteria.

**Medicaid:** A joint federal-state program designed to provide health coverage for America’s low-income population. It accounts for 16% of national health expenditure and typically has low reimbursement rates.

**Medicare:** A federal government program designed to provide health coverage for senior and disabled citizens. It accounts for 20% of national health expenditure, and its control over provider reimbursement massively influences private health insurance companies’ decisions.

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