Medicare Quality Payment Program Overview (MACRA)

December 2016
Some general observations

- MACRA is complex
  - More than a “replacement for the SGR”
- Many of the “new” requirements are revisions to the current FFS program
  - Impacts of previous law not universally experienced, understood, or in full effect
- One goal of MACRA was to simplify administrative processes for physicians
  - Compared to recent past framework, there are significant improvements
- MACRA and ACA dynamics are often confused
- More work remains
MACRA: New vs. reorganized

**New**

- Bonus opportunities (APMs & MIPS)
- Greater support for physicians that want to pursue new models
- Improvement Activities requirement

**Re-organized**

- PQRS, MU and VBM
  - Penalties reduced in absolute terms & through partial credit
- Reduce net administrative burdens
- Greater flexibility for physicians
- Low score in one area can be made up by high score in other components
- No more double jeopardy for failing PQRS (trigger VBM failure)
AMA advocacy

• Our overarching aims in shaping regulations:
  – Choice, flexibility, simplicity, feasibility

• Six internal measures for judging success:
  – Start date and reporting period
  – Simplify the MIPS program
  – Increase the low volume threshold for MIPS reporting
  – More relief for small and rural practices
  – Expand opportunities for APMs

• Cannot overstate contribution of constructive CMS approach
MACRA Basics
MACRA established two Medicare paths for physicians

- MACRA was designed to offer physicians a choice between two payment pathways:
  - A modified fee-for-service model (MIPS)
  - New payment models that reduce costs of care and/or support high-value services not typically covered under the Medicare fee schedule (APMs)
- In the beginning, most are expected to participate in MIPS
- CMS named the physician payment system created by MACRA the Quality Payment Program (QPP)
MIPS aims:
- Align 3 current independent programs
- Add 4th component to promote improvement and innovation
- Provide more flexibility and choice of measures
- Retain a fee-for-service payment option

Clinicians exempt from MIPS:
- First year of Part B participation
- Medicare allowed charges ≤ $30K or ≤ 100 patients
- Advanced APM participants
Low-volume threshold exemption

- Physicians with Medicare allowed charges of $30,000 or less or 100 or fewer Medicare patients
- Eligibility calculated by CMS
  - Notification should occur in December
  - Based on 12-month historical data (September-August)
  - Includes Part B drug costs, but not Part D
- Exempted physicians receive annual fee schedule updates, but no bonuses or penalties
MIPS component weights (when fully transitioned)

**Component Weights**

- **Quality**
- **ACI**
- **Imp. Activities**
- **Cost**

**Component Scoring**

- **Quality:**
  - 60 points for groups ≤ 15
  - 70 points for larger groups
- **Advancing Care Information:**
  - 50 points base score
  - 90 points performance score
- **Improvement Activities:**
  - 40 points (2-4 activities; 1-2 activities for practices ≤ 15 clinicians, rural practices, and non-patient facing physicians)
- **Cost:**
  - 10 points per measure
  - Score is average of attributable measures

For 2017:
- **Quality** = 60%
- **ACI** = 25%
- **IA** = 15%
- **Cost** = 0%
### Pick Your Pace: 2017 transitional performance reporting options

<table>
<thead>
<tr>
<th>Reporting Option</th>
<th>Requirements</th>
<th>2019 Adjustments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MIPS Testing</strong></td>
<td>• Report some data at any point in CY 2017 to demonstrate capability&lt;br&gt;• 1 quality measure, or 1 improvement activity, or 4/5 required ACI measures&lt;br&gt;• No minimum reporting period&lt;br&gt;• No negative adjustment in 2019</td>
<td>No negative adjustment in 2019</td>
</tr>
<tr>
<td><strong>Partial MIPS reporting</strong></td>
<td>• Submit partial MIPS data for at least 90 consecutive days&lt;br&gt;• 1+ quality measure, or 1+ improvement activities, or 4/5 required ACI measures&lt;br&gt;• No negative adjustment in 2019&lt;br&gt;• Potential for some positive adjustment (&lt; 4%) in 2019</td>
<td>No negative adjustment in 2019</td>
</tr>
<tr>
<td><strong>Full MIPS reporting</strong></td>
<td>• Meet all reporting requirements for at least 90 consecutive days&lt;br&gt;• No negative adjustment in 2019&lt;br&gt;• Maximum opportunity for positive 2019 adjustment (≤ 4%)&lt;br&gt;• Exceptional performers eligible for additional positive adjustment (up to 10%)</td>
<td>Maximum opportunity for positive 2019 adjustment (≤ 4%)&lt;br&gt;Exceptional performers eligible for additional positive adjustment (up to 10%)</td>
</tr>
<tr>
<td><strong>Advanced APM participation</strong></td>
<td>• No MIPS reporting requirements (APMs have their own reporting requirements)&lt;br&gt;• Eligible for 5% advanced APM participation incentive in 2019</td>
<td>No MIPS reporting requirements&lt;br&gt;Eligible for 5% advanced APM participation incentive in 2019</td>
</tr>
</tbody>
</table>

