et me state this from the start: I believe CMS Acting Administrator Andy Slavitt when he says that the rules of his agency’s Medicare reimbursement reform don’t slight small practices and are designed to make it easier to report quality data.

He’s right. To an extent. For 2017. When the final rule for the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was released last month, this publication and others noted the increased flexibility for small practices to avoid a penalty under CMS’ Quality Payment Program. Some of the most onerous aspects of the proposed rule were relaxed and medical associations, for the most part, voiced their appreciation to federal regulators.

CMS has done a great job at making it easier for small practices to participate under the program’s Merit-based Incentive Payment System (MIPS). Practices need only report six quality measures of their own choosing for the bulk (60%) of their score. Other key categories involve reporting four or five measures that they likely already report on through current federal initiatives (like Meaningful Use).

And CMS has even made reporting easier. Want to avoid a Medicare payment penalty in 2019? Simply report something—one quality measure or one improvement activity. Bingo, your practice just ducked a potential 4% hit to your Medicare reimbursement two years down the line. And while you’re at it, maybe you want to submit a little more data reflecting 90 days’ worth of activity and possibly earn a small boost to your Medicare pay.

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CMS has said “stay tuned” when it comes to 2018 data reporting. The promise of virtual reporting, where small and solo docs can “team up” to report data, is coming and it’s unclear at this point whether this same flexibility will continue once the program enters its second year.

And as Slavitt told Medical Economics (be sure to read our exclusive interview with him in this issue), MIPS may be great for small practice physicians today, but he predicts that in two years (actually 13 months) one of every four small practices will actually be in the Advanced Alternative Payment Model (APM) track—eschewing all category reporting by adopting a payment model like an accountable care organization, patient-centered medical home, or other, yet-to-be-defined models.

CMS is working hard to gain the trust and participation of small practices. The final rule and its modifications are proof of that. But following 2017, the agency says it will either roll out some other payment models itself or let physicians propose models to improve the care quality of Medicare beneficiaries.

One hopes CMS is not making concessions to lure small practices into getting entrenched in the program today only to enact stricter requirements tomorrow. Only time will tell.

Keith L. Martin is editorial director for Medical Economics. How do you feel about changes to Medicare’s reimbursement program? Tell us at medec@ubm.com.