AAMC
Tomorrow's Doctors, Tomorrow's Cures®

Starting to Prepare in 2017 for the New Physician Payment System Under MACRA

The Medicare Access CHIP Reauthorization Act (MACRA) final regulations will be issued in the fall of 2016. **The AAMC is committed to providing assistance to members during the transition to MACRA. This summary of actionable steps, one of the many resources we will provide, should help you position your practice for success. The steps will be updated periodically as we learn more about MACRA and identify best practices.**

MACRA establishes two payment tracks: the Merit-based Incentive Payment System (MIPS) and advanced Alternative Payment Models (APMs). The MIPS program consolidates the payment adjustments from the Medicare Electronic Health Record (EHR) Incentive Program ("meaningful use"), the Value-based Modifier (VM), and the Physician Quality Reporting System (PQRS) into a large pay-for-performance program. Providers will be measured on quality, resource use, clinical practice improvement activities (CPIA), and advancing care information (ACI), which will result in an overall composite performance score (CPS) that will determine their Medicare payment starting two years after the performance period.

Eligible clinicians also have an option to participate in APMs that may qualify to receive a 5% payment bonus. To receive the bonus, clinicians must participate in advanced APMs and meet certain thresholds of percentage of Medicare patients or payments provided through those APMs. Clinicians who are deemed by the Centers for Medicare and Medicaid Services (CMS) to be qualifying participants will not be subject to MIPS.

Four Options for Calendar Year 2017 to Allow Flexibility for the Transition Period

Your performance in 2017 will determine Medicare Part B payment adjustments in 2019. If you choose to do no reporting in 2017, your 2019 Part B payments will be subject to a negative 4% payment adjustment. The legislation requires that you be scored in four areas: quality, advancing care information, clinical practice improvement activities, and resource use. For 2017, the resource use category will not be counted in the performance score, so your score will be derived from no more than three categories. The amount of money garnered from negative updates sets the pool for positive updates. Because the number of eligible clinicians receiving a negative update is now expected to be smaller than previously anticipated, the amount of money available for the positive updates will also be less than anticipated.

You have the following four options during the first year of participation, known as the "transition year":

1. For MIPS, report for a full, continuous 90-day period or up to the full year and on all required measures to maximize the chances to qualify for a positive adjustment. Exceptional performers—those who receive a final score of 70 or higher—may receive an additional positive adjustment.

2. For MIPS, report for a full, continuous 90-day period but for less than a full year and on more than one quality measure, more than one improvement activity, or more than the required measures in advancing care information to avoid a negative adjustment and, possibly, receive a positive adjustment.

3. For MIPS, report on one quality measure, one clinical improvement activity, or one of the required measures of advancing care information to avoid a negative adjustment. Eligible clinicians who do not report even one measure or activity will receive a negative 4% payment adjustment.

4. Participate in advanced APMs and qualify for a 5% bonus incentive payment.

Under MIPS, the performance categories, for the first year, are weighted as follows:

- Quality (60%): The number of measures you are required to report on varies based on your reporting option.*
- Advancing care information (ACI) (25%): You must fulfill the required measures for a minimum of 90 continuous days and can report additional measures for bonus credit—however, you are not required to submit measures if they do not apply to you.
- Clinical practice improvement activity (CPIA) (15%): The number of activities varies by group size but must be reported for a minimum of 90 continuous days.
- Resource use (0%): No data submission is required, but CMS will calculate your performance on certain cost measures and give you this information in performance feedback.

*If you are a Group Practice Reporting Option (GPRO) Web Interface user, you are required to submit quality data for the full 12 months regardless of which option you pick.

Preliminary Steps for Your Team

The steps summarized in the figure below will help your team prepare for MACRA.

Notes: QRURs = Quality and Resource Use Reports; TIN = tax identification number; MIPS = Merit-based Incentive Payment System; APM = Alternative Payment Model.

Forming a MACRA Team

Implementing MACRA within your practice will require the collaboration of multiple systems and disciplines. You could consider including on the team individuals with the following roles:

- Clinical leadership (for example, medical directors, physicians, and nursing staff)
- Information technology staff and data analysts
- Practice or project managers
- Quality improvement and programs staff
- Billing staff
- Finance staff
- Senior leadership

For further information, visit the CMS and AAMC MACRA webpages (qpp.cms.gov and aamc.org/MACRA) or email **teachingphysicians@aamc.org**.