With Final MACRA Rule, CMS Increases Flexibility

BY LEAH RALPH

On Friday, October 14, the Centers for Medicare & Medicaid Services (CMS) released its final rule on the MACRA Quality Payment Program (QPP), solidifying transformational changes in the way physicians will be reimbursed for Medicare Part B services. ACCC is conducting an in-depth analysis of the rule; however, an initial look reveals that CMS heard stakeholders' messages loud and clear: Make the transition to MACRA as simple and flexible as possible. Here are some top-level highlights from the final rule:

- **Low-volume threshold exemption.** The agency broadened the low-volume threshold exemption from the Merit-Based Incentive Payment System (MIPS), exempting practices with less than $30,000 in Medicare charges or fewer than 100 unique Medicare patients per year. CMS estimates this will exclude about one-third of physicians from having to report under the QPP.
- **Pick your pace.** CMS is allowing physicians to "pick their pace" in 2017, enabling physicians to avoid negative penalties in 2019 by reporting on some data (i.e., one measure in the quality, practice management, or meaningful use categories) for some period of time (less than 90 days). The takeaway: even minimal performance reporting will exempt physicians from any penalties, and opportunities for a shorter, 90-day reporting period will make providers eligible for positive adjustments. (Providers must start collecting data between January 1, 2017, and October 2, 2017, and report no later than March 31, 2018.)
- **Resource use category weighted zero in first year.** MIPS has four components, and originally the resource use (cost) category was going to account for 10 percent of your score starting in 2017. CMS has now said this category will hold zero percent weight toward your MIPS score in the first year [in 2017, the percentages will be: 60 percent quality measures, 25 percent advancing care information (EHR use), and 15 percent clinical improvement activities].
- **Expanding opportunities to participate in APMs.** CMS has also said it plans to expand opportunities to participate in models that qualify as "advanced alternative payment models" (APMs) in 2017 and 2018. The Center for Medicare and Medicaid Innovation (CMMI) also recently informed Oncology Care Model (OCM) practices that CMS is amending the program to allow OCM practices to take two-sided risk as early as January 2017 to qualify as an advanced APM (two years earlier than the model originally allowed). Although most OCM practices are not ready to take downside risk, CMS is also allowing OCM practices to substitute their reporting on quality and practice improvement activities for MIPS reporting—no additional reporting is needed.

In our comments on the proposed rule, ACCC asked for increased flexibility for practices who are still building the infrastructure to meet these requirements, and a streamlining of reporting requirements as our members increasingly engage in new delivery models and navigate the path to value-based care. ACCC's major concerns were around timeline and administrative burden. In the final rule, CMS was responsive in many ways, but ACCC will continue to work with the agency to reduce regulatory burden and make this a workable payment system for our members. We hope that CMS will provide flexibility beyond 2017 if needed.

For more information, CMS launched a website for physicians that explains the program and allows you to explore and identify different measures that are most meaningful to your practice, available at qpp.cms.gov/education?linkId=29935271. Access ACCC's archived "MACRA: What You Need to Know About the Final Rule" webinar, along with a summary of the rule, in the ACCC Resources section of MyNetwork (mynetwork.accc-cancer.org/). You can also find great checklists on how to prepare for QPP participation on both the Amercian Medical Association (ama-assn.org) and the American Society of Clinical Oncology (asco.org) websites. OI

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