"THE END OF MEANINGFUL USE"

NOT SO FAST... AND WHAT COMES NEXT?

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Key Points from the CMS blog by Karen DeSalvo and Andy Lavitt:

- The changes to Meaningful Use will take time and providers must still follow the current program. Don't expect to hear anything until summer. MU is legislated (law), so CMS cannot just stop doing it; they can only manage how it is implemented. *Stage 3 still exists*, but we do not know what it will look like.
- HHS' goal is that 30% of Medicare payments will be linked to value-based care in 2016, and 50% by 2018; this means structured data and reportable quality measures are your targets for action.
- Interoperability will continue to be a priority, which will continue to drive national interoperability standards that are based in "real-world uses of technology, like ensuring continuity of care during referrals or finding ways for patients to engage in their own care." - Dr. Karen DeSalvo, National Coordinator for Health Information Technology.
- Hospitals have a different set of statutory requirements. "We will continue to explore ways to align with principles we outlined above as much as possible for hospitals and the Medicaid program." – Dr. DeSalvo.

The new program will largely center on the Medicare Access and CHIP Reauthorization Act of 2015. MACRA links payment to value through the Merit-Based Incentive Program (MIPS) and measures physicians on four categories: quality, cost, technology use and practice improvement. *MACRA requires MU compliance as a 25% part of the MIPS program calculation*, but the "how" MU is utilized in the future is the subject of great discussion, and CMS states they will publish more details this spring. HHS and CMS have some latitude to make programmatic changes through the pending rulemaking process later this year.

Four key themes of the new program:

1. The focus will no longer be on rewarding providers for using technology. Instead, it will **reward them for positive outcomes achieved with their patients.**
2. To move away from a program centered on government regulations, **providers will be able to customize their goals**, and tech companies can develop products based on individual practice needs.
3. The new program seeks to lower the barriers to entry for startups and new players in the field by requiring open application programming interfaces. **This will permit apps, analytic tools and connected technologies to move data as necessary.**
4. Interoperability remains a key factor for **using technology to close referral loops and boost patient engagement.** You will hear more about this in things like patient information apps, and being able to send information to their providers' EHR or portal.

References:

1. http://www.beckershospitalreview.com/healthcare-information-technology/cms-andy-slavitt-hints-at-mu-s-finale-6-things-to-know.html
2. http://www.healthcareitnews.com/news/meaningful-use-still-effect-slavitt-and-desalvo-say-macra-changes-will-take-time?mkt_tok=3RkMMJWWfF9wsRonuqjMdu%2FhmjTEU5z17e4oWqa%2Fiokz2EFye%2BLIHETpodcMTcBmNr7YDBceEJhqyQJxPr3MLtINwNlqRhPrCg%3D%3D

TAKE HOME MESSAGE – FOCUS ON GOOD DATA COLLECTION, CDS, AND QUALITY METRICS

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MACRA

Medicare Access and CHIP Reauthorization Act of 2015

- It won't be remembered for the repeal of the SGR
- Merit-Based Incentive Payment System (MIPS)
- Composite Score – publicly reported and used for bonus/penalty calculations (0-100)
  - Quality Measures (30%)
  - Resource Use (30%)
  - EHR Adoption (25%)
  - Clinical Practice Improvement (15%)
- Alternative Payment Model (APM) Participation – Participating physicians exempted and receive 5% bonus (2019-2024)

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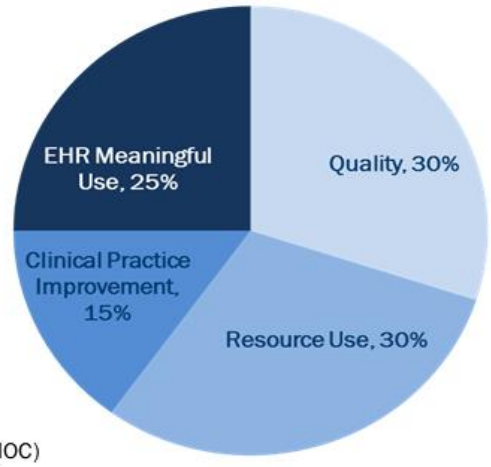
Year 1 of MIPS Program

- Meaningful Use requirements
- Meaningful Use weight may be adjusted down to 15 percent if 75% or more EPs are meaningful users



- PQRS measures
- eCQMs
- QCDR measures
- Risk-adjusted outcome measures

- Expanded Practice Access
- Population Management
- Care Coordination
- Beneficiary Engagement
- Patient Safety
- Practice Assessment (ex. MOC)
- Patient-Centered Medical Home or specialty APM

- Value-Based Modifier measures
- Risk-adjusted outcome measures
- Part D drug cost (if feasible)

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