2017 MACRA READINESS CHECKLIST

The checklist below will help you begin to prepare your practice for the changes in 2017 Quality Reporting.

MIPS READINESS	
Determine if you are eligible	
	You have at least $30,000 in Medicare Part B allowed charges per year.
	You see at least 100 Medicare patients per year.
	This is not your first year as a Medicare Participating Provider.
	You do not participate significantly in an Advanced APM (receive 25% of Medicare payments or see 20% of Medicare patients through an Advanced APM).
Determine how you will report	
	MIPS reporting can be completed via a registry, EHR or a CMS portal. Evaluate the best approach for your practice.
	Choose one of 3 reporting options. • Option 1 – Test: Submit some data (No payment adjustment) • Option 2 – Partial year reporting (Eligible for "small" positive adjustment) • Option 3 – Full year reporting (Eligible for "modest" positive adjustment)
	If you are in a group, decide if you will report via the Group Reporting Option (GPRO) or individually.
Register for ASA Quality Reporting through AQI/NACOR	
	Participation in a Qualified Clinical Data Registry (QCDR) or Qualified Registry (QR) such as NACOR helps satisfy the quality reporting requirement and is relevant to several Improvement Activities in the Improvement Activities component of MIPS.
Review your QRUR Report to identify where improvements can be made	
	CMS publishes a Quality and Resource Use Report (QRUR) biannually to help practices understand their cost and quality assessments under the Value Modifier and quality measure under PQRS. Under MIPS your cost score will be used to assess the cost component. To access your practice's QRUR report, visit the CMS Enterprise Portal.
IMPROVEMENT ACTIVITIES (IA)	
Review CMS' list of Improvement Activities	
	Identify activities that are most relevant to your practice. You will need to select and complete activities equaling 40 points annually to get full credit for this MIPS component. Improvement Activities are weighted as medium (10 points) or high (20 points). Eligible clinicians (ECs) can attest to any combination as long as they equal 40 points (e.g., 4 medium; 2 medium, 1 high; 2 high). Non-patient facing ECs requirements are different in that the IAs are doubled in weight: medium = 20 points, high = 40. Again, non-patient facing ECs have to reach 40 points (e.g., 2 medium or 1 high).

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ADVANCED APM READINESS	
Determine your eligibility to participate in an Advanced Alternative Payment Model (APM)	
	Reporting options under this category are relatively limited due to the restrictive criteria to quality as an Advanced APM. An Advanced APM must meet the following three criteria: 1. Require participants to use certified electronic health record technology (CEHRT); 2. Provide payment for covered professional services based on quality measures comparable to those used in the quality performance category of MIPS; and 3. Either: (1) be a Medical Home Model expanded under CMS Innovation Center authority; or (2) require participating APM Entities to bear more than a nominal amount of financial risk for monetary losses.
Determine if you're already involved in a CMS Innovation Center Payment Model	
	If the facility where you practice is already within a mandatory reporting metropolitan statistical area (MSA) for a CMS Innovation payment model (e.g., CJR, SHFFT, AMI, etc.), you are likely to already be enrolled in an Advanced APM.
Review the complete list of APMs to determine your practice's eligibility to participate in a MIPS APM	
	Even if you're involved in or considering participation in an APM that does not currently qualify for Advanced status, participating in a MIPS APM has advantages.
Determine if you will meet the criteria to receive the 5% bonus under the Advanced APM pathway	
	Just because you see patients within an APM doesn't mean you will automatically qualify under the Advanced APM pathway. The following are the criteria to be considered a Qualified Participant (QP): • You receive 25% of your Medicare Part B payments through an Advanced APM, or • See 20% of your Medicare patients through an Advanced APM. **NOTE:** If you leave the Advanced APM in the middle of a reporting year, you should make sure you've seen enough patients or received enough payments through an Advanced APM to qualify for the 5% bonus. If you haven't met these thresholds, you may need to submit MIPS data to avoid a downward payment adjustment.
Engage your hospital(s) and practice to ensure your interests are heard in cost sharing discussions	
	A key component of most APMs is two-sided financial risk where providers can be either responsible for overspending or eligible for bonuses. It's important to be aware of the cost sharing arrangements between you, the provider and the APM facilitator (i.e., APM entity).