preceptors, the value of rural family medicine experiences, understanding the full scope of family medicine, and the importance of "top down" institutional influences.

**Impact of Organizational Programming:** Through work with the AAFP, preliminary data analysis on family medicine Interest Groups (FMIGs) identified significant positive correlates to match rates. Data showed that FMIG support is an important strategy for maintaining and increasing student choice, but should not be the only strategy, as students are motivated by different experiences and values. Attending the AAFP National Conference and AAFP student membership may also play an important role.

## Process of Medical Education

**Identity of "What Matters:"** To identify changes in medical education with the greatest potential influence on student choice, the ADFM surveyed Department Chairs, medical school models of positive deviance were investigated, and focus groups of key stakeholders were conducted. A partnership between FMAHealth, AAFP, STFM, and ADFM created a Family Medicine Student Choice Learning and Action Network (SCLAN) to learn, test and measure the impact of interventions. ADFM's work on the Best Practice Guidebook Project will provide a SLAN pilot tool.

**Training Future Advocates:** As family physicians, one of our most important roles is as advocates for our patients. A CERA Program Director survey and national student/resident survey will identify needs and contribute to a model curricular resource for advocacy training.

**Leadership Development:** Through the Primary Care Leadership Collaborative (PCLC), a collaboration between FMAHealth, AAFP, and Primary Care Progress, a new FMIG leadership model is being tested teaching relational leadership skills. PCLC trains medical students to take meaningful action that advances their local primary care communities.

**Shortage of High Quality Primary Care Community Preceptors:** Identified by FMAHealth as an important issue, STFM convened a multi-stakeholder preceptor summit which included students, residents, health system leaders, policy experts, clerkship directors, community preceptors, and non-precepting physicians. The subsequent action plan identifies partnerships and initiatives to drive health system change.

## Practice Transformation

Burnout prevention and wellness are major focus areas for physicians and trainees. Student and resident leaders implemented awareness-building strategies and assessed what has the biggest potential for change.

## Payment Reform

**Faculty Salary Gap:** In addition to the broad impact which payment reform has on primary care physician workforce development,[2] the payment gap between faculty and employed/private practice physicians should be a part of payment reform work.

These programs highlight the collective impact of family medicine organizations on increasing student choice. Looking deeper into the evidence, collaborative opportunities within and outside family medicine, and innovative work around the four pillars will allow each of us to contribute to the shared aim.

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# THE NEW MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS): POTENTIAL IMPACT ON RESIDENT MOONLIGHTING

In 2015, the Medicare Access and Children's Health Insurance Program Reauthorization Act (MACRA) changed how payments are made by Medicare to physicians and other health care providers. This new system set up a 2-track, value-based payment model Medicare physician payment system, called the Quality Payment Program. The 2 tracks are the Alternative Payment Model (APM) and the Merit-Based Incentive Payment System (MIPS). Physicians can choose the track in which they will participate based on their

practice size, specialty, location, or patient population as long as they meet the eligibility criteria. Both tracks will be using performance data collected 2 years before the payment year to determine the compensation rate. The collection of the data started in January 2017 for payments to be made in 2019.[1] This system may have unintended consequences for residents who moonlight.

Most physicians will participate in the MIPS track which is based on existing quality and value activities with few entry requirements or exceptions, making it easy to become a participant. Physicians in this track receive a score based on 4 categories from their performance for the previous 2 years: quality, cost, advancing care information, and improvement activities. Scores are added and weighted before being compared to a "performance threshold." Adjustments in Medicare payments are made based on where the score lies in comparison to the threshold. [2]

To participate in the MIPS track, a physician must have completed their first year as a Medicare provider using their own Medicare provider number, have Medicare billing of at least $30,000 a year and provide care for more than 100 Medicare patients a year. Normally, residents would not qualify to enroll in MIPS until after their first year of practice after graduation. They would not be able to meet all the criteria. This would also exclude them from the collection of any performance data to calculate their MIPS score as well.[3]

If a resident obtains their own Medicare provider number prior to graduation, however, and utilizes it for billing during moonlighting activities, this could trigger the collection of their performance data during their residency training. Depending on where they moonlight, their performance score components could be much lower than the established threshold, thereby placing them at risk of receiving a negative payment adjustment in 2 years. This could negatively impact their ability to secure a position with a practice and reduce their overall salary level. Practices may be hesitant to hire a physician with a low MIPS score because it could adversely affect the entire practice.

As part of our practice management curriculum, guidance is needed for our residents regarding the MACRA system and the MIPS track. They need to be informed of the risk of obtaining their own Medicare Provider number and utilizing it for billing while moonlighting. It is important they understand that MIPS scores stay with you and follow you even when you change practices or employers.

This is a great opportunity for us to prepare our residents for entering into a new system which we all hope will improve reimbursement under Medicare. We can teach them how to maximize a new process versus teaching them how to survive under the flawed sustainable growth rate formula-based system many of us have experienced. If we show them how to be successful, not only will our residents win, but so will the thousands of Medicare patients who are struggling to find physicians who will see them.

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