The only physicians who will experience negative payment adjustments (-4%) in 2019 are those who report no data in 2017.
### Other transition elements

#### 2017
- 90-day reporting for all MIPS elements
- Quality reporting threshold maintained at 50%
- ACI required measures reduced to 4/5 (depending on whether using 2014 or 2015 certified technology)
- Cost component of MIPS weighted 0%; quality component raised to 60% (for 2019 adjustments)

#### 2018 (subject to rulemaking)
- 90-day reporting likely maintained for ACI and Improvement Activities only
- Quality threshold likely increased to 60%
- ACI required measures is 5 (must use 2015 certified technology)
- Cost component weight increased to 10%; quality component reduced to 50% (for 2020 adjustments)

#### Future years
- Full-year reporting for ACI?
- Quality threshold anticipated to increase over time
- Cost component weight will increase to 30% (for 2021 adjustments and beyond)
- Quality component weight will decrease to 30% (for 2021 adjustments and beyond)
Calculating payment adjustments

- Quality score weighted
- Cost score weighted
- ACI score weighted
- Improvement Activity score weighted

Final Performance Score

**Final score at threshold (tied to average performance) = 0%**

**Final score above threshold = 0% to +X%**

**Final score below threshold = 0% to -X%**

*Depending on final score distribution, upward adjustments only could increase up to 3x to maintain budget neutrality*

Physicians with final scores ≤ 25% of threshold receive maximum reduction

Up to $500 million available 2019-2024 to provide 10% extra bonus for exceptional performance (≥ top 25% of those above the threshold)

**Maximum adjustment ranges = +/-4% in 2019, +/- 5% in 2020, +/- 7% in 2021, +/- 9% in 2022 onward**
2019 payment adjustments (based on 2017 transition)

Quality score weighted (60%)

Cost score weighted (0%)

ACI score weighted (25%)

Improvement Activity score weighted (15%)

Final Performance Score

Final score above threshold (up to 70 points) = up to 0 to +4%

Final score at 2017 threshold of 3 points (one data element reported) = 0%

No data reported = -4%

Up to $500 million available to provide 10% extra bonus for those who meet or exceed a 70 point threshold

Adjustment amounts depend on:
- choice of 90-day or full-year reporting
- whether some or all data elements are reported
- performance under each reported measure compared to other physicians
- whether bonus points are earned
- budget neutrality calculations
# 2019 (first year) penalty risks compared

<table>
<thead>
<tr>
<th>Prior Law</th>
<th>2019 adjustments</th>
<th>MIPS factors</th>
<th>2019 scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>PQRS</td>
<td>-2%</td>
<td>Quality measurement</td>
<td>60% of score</td>
</tr>
<tr>
<td>MU</td>
<td>-5%</td>
<td>Advancing Care Info.</td>
<td>25% of score</td>
</tr>
<tr>
<td>VBM</td>
<td>-4% or more*</td>
<td>Resource use</td>
<td>0% of score</td>
</tr>
<tr>
<td>Total penalty risk</td>
<td>-11% or more*</td>
<td>Improvement Activities</td>
<td>15% of score</td>
</tr>
<tr>
<td>Bonus potential (VBM only)</td>
<td>Unknown (budget neutral)*</td>
<td>Total penalty risk</td>
<td>Max of -4%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bonus potential</td>
<td>Max of 4%, plus potential 10% for high performers</td>
</tr>
</tbody>
</table>

