HEALTH LAW ALERT

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CMS Issues Final MACRA Rule: Expands Exemptions and Flexibility for Smaller Practices

By Mazen Asbahi, Partner

Last Friday, the Center for Medicare and Medicaid Services ("CMS") issued its Final Rule implementing the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA"), which marks a milestone in efforts to improve and reform the health care system, especially, the shift from fee-for-service payments and towards a value-based payment system. The law goes into effect on January 1, 2017.

MACRA received bi-partisan support in Congress to finally abolish the long-reviled Medicare Sustainable Growth Rate ("SGR") formula for updates to the Physician Fee Schedule ("PFS"). Alternatively, MACRA introduced a new approach to payment that rewards the delivery of high-quality care and value-based medicine through two distinct tracks that are collectively referred to as the Quality Payment Program:

- Advanced Alternative Payment Models ("Advanced APMs"), which include Accountable Care Organizations ("ACOs"), Medical Home Models, and innovative episode payment models for cardiac and joint care; and

- The Merit-based Incentive Payment System ("MIPS"), which consolidates certain components from the three existing programs: the Physician Quality Reporting System ("PQRS"), the Physician Value-based Payment Modifier ("VM"), and the Medicare Electronic Health Record Incentive Program ("Meaningful Use").

Practices participating in an Advanced APMs will get a bonus in 2019 equal to 5.0% of their Medicare reimbursements and are exempt from MIPS reporting requirements. Alternatively, clinicians will default to MIPS, which requires reporting data for the 2017 performance period in order to avoid a negative adjustment of 4.0% in their Medicare reimbursements. The Final Rule anticipates that most smaller practices will choose the MIPS track which gives them more choices in how they will report their data in 2017. The options for reporting are:

- Submit a minimum amount of information, such as an individual quality performance measure or clinical improvement activity;

- Submit data covering 90 days or more with more than one quality measure or improvement activity; or

- Submit a full year of data.

By reporting such data, providers may be eligible for a small positive adjustment to their Medicare reimbursements. Full reporting will give providers a potential positive adjustment of 9.0% in 2022.

Responding to concerns about the impact of the Quality Payment Program on smaller practices, CMS broadened its exclusion for providers who treat a low volume of Medicare patients from MIPS. CMS will exempt physician practices with less than $30,000 in Medicare charges or fewer than 100 unique Medicare patients per year. Further, CMS has allocated $100 million over the next 5 years to assist smaller practices, practices in rural areas, or areas with a shortage of health professionals to adjust to the new Quality Payment Program.

In upcoming alerts, we will explore the details around reporting requirements, performance categories, quality measures and improvement activities, as well as the alternative payment models addressed in the Final Rule.

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