Internship Training

At

Deloitte Consulting US India Pvt. Ltd, Bangalore

"MACRA: Analysis of Medicare Payments model and Physician awareness about MACRA."

Submitted by

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PG/15/004

Under the guidance of

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Post-graduate Diploma in Hospital and Health Management

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International Institute of Health Management Research, New Delhi

TO WHOMSOEVER IT MAY CONCERN

This is to certify that Aditi Ray student of Post Graduate Diploma in Hospital and Health Management (PGDHM) from International Institute of Health Management Research, New Delhi has undergone internship training at Deloitte Consulting US India Pvt. Ltd, Bangalore from 6 Feb 2017 to 12 May 2017

The Candidate has successfully carried out the study designated to him during internship training and his approach to the study has been sincere, scientific and analytical. The Internship is in fulfillment of the course requirements.

I wish him all success in all his future endeavors.

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Certificate of Approval

The following dissertation titled **““MACRA: Analysis of Medicare Payments model and Physician awareness about MACRA.”**

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CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled MACRA: Analysis of Medicare Payments model and Physician awareness about MACRA" and submitted by Aditi Ray Enrollment No. PG/15/004 under the supervision of Dr. Preetha G.S for award of Postgraduate Diploma in Hospital and Health Management of the Institute carried out during the period from 6 Feb 2017 to 12 May 2017 embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other Institute or other similar institution of higher learning.

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ACRONYMS

MACRA	Medicare access and CHIPS reauthorization act
MIPS	Merit based payment incentive
APM	Advanced payment model
ACI	Advance care information
MU	Meaningful use
CMS	Centres for Medicare & Medicaid Services
QPP	Quality Payment Program
NPI	National Provider Identifier
CEHRT	Certified Electronic Health Records Technology
CPS	Composite performance score
SGR	Sustainable Growth Rate
HHS	Health and Human Services
PQRS	Physician quality reporting system
VBM	Value-based payment modifier
ACO	Affordable care organization
MSSP	Medicare shared savings program
HIT	Health information technology
QCDR	Qualified clinical data registry
CPC	Comprehensive primary care plus
OCM	Oncology care model
FFS	fee-for-service
VDT	View, download or transmit
CPIA	Clinical practice improvement activity
TIN	Tax identification number
CDSS	Clinical decision support system
CPOE	Computerized physician order entry
ESRD	End stage renal disease
QP	Qualified physicians
EP	Eligible physicians
PFPM	Physician focused payment model
PTAC	Payment model technical advice committee

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1.1Organization profile

Introduction

Internship is an integral part of MBA Hospital and Health Management program. The organization, in which the intern has done Internship at is Deloitte consulting USI. The Organization is compliant to ethical practices with respect to clients as well as the employees. Deloitte has various services lines within the projects. The intern has worked in the Application Management Support (AMS) service line. The first few weeks after reporting to Deloitte were extensively for compliance trainings and obtaining certificates for the same. When all the formalities were done then the intern was allowed to enter the secured bay where the project is based. The final topic was decided after discussions with the mentors assigned at the organization and the topic was found to be Study on MACRA: Analysis of Medicare Payments model and Physician awareness about MACRA.

Accordingly the project took its own pace at the organization with lapsing weeks. The last month was given for the reporting and compiling the Dissertation project work. Simultaneously the intern was supposed to clear exams specific to the Deloitte's project requirements. The presentation for the Dissertation was reviewed by the Life Sciences and Health care Industry (LHSC) Director, Senior Managers, Managers and project Mentors. All in all the experience at Deloitte gave the confidence as a professional in the Health care Industry.

Goals of Internship

1. To develop responsibility, and professionalism in a real-world setting
2. To enhance skills in Healthcare segment with respect to providers and payers
3. To use college knowledge towards problem solving

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2.1 Executive summary

This report represents the information about the MACRA(The Medicare Access and CHIP Reauthorization Act of 2015) .The purpose of the study is to know about the Quality payment program, changes in Medicare payment for the physicians, changes from Meaningful use to Advancing care Information and physician awareness about MACRA.