*VBM was in effect for 3 years before MACRA passed, and penalty risk was increased in each of these years; there were no ceilings or floors on penalties and bonuses, only a budget neutrality requirement.
Merit-based Incentive Payment System (MIPS)
Getting started: Choose a reporting option

### Individual Reporting
- Claims*
- EHR
- Clinical Data Registry, or
- Qualified Clinical Data Registry

*Claims reporting option available only if reporting as an individual

### Group Reporting (GPRO)
- A group is classified as two or more eligible clinicians (ECs)
- A physician in a group may choose to participate as an individual under MIPS
- Reporting options:
  - EHR
  - Clinical Data Registry
  - Qualified Clinical Data Registry, or
  - Web-Interface**

**Web-Interface option open only to practices of 25 or more ECs due to CMS sampling methodology and restrictive nature of quality measures that are reported under this mechanism
Quality reporting in MIPS vs. PQRS

PQRS

- 9 measures
- Pass/ fail approach
- 2% penalties, no bonuses
- Measures must fall across specific domains
- One cross cutting measure required

MIPS Quality

- 6 measures (or 1 specialty set)
- Partial credit allowed toward positive payment adjustments
- Flexibility in measure choice
- No domains, no cross cutting measures
- Bonuses available for reporting through EHR, qualified registry, QCDR, or web interface
Quality category reporting

• 1 Administrative Claims measure
  – *All-cause hospital readmission* measure finalized for groups of 16 or more (vs. 10 in proposed rule) with 200 attributed measures
  – Will be calculated by CMS from administrative claims data

• 6 measures must be reported, or a specialty measure set
  – 1 must be an outcome measure
  – If no applicable outcome measure available, must report 1 other “high priority measure” instead
    • High priority areas include: appropriate use, patient safety, patient experience, care coordination
  – For maximum points, measure must be reported on 50% of eligible patients in 2017
    • Threshold increases to 60% of eligible patients in 2018
Quality category bonus point scoring

• Additional points awarded for:
  – Electronic reporting via clinical registry, EHR, qualified clinical data registry, or web-interface
  – Reporting on CG-CAHPS survey measure
  – Additional outcome of additional high priority measures outside the 1 required
ACI reporting in MIPS vs. meaningful use

**MU**
- 100% score required on all measures to avoid penalty
- Included redundant measures and problematic CPOE, CDS, and clinical quality measures
- Full-year reporting (although twice reduced in Q4)

**MIPS ACI**
- Pass-fail program replaced with base and performance scoring
  - 4/5 base measures required
  - Partial credit allowed for performance measures
- Fewer measures: CPOE, CDS, and clinical quality measures eliminated
  - Public health registry reporting optional
  - Performance score thresholds eliminated
  - 90-day reporting periods for 2017 and 2018
  - Bonuses available for registry reporting and use of CEHRT in IA
### ACI performance category scoring: required measures (50% score)

<table>
<thead>
<tr>
<th>Objective</th>
<th>ACI Measure</th>
<th>Reporting Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protect patient health information</td>
<td>Security risk analysis</td>
<td>Yes/No statement</td>
</tr>
<tr>
<td>Electronic prescribing</td>
<td>E-prescribing</td>
<td>Numerator/ denominator</td>
</tr>
<tr>
<td>Patient electronic access</td>
<td>Provide patient access</td>
<td>Numerator/ denominator</td>
</tr>
<tr>
<td>Health information exchange</td>
<td>Send summary of care</td>
<td>Numerator/ denominator</td>
</tr>
<tr>
<td>Health information exchange (2015 CEHRT only)</td>
<td>Request/ accept summary of care</td>
<td>Numerator/ denominator</td>
</tr>
</tbody>
</table>
### 2017 ACI performance category scoring: optional measures (to reach full score)

