MACRA action kit checklist

On Oct. 14, 2016, the Centers for Medicare & Medicaid Services (CMS) released the final rule with comment period to implement MACRA's Merit-Based Incentive Payment System (MIPS) and advanced alternative payment models (APMs). Collectively, these programs are part of what CMS now calls the Quality Payment Program (QPP).

Physicians have the opportunity to pick their pace of participation during the 2017 QPP transition year. During the 2017 transition year, physicians only need to report one quality measure for one patient, one Improvement Activity, or all of the required Advancing Care Information (ACI) measures to avoid a negative payment adjustment in 2019. While the performance year is 2017, physicians will not receive their payment adjustment until two years later.

Taking steps now to prepare for 2017 and beyond can ease the transition for your practice and position you to earn financial rewards for the high-value care your provide. As many of the requirements that are simplified during the 2017 transition year will continue and expand in future reporting years, determining how your practice can succeed in the years ahead should start now. Going forward be sure to watch for additional announcements and new detailed educational materials from the American Medical Association.

Steps you can take now to prepare

Whether you ultimately participate in an APM or the MIPS, taking action in the following areas can position your practice for success in the future.

General considerations

- ☐ Determine whether you have $30,000 or less in Medicare charges OR 100 or fewer Medicare patients annually. If so, you are exempt from MIPS participation. Physicians below the low-volume threshold should receive a communication from CMS notifying them of their exempt status in December 2016.
- ☐ If you are not already participating in a qualified clinical data registry (QCDR), contact your specialty society about participating in theirs—data registries can streamline reporting and assist with MIPS performance scoring.
- ☐ Determine whether your practice meets the requirements for small, rural, health professional shortage area or non-patient facing physician accommodations.
- ☐ Determine whether you want to participate as an individual or group. If participating and reporting as a group, all physicians in the group must report on the same measures across *all four* categories.

Quality

- ☐ Check your Medicare Physician Quality Reporting System (PQRS) feedback reports. Make sure that you understand your current quality metrics reporting requirements and how you are scoring across both PQRS and private payers. Determine which quality measures you plan to report on—there are individual measures and specialty-specific measure sets, as well as QCDR specific measures. CMS has provided a tool to review and select MIPS-approved quality metrics at qpp.cms.gov/measures/quality.
- ☐ Access and review the 2015 annual PQRS feedback reports to see where improvements can be made. Authorized representatives of group and solo practitioners can view the reports on the CMS Enterprise Portal using an Enterprise Identity Data Management account with the correct role.
- ☐ Consider whether you plan to report through claims, electronic health record (EHR), clinical registry, qualified clinical data registry (QCDR) or group practice reporting option (GPRO) Web-interface. The GPRO Web-interface is only available for physicians in practices of 25 or more eligible clinicians. Claims reporting is only available for physicians reporting individually.
- ☐ If you plan to report through an EHR, verify directly with your vendor that they will support the Quality category, which is one of four components of the MIPS program.
- ☐ Seek local support for your quality improvement activities. Many local organizations such as Practice Transformation Networks provide resources and technical support—often free of charge—to help small physician practices succeed.
- ☐ If you are in a group of 16 or more eligible clinicians, review your Medicare quality and resource use report (QRUR) to determine how you will be assessed for patient readmissions to the hospital.

Cost

In 2017 CMS will not include cost measures in the final MIPS score.

- ☐ Plan to review feedback CMS provides for informational purposes throughout the 2017 performance period that will affect your cost score in future years.
- ☐ Check your Medicare QRURs to see where improvement can potentially be made.
- ☐ Review the 10 episode-based measures finalized for 2017.
- ☐ Identify your most costly patient population conditions and diagnoses.
- ☐ Identify the lead clinician for each attributed patient for each measure.
- ☐ Identify targeted care delivery plans for these conditions.
- ☐ Identify any internal workflow changes that can be made to support care delivery plans.
- ☐ Identify potential partners outside of your practice to advance a coordinated care plan (e.g., other specialists to whom you refer patients).

Improvement Activities

- ☐ Review the final rule's list of Improvement Activities to evaluate what activities your practice is already doing and what adjustments it should make to complete additional activities in 2017.
    - Consider completing appropriate American Medical Association STEPS Forward™ program modules that qualify for Improvement Activities requirements.
- ☐ The reporting period for Improvement Activities is 90 days. Consider which 90 days in 2017 would work best for your practice's selected Improvement Activities.
- ☐ If you participate in a patient-centered medical home (PCMH), or comparable specialty practice (including those certified by a national, regional or state program, private payer, or other body that administers PCMH accreditation and certifies 500 or more practices for PCMH accreditation or comparable specialty practice certification), you will receive full credit in the Improvement Activities performance category.
- ☐ Determine if you participate in a MIPS APM. If so, you will receive full credit in the Improvement Activities category for 2017.

Advancing Care Information (formerly Meaningful Use)

- ☐ Speak with your vendor about how their EHR product supports new payment model adoption. For example: How does their product support Medicare quality reporting? Document these conversations.
- ☐ If you have an EHR, make sure it is certified EHR technology, which is often referred to as "Certified Electronic Health Record Technology" (CEHRT). Determine whether it is 2014- or 2015-edition CEHRT. The version will determine number of required ACI measures on which you must report in 2017 (4 or 5, respectively).
- ☐ Consider how to ensure that you can report at least one unique patient (or answer "yes," as applicable) for each measure of the base score's four measures in 2017. For example:
    - Your EHR may allow you to send a secure message through the patient portal to all of your patients at once. If so, and doing so is appropriate for your practice, consider sending an appointment reminder to all of your patients in 2017.
- ☐ Conduct a careful security risk analysis in early 2017. Failure to properly do so will result in a score of zero for this category. Your risk analysis should comply with the HIPAA Security Rule requirements. The AMA website has resources to help with this step.
- ☐ Determine whether there is a public health or clinical data registry to which you can report to receive bonus percentage points towards your total Advancing Care Information score.
- ☐ Physicians may receive bonus percentage points toward their Advancing Care Information score by using CEHRT to perform one or more of 18 designated Improvement Activities. Review these activities to see if any of them are appropriate for your practice.

Alternative Payment Models or APMs

- ☐ Confirm whether you are a participant in any of the advanced APMs. If not, contact your specialty society or state medical society to find out if there are APM opportunities for your practice.
- ☐ Evaluate whether you are likely to meet the required percentage of patients or payments for significant participation in an advanced APM, which would qualify you for incentive payments.
- ☐ Determine whether 50 percent of the clinicians participating in the APM use certified EHR technology to document and communicate clinical care information.

Physician attestation requirements

- ☐ Communicate your requirements to limit data blocking to your health information technology (IT) vendors.
- ☐ Obtain assurances from your health IT vendors that your EHR and other health IT products were connected in accordance with your data blocking attestation requirements.
- ☐ Obtain assurances from your health IT vendors that your EHR is implemented in a manner that will enable you to demonstrate that you have not knowingly or willfully limited the interoperability of your EHR.

Education

- ☐ Check out the AMA's Payment Model Evaluator to help decide which path your practice should take to maximize success.
- ☐ The AMA will continue to develop and revise resources and tools to help physicians succeed in the QPP program, so please visit our QPP resource and STEPS Forward™ webpages often.

ama-assn.org/medicare-payment

16-37947:PDF:12/16