A descriptive study conducted by reviewing documents and secondary data collected by review of literature. Study reveals that MACRA repeals the Medicare Sustainable Growth Rate (SGR) methodology for updates to the Physician Fee Schedule (PFS) and replaces it with a new approach to payment called the Quality Payment Program (QPP). QPP rewards the delivery of high-quality patient care through two avenues: Advanced Alternative Payment Models (Advanced APMs) and the Merit-based Incentive Payment System (MIPS). MIPS will consolidate components of three existing programs, the Physician Quality Reporting System (PQRS), the Physician Value-based Payment Modifier (VM), and the Medicare Electronic Health Record (EHR) Incentive Program for Eligible Professionals (EPs), and will continue the focus on quality, cost, and use of certified EHR technology (CEHRT) in a cohesive program that avoids redundancies. Physicians who participate in Advanced APM i.e., physicians who are QPs will receive a 5 percent lump sum bonus payment on their fee-for-service reimbursements for years 2019-2024, physicians who participate in MIPS receive payments based on composite performance score(CPS), CPS score determines whether the physician will get positive payments ,negative payments or neutral payments. The Deloitte Center for Health Solutions 2016 Survey of US Physicians sheds light on physicians' awareness of MACRA, their perspectives on its implications, and their readiness for change, Deloitte survey found that many physicians are unaware of MACRA. Many also realize they likely will have to make changes to their practice to succeed under it; recognize they will need to bear increased financial risk; and understand they will require resources and support to develop the capabilities to do so. The Advancing Care Information performance category replaces the Medicare EHR Incentive Program for eligible professionals, also known as Meaningful Use. For scoring purposes, in the Advancing Care Information performance category (weighted at 25% of the total score), MIPS eligible clinicians may earn a maximum score of up to 155%, but any score above 100% will be capped at 100%. MIPS eligible clinicians must use certified electronic health record technology (CEHRT) to report to the Advancing Care Information performance category.

2.2 Background

Before MACRA, the payment to the physician for Medicare B program was done by Medicare's sustainable growth rate (SGR) payment formula. This model has been an annual nightmare for policymakers and physicians. It was created in 1997 as one of numerous changes to Medicare under the Balanced Budget Act- a way to restrain the government's spending on Medicare. Medicare Part B expenditures exceeded a target tied to overall economic growth, the physician fee schedule would be cut the following year. If spending fell below the target, physician payments would be increased. Although cuts to the physician fee schedule were called for under the formula every year after the first few years, the cuts have taken effect only once -- in 2002, when the SGR called for a 5.4% cut. Instead, the SGR has been better at threatening physicians with dramatic cuts to the fee schedule than at actually holding down costs [2]

Each year, when healthcare cost growth has exceeded this growth target, Congress has passed a short-term measure called a “doc fix” to avoid making the stipulated cuts.

Thus, to overcome all the inefficiencies on April 16, 2015, President Obama signed into law the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), changing the healthcare financing system in the most significant and far reaching way since the Program's inception in 1965 and ending annual temporary patches and massive lobbying efforts since the late 1990s to prevent significant reimbursement cuts for physicians serving Medicare beneficiaries caused by the so-called Sustainable Growth Rate (SGR) formula.

MACRA repealed the flawed Sustainable Growth Rate (SGR) payment system, which governed how physicians and other clinicians paid under Part B of the Medicare program.

MACRA replaces the 1997 Balanced Budget Act's SGR that used to determine annual physician payment updates. After approximately 20, so called "doc fixes," MACRA passed to replace the SGR in part because the formula addressed neither service frequency and intensity nor quality improvement.

MACRA replaced the SGR, and its fee-for-service (FFS) reimbursement model, with a new two-track system that requires physicians and clinicians to accept downside risk: Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs).

2.3 Introduction

2.3.1 Introduction to MACRA

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is set to change reimbursement for clinicians who receive Medicare Part B payments. MACRA repealed the Medicare physician Sustainable Growth Rate (SGR) formula, historically used to control the growth of physician reimbursement, and replaced it with the Quality Payment Program (QPP). The QPP affect all health care organizations and providers, as it will change the future of Medicare and the trajectory of the US health care industry's movement to quality-based payments (e.g., risk-based contracting models, payment for quality over volume, population health management).

MACRA Goals

Through MACRA, The U.S. Department of **Health and Human Services** (**HHS**) aims to:

• Offer multiple pathways with varying levels of risk and reward for providers to tie more of their payments to value.

• Over time, expand the opportunities for a broad range of providers to participate in APMs.

• Minimize additional reporting burdens for APM participants.

• Promote understanding of each physician or practitioner's status with respect to MIPS and/or APMs.

• Support multi-payer initiatives and the development of APMs in Medicaid, Medicare Advantage, and other payer arrangements.[3]

The proposed changes of MACRA will replace the patchwork system of Medicare reporting programs with a flexible system that allows the physician to choose from two paths of quality payment program that link the quality to Payment:

Merit Based Incentive Payment System and Alternative Payment Models.

The MACRA abolishes the SGR and from 2015 through 2025 provides physicians with a stable, sometimes flat, update to the Medicare physician fee schedule. Beginning in 2026, physicians and other healthcare professionals will receive different annual updates

depending on whether paid under the new MIPS (0.25%) or primarily through advanced APMs (0.75%).

Merit-based Incentive Payment System (MIPS).

MIPS is similar to the FFS (Fee for Service) model with a direct tie to quality performance. Beginning in 2019, the MIPS will be the default payment system for physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists and practice groups that include these professionals. The MACRA sunsets three current-law reporting and pay-for-performance programs – the physician quality reporting system (PQRS),Medicare Electronic Health Record (EHR) Incentive programs for eligible professionals, and the value-based payment modifier (VM) – and consolidates the measures and processes of these programs into the MIPS. Physicians and other eligible clinicians assessed in the MIPS under four performance categories:

Quality: CMS proposes that eligible clinicians expected to report on at least six measures drawn from a list of over 200 measures. Eligible clinicians would report using a single mechanism (e.g., registry, EHRs, Medicare claims).