<table>
<thead>
<tr>
<th>Objective</th>
<th>ACI Measure</th>
<th>Performance score</th>
<th>Reporting requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient electronic access</td>
<td>Patient-specific education</td>
<td>Up to 10%</td>
<td>Numerator/ denominator</td>
</tr>
<tr>
<td>Coordination of care/ patient engagement</td>
<td>View, download or transmit</td>
<td>Up to 10%</td>
<td>Numerator/ denominator</td>
</tr>
<tr>
<td>Coordination of care/ patient engagement</td>
<td>Secure messaging</td>
<td>Up to 10%</td>
<td>Numerator/ denominator</td>
</tr>
<tr>
<td>Coordination of care/ patient engagement</td>
<td>Patient-generated health data</td>
<td>Up to 10%</td>
<td>Numerator/ denominator</td>
</tr>
<tr>
<td>Health information exchange</td>
<td>Clinical information reconciliation</td>
<td>Up to 10%</td>
<td>Numerator/ denominator</td>
</tr>
<tr>
<td>Public health/ data registry reporting</td>
<td>Immunization registry reporting</td>
<td>0 or 10%</td>
<td>Numerator/ denominator</td>
</tr>
</tbody>
</table>
ACI bonus point scoring

• 5% bonus potential for reporting (via Yes/No statement) to one or more additional public health and clinical data registries:
  – Syndromic surveillance
  – Electronic case (in 2018)
  – Public health registry
  – Clinical data registry

• 10% bonus potential for reporting certain Improvement Activities (IAs) using CEHRT
Improvement Activities (formerly CPIA)

- New component, intended to provide credit for practice innovations that improve access and quality
  - Over 90 activities that cross 8 categories
  - No required categories
- 40 points required for medium and large practices (2-4 activities)
- Only 1-2 activities required for groups ≤ 15, rural and HPSA practices, non-patient facing specialists
  - Most physicians fall into this category
- Participation in 2017 MIPS APMs and non-advanced medical homes worth 40 points
  - PCMH definition expanded to include national, regional, state, private payer, and other certifications
Improvement Activities categories

- Expanded Practice Access
- Population Management
- Care Coordination
- Beneficiary Engagement
- Patient Safety & Practice Assessment
- Achieving Health Equity
- Emergency Response and Preparedness
- Integrated Behavioral & Mental Health
## Cost in MIPS vs. VBM

### VBM
- Included both quality reporting and resource-use measures
- PQRS failure counted twice in penalty calculations
- Poor risk adjustment produced penalties for treating sickest patients
- No statutory limits on penalty risk

### MIPS Cost
- Focuses solely on cost; no duplicative quality reporting, no duplicative penalties
- 10 episode groups finalized; others being tested and refined
- Plans to improve attribution methods in 2018 (for 2020 payments)
- Part D drug costs will not be included in calculation
- During 2017 transition, category weight will be zero
- Reports provided to physicians in transition for review only; will include total costs per capita and Medicare spending per beneficiary

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No physician reporting required for this component; calculated by CMS based on claims submitted.
Cost category measures

- **Cost based**
  - Medicare spending per beneficiary
  - Total per capita cost

- **Episode based**
  - Cataract/lens surgery
  - Mastectomy
  - Aortic/mitral valve surgery
  - Coronary artery bypass graft
  - Repair of hip/ femur fracture or dislocation
  - Cholecystectomy and common duct exploration
  - Colonoscopy and biopsy
  - Transurethral resection of the prostate for benign prostatic hyperplasia
  - Hip replacement or repair
  - Knee arthroplasty
  - *All 10 have been included in 2014 and 2015 Supplemental QRURs*
Small practice accommodations and impacts

- Low volume threshold
- “Pick your pace” transition for 2017
  - CMS estimates 90% of eligible clinicians will get zero or positive adjustments
  - CMS estimates 80% of those will be in groups ≤ 10
- Eased requirements for Improvement Activities component
- $100 million in grants for technical assistance to small practices via QIOs, regional health cooperatives, etc.
- Participation in rural health clinics sufficient for full Improvement Activities score for rural and small practices
- Future rulemaking to address virtual groups, pooled financial risk arrangements
Alternative Payment Models (APMs)
APMs participation options as outlined by CMS

- “Advanced” APMs—term established by CMS; these have greatest risks and offer potential for greatest rewards
- Qualified Medical Homes have different risk structure but otherwise treated as Advanced APMs
- MIPS APMs receive favorable MIPS scoring
- Physician-focused APMs are under development
CMS criteria for Advanced APMs

• 50% of participants must use certified EHR technology
• Must report and at least partially base clinician payments on quality measures comparable to MIPS
• Bear “more than nominal risk” for monetary losses
  • Defined as the lesser of 8% of total Medicare revenues or 3% of total Medicare expenditures
  • Primary Care Medical Home models with < 50 clinicians have different standards (2.5%-5% total Medicare revenues)
• Physicians may be Qualified Participants (QPs) or Partially Qualified Participants (PQPs) based on revenue and patient thresholds, with differential rewards
MACRA incentives for Advanced APM participation

