MACRA in 2017: Breathe Deeply and Slowly Back Away from Your Computer

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With 1,000 pages of proposed regulations released earlier this year for MACRA, providers have been holding their breath to see just how difficult quality and Meaningful Use (MU) reporting will be in 2017. CMS received almost 4,000 comments about the proposed MACRA regs and the vast majority of the comments were negative. The biggest problem expressed was the complexity of the regulations and the short time period to implement them. Congress had stated in the MACRA statute passed in 2015 that the implementation date was January 1, 2017; therefore, CMS was required to lay that out as the proposed timeline for implementation.

Now, though, CMS has reconsidered and is proposing a more creative option. Providers will be able to report in 2017 in a way that fits their own schedule. CMS is proposing a flexible reporting schedule for all providers in 2017 where the amount of data and the type of transmission will be driven by the provider's own readiness level. Although the details have not been fully fleshed out yet and will most likely not be known until the final MACRA regulations are released in late October or early November, 2016, the framework was discussed by Andy Slavitt, the Acting Administrator for CMS.

According to Mr. Slavitt, the following options will be made available to providers for 2017 CMS reporting requirements:

- **Avoiding Penalties:** Providers will be able to submit "some" data to the Quality Payment Program (i.e., QPP, previously called PQRS) to avoid any downward payment from CMS for Medicare Part B claims. Without such submission, the MACRA statute states that a provider would be subject to a 4% penalty. *Unresolved Issues:* CMS will have to specify how much data is "some" and whether it includes submission of both MU data and quality data or just quality.

- **Receiving Partial Credit for Reporting:** Providers will be able to report under the proposed MIPS schedule, but reporting will be required for only part of the year. This option will allow providers to be eligible for at least part of the MIPS bonus payment for QPP reporting. *Unresolved Issues:* CMS will have to specify if the reporting period is for a set period such as 90 days, or possibly 6 months. In addition, they will have to clarify if providers receive full credit for reporting MU data, or if they will be "scored" on their participation. If submitting Clinical Practice Improvement data (the new category of reporting), CMS will have to specify if the practice will still be required to participate for at least 3 months in 2017 before reporting or if the timeline for participation will be shortened.

- **Receiving Full Credit for MIPS Reporting:** For practices that understand the MIPS reporting option as it will be laid out in the final rule, the practice can report for the full 2017 calendar year for all required reporting areas: MU (also called "technology reporting" or "Advancing Care Information"), quality reporting for a required number of measures, and Clinical Practice Improvement. CMS will calculate the cost factor for patients attributed to the practice. This option will qualify a provider or practice for MIPS incentives, but not specified as to amount of incentive. *Unresolved Issues:* It is not clear if all reporting options will be available to providers in 2017, such as group reporting for a tax ID number. It is also unclear whether the weighting of each category will be the same, such as all the elements in the Advancing Care information categories and how providers/practices will be judged against performance.

- **Advanced Alternative Payment Models (APM):** For providers participating in an Advanced APM and completing all the required reporting for that model, providers would be eligible for the 5% automatic bonus payment spelled out in MACRA as well as any additional payment under the model. *Unresolved Issues:* Providers will have to wait until the final regulations to see if CMS modified the definition of an "Advanced APM provider" to allow for more flexibility on what is determined to be "risk-bearing." Risk bearing at a CMS pre-determined level is a requirement of an Advanced APM. For providers that are in Advanced APMs but not meeting the required risk-bearing thresholds, then it would be important to understand what additional reporting they would have to do to qualify them for MIPS incentives.

Watch for additional information in this newsletter about the MIPS rollout as the final regulations are released in a little over one month.