Resource use: CMS would calculate two overall cost measures currently used in the VM program, as well as several clinical condition and treatment episode cost measures **Clinical practice improvement activities**: This category will reflect participation in activities such as expanded practice access; population management; care Coordination; beneficiary engagement; patient safety And practice assessment; and participation in an APM. Clinicians would select from a list of available activities

Advancing care information (ACI): This category is restructured approach to current-law meaningful use requirements.

Based on their performance in these four categories, physicians and eligible providers will receive a payment adjustment. The payment adjustment is +/- 4 percent in 2019, rising to +/- 9 percent in 2022 and subsequent years. In addition, for 2019 through 2024, the Secretary will designate a threshold for "exceptional performance" on the MIPS.[4]

Participation in Advanced APMs, MACRA creates incentives for physicians to participate in advanced APMs, thereby moving the Medicare program away from FFS and closer to a payment system tied to patient outcomes and population health. Beginning in 2019, the APM track allows physicians receiving a significant portion of their

payments through advanced APMs to be exempt from most MIPS provisions, and through 2024, to receive a lump sum payment of 5 percent of their covered services from the previous year. While CMS will specify in regulation, which APMs qualify for the APM track, the MACRA requires that APMs meet certain criteria. Specifically, to qualify as an advanced APM, a model must require use of certified EHR technology; Provide payment based on quality measures comparable to those used in the MIPS quality category and bear financial risk for more than a nominal amount of monetary loss, or be a medical home that meets certain criteria. Specifically, advanced APM participants would be required to refund Medicare if their spending under the model exceeds a projected amount (known as downside risk). APMs under Medicare include models tested by the Center for Medicare and Medicaid Innovation; a Medicare Shared Savings Program (MSSP) ACO; or certain other demonstrations required by federal law. Models that would qualify as advanced APMs are MSSP Tracks 2 and 3, the Next Generation ACO model, the Comprehensive End stage Renal Disease Care model, and the Oncology Care program.

2.3.2 Review of literature

MACRA 2.0: are you ready for MIPS?

(Hirsch et al 2016)

In 2015, the Medicare Access and CHIP Reauthorization Act (MACRA) was passed into law. MACRA has dramatic implications for all US based healthcare providers. MACRA permanently repealed the Medicare Sustainable Growth Rate to stabilize physician part B Medicare payments, consolidated pre-existing federal performance programs into the Merit based Incentive Payments System (MIPS), and legislatively mandated new approaches to paying clinicians. MIPS unifies, updates, and streamlines previously existing federal performance programs, thereby reducing onerous redundancies and overall administrative burden, while consolidating performance based payment adjustments. While MIPS may be perceived as a straightforward continuation of fee for service methodology with performance modifiers, MIPS is better viewed as a stepping stone toward eventually adopting alternative payment models in later years. In October 2016, the Centers for Medicare and Medicaid Services (CMS) released a final rule for MACRA implementation, providing greater clarity regarding 2017 requirements. The final rule provides a range of options for easing MIPS reporting requirements in the first performance year

Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models. Final rule with comment period

Centers for Medicare & Medicaid Services (CMS)

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repeals the Medicare sustainable growth rate (SGR) methodology for updates to the physician fee schedule (PFS). It replaces with a new approach to payment called the Quality Payment Program .It rewards the delivery of high-quality patient care through two avenues: Advanced Alternative Payment Models (Advanced APMs) and the Merit-based Incentive Payment System (MIPS) for eligible clinicians or groups under the PFS. This final rule with comment period establishes incentives for participation in certain alternative payment models (APMs) and includes the criteria for use by the Physician-Focused Payment Model Technical Advisory Committee (PTAC) in making comments and recommendations on physician-focused payment models (PFPMs). Alternative Payment Models are payment approaches, developed in partnership with the clinician community, that provide added incentives to deliver high quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population. This final rule with comment period also establishes the MIPS, a new program for certain Medicare-enrolled practitioners. MIPS will consolidate components of three existing programs, the Physician Quality Reporting System (PQRS), the Physician Value-based Payment Modifier (VM), and the Medicare Electronic Health Record (EHR) Incentive Program for Eligible Professionals (EPs), and will continue the focus on quality, cost, and use of certified EHR technology (CEHRT) in a cohesive program that avoids redundancies. Enters for Medicare & Medicaid Services (CMS)

Unpacking MACRA: The proposed rule and its implications for Payment and Practice.

(Haycock, 2016)

The Centers for Medicare & Medicaid Services (CMS) has released a proposed rule that details a consolidated pay-for-performance provider payment system within the Medicare Access and CHIP Reauthorization Act. This proposed rule establishes policy for the new provider Merit-