Model design
• APMs have shared savings, flexible payment bundles and other desirable features

Bonuses
• In 2019-2024, 5% bonus payments made to physicians participating in Advanced APMs

Higher updates
• Annual baseline payment updates will be higher (0.75%) for Advanced APM participants than for MIPS participants (0.25%) starting 2026

MIPS exemption
• Advanced APM participants do not have to participate in MIPS (models include their own EHR use and quality reporting requirements)
Current Advanced APMs

- Comprehensive ESRD Care Model (13 ESCOs)
- Comprehensive Primary Care Plus (14 states, practice applications closed 9/15/16)
- Medicare Shared Savings Track 2 (6 ACOs, 1% of total)
- Medicare Shared Savings Track 3 (16 ACOs, 4% of total)
- Next Generation ACO Model (currently 18)
- Oncology Care Model Track 2 (A portion of 196 practices will qualify)
New Advanced APMs for 2018 (subject to rulemaking)

ACO Track 1+

Voluntary bundled payment models

Comprehensive Care for Joint Replacement Payment Model (CEHRT Track)

Advancing care coordination through episode payment models Track 1 (CEHRT)

Vermont Medicare ACO Initiative (all payer ACO model)
### MIPS APMs

#### Criteria
- APM entity participates in a model under an agreement with CMS
- Entity includes at least one MIPS eligible clinician on a participant list
- Payment incentives based on performance on cost and quality measures (either on entity or individual clinician level)

#### 2017 qualified models
- MSSP Track 1 counts

#### Advanced APM benefits do not apply
- Must participate in MIPS to receive any favorable payment adjustments
- Do not qualify for 5% APM bonus payments 2019-2024
- Not eligible for higher baseline annual updates beginning 2026

#### Other benefits
- 2017 MIPS APMs receive full Improvement Activities credit (could vary in future years)
- Models have simplified MIPS reporting
- APM-specific rewards (e.g., shared savings, guaranteed payments)
- Eligible for annual MIPS bonuses, which continue indefinitely (vs. 6 years for 5% APM bonuses)
## Requirements and payments for APM participants

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Qualified Participant in Advanced APM</th>
<th>Partially Qualified Participant in Advanced APM</th>
<th>MIPS APM participant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient and revenue thresholds required</td>
<td>≥25% revenues or ≥20% patients in 2019, rising to 75% or 50%, respectively by 2023</td>
<td>≥20% revenues or ≥10% patients in 2019, rising to 50% and 35%, respectively, by 2023</td>
<td>None</td>
</tr>
<tr>
<td>Eligible for APM bonus, higher updates</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Must participate in MIPS</td>
<td>No</td>
<td>Optional (but no performance adjustments without MIPS)</td>
<td>Yes</td>
</tr>
<tr>
<td>MIPS scoring and adjustments</td>
<td>N/A</td>
<td>Favorable weighting and scoring</td>
<td>Favorable weighting and scoring</td>
</tr>
</tbody>
</table>
Timeline for determining eligibility and bonuses

- APM participants will be identified by CMS via 3 “snapshots”
  - March 31, June 30, August 31
  - Physicians listed as participants on one of those dates will be considered participants for that performance year
- Performance year ends August 31
  - Provides time for MIPS reporting for those not meeting thresholds
- 5% bonus will be calculated on Medicare revenues for second calendar year
  - Lump sum payment provided in third calendar year
- Example:
  - 2017 performance year determines eligibility (as of August 31)
  - 2018 year-end revenues provide base for calculating bonus
  - Lump sum bonus payment mid-2019 after all 2018 claims are submitted
Moving Forward
### Timeline on payment adjustments

<table>
<thead>
<tr>
<th>Year</th>
<th>Fee Schedule Updates</th>
<th>MIPS</th>
<th>QPs in Adv. APMs</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>0.5% annual baseline updates</td>
<td>Max Adjustment (additional bonuses possible)</td>
<td>5% bonus</td>
</tr>
<tr>
<td>2017</td>
<td>0.5% annual baseline updates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>0.5% annual baseline updates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2019</td>
<td>No annual baseline updates</td>
<td>4%</td>
<td></td>
</tr>
<tr>
<td>2020</td>
<td>No annual baseline updates</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>2021</td>
<td>No annual baseline updates</td>
<td>7%</td>
<td></td>
</tr>
<tr>
<td>2022</td>
<td>No annual baseline updates</td>
<td>9%</td>
<td></td>
</tr>
<tr>
<td>2023</td>
<td>No annual baseline updates</td>
<td>9%</td>
<td></td>
</tr>
<tr>
<td>2024</td>
<td>No annual baseline updates</td>
<td>9%</td>
<td></td>
</tr>
<tr>
<td>2025</td>
<td>No annual baseline updates</td>
<td>9%</td>
<td></td>
</tr>
<tr>
<td>2026 on</td>
<td>No annual baseline updates</td>
<td>9%</td>
<td></td>
</tr>
</tbody>
</table>

- **Fee Schedule Updates**: 0.5% annual baseline updates for 2016, 2017, 2018, and 2019; no annual baseline updates for 2020 on.
- **MIPS**: Max Adjustment (additional bonuses possible) for 2016 on, with yearly increases of 4%, 5%, 7%, 9%, 9%, 9%, and 9%.
- **QPs in Adv. APMs**: 5% bonus consistently from 2016 on.
## Milestones

### 2017

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 1</td>
<td>First transitional performance period begins</td>
</tr>
<tr>
<td><strong>Spring</strong></td>
<td>PQRS, VBM, MU pay adjustments (2015 performance)</td>
</tr>
<tr>
<td>Oct 1</td>
<td>Last chance to start 90-day reporting period</td>
</tr>
<tr>
<td>Nov 1</td>
<td>2018 performance threshold announced</td>
</tr>
<tr>
<td>Dec</td>
<td>Notification of LVT exception (9/1/16-8/31/17)</td>
</tr>
</tbody>
</table>

### 2018

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 1</td>
<td>Second transitional performance period begins</td>
</tr>
<tr>
<td>Jan 2-Mar 31</td>
<td>Submission period for 2017 performance data</td>
</tr>
<tr>
<td><strong>Spring</strong></td>
<td>Final PQRS, VBM, MU pay adjustments (2016 performance)</td>
</tr>
<tr>
<td>Nov 1</td>
<td>2019 performance threshold announced</td>
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<tr>
<td>Dec</td>
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### 2019

<table>
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<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 1</td>
<td>QPP transitional reporting completed</td>
</tr>
<tr>
<td><strong>Spring</strong></td>
<td>First QPP pay adjustments implemented (2017 performance)</td>
</tr>
</tbody>
</table>
What Physicians Can Do to Prepare
AMA MACRA checklist

✓ Are you exempt from MIPS?
  ✓ Low volume provider?
  ✓ Qualified participant in an advanced APM?
✓ Do you want to participate as an individual or as a group?
✓ Do you meet requirements for small, rural, non-patient-facing accommodations?
✓ Do you/ can you participate in a qualified clinical data registry?
✓ Do your PQRS and QRUR reports reveal areas for improvement?
✓ Which Improvement Activities are you engaged in now? What are you interested in doing?
✓ Is your EHR certified? If so, is it the 2014 or 2015 edition? Does your vendor support Medicare quality reporting?

More detailed checklist available on AMA website
AMA Understanding Medicare Reform home page

www.ama-assn.org/MACRA

Links and tabs to:
• Detailed AMA comments and recommendations
• Specific info on MIPS and APMs
• STEPSForward modules
• Checklist to prepare
• MACRA Action Kit and slides from A-16
• Links to specialty society MACRA resources
• Other MACRA resources, links, and news stories
AMA Payment Model Evaluator tool
CMS measure selection tool

www.qpp.cms.gov
Explore Measures
Explore Quality Measures
Take advantage of educational opportunities

www.stepsforward.org

Completion of select STEPS Forward™ modules meets eligibility criteria for Improvement Activity category credit
Other learning opportunities

Sharing information from experienced physicians
- Podcast interviews
- Instructional videos
- Demos

Educational events
- Webinars (Nov. 21 and Dec. 6)
- Seminars (Dec. 1 in Atlanta; Dec. 10 in San Francisco)

Also:
- Paid media
- Social media
- Federation outreach