PUBLICATION

CMS Releases MACRA Proposed Rule for 2018

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On June 20, the Centers for Medicare and Medicaid Services (CMS) released a proposed rule entitled, "Medicare Program; CY 2018 Updates to the Quality Payment Program." CMS proposes changes for the second year (2018) of the Quality Payment Program established under the Medicare Access and CHIP Reauthorization Act (MACRA). The proposed rule aims to simplify reporting requirements and provide greater flexibility for eligible small, independent and rural providers. Comments on the proposed rule are due on August 21, 2017.

Background

Enacted in 2015, MACRA repealed the Medicare Sustainable Growth Rate (SGR) formula that CMS previously used to set reimbursement rates for Medicare providers. MACRA replaced SGR with a two-track value-based payment structure:

1. **Merit Based Incentive Payments Systems (MIPS)**, which consolidated the prior Medicare quality reporting programs (i.e., the Physician Quality Reporting System, the Value-Based Payment Modifier) and the Medicare Electronic Health Record (EHR) Incentive Program into a new system that provides annual updates to eligible providers based on performance across four categories of measurement: quality, improvement activities, advancing care information and cost; and
2. **Advanced Alternative Payment Models (APMs)**, which provide additional incentive payments to encourage providers to participate in CMS-approved Advanced APMs (e.g., the Comprehensive Primary Care Plus model and Tracks 2 and 3 of the Medicare Shared Savings Program).

Eligible providers were able to participate in either track, beginning in 2017. Given the significant changes under the new reimbursement framework, CMS designated 2017 a transition year. For 2017, providers were given the opportunity to pick their pace for collecting and submitting data for the first performance year to avoid a negative payment adjustment in 2019.

Proposed Changes for 2018

CMS proposes a number of changes to the Quality Payment Program for 2018. Importantly, CMS seeks to continue to reduce provider burden, improve care coordination and support greater transition into Advanced APMs.

Key MIPS changes:

- Continues the "Pick-Your-Pace" option for provider reporting requirements, allowing eligible providers to report a limited amount of quality data to qualify for MIPS and avoid payment penalties.
- Creates a "virtual group" reporting option, allowing eligible providers to pool the information on how they care for patients to be reported and evaluated under the Quality Payment Program.
- Increases the low-volume threshold exempting small practices from MIPS participation from ≤ $30,000 in Medicare Part B allowed charges OR ≤ 100 Medicare Part B patients to ≤ $90,000 in Medicare Part B allowed charges OR ≤ 200 Medicare Part B patients.

- Eliminates the requirement for eligible providers to use the 2015 Certified Electronic Health Record Technology (CEHRT) and allows the use of either the 2014 or 2015 Edition CEHRT, while offering bonuses for providers that only use the 2015 Edition CEHRT.
- Implements a new optional voluntary facility-based scoring mechanism under MIPS to provide greater flexibility for eligible providers who see limited numbers of patients face-to-face or primarily in a hospital setting.
- Delays the inclusion of payment adjustments for the cost category under MIPS for an additional year, from 2020 to 2021, by adjusting the weight to the final score for cost from 10 percent to 0 percent and quality from 50 percent to 60 percent for 2020. The category weights are unchanged for the 2021 payment year and beyond.
- Includes new bonus adjustments under MIPS of up to three bonus points for eligible providers treating complex patients or five bonus points for eligible providers in small practices (defined as 15 or fewer clinicians).

Key Advanced APMs changes:

- Extends the revenue-based nominal amount standard, which previously applied through performance year 2018, for two additional years (through performance year 2020). This standard allows an APM to meet the financial risk criterion to qualify as an Advanced APM if participants are required to bear a total risk of at least eight percent of their Medicare Parts A and B revenue.
- Provides greater detail about how the All-Payer Combination Option will be implemented. This option allows eligible providers to become qualifying participants (QPs) for APMs through a combination of Medicare participation in Advanced APMs and participation in Other Payer Advanced APMs. This option will be available beginning in performance year 2019.
- Provides greater detail on how eligible providers participating in selected APMs will be assessed under the APM scoring standard. This special standard is intended to reduce the burden for certain APMs (MIPS APMs) participants who do not qualify as QPs, and are therefore subject to MIPS.

Based on these proposed changes, CMS estimates that the proposed rule would allow another 134,000 providers to be exempt from MACRA's MIPS program in 2018, in addition to the roughly 800,000 providers who did not participate in 2017.

Please feel free to reach out to our team directly if you have any questions or need assistance submitting comments before the August 21 deadline. We will continue to monitor and report on the proposed regulation as it is finalized over the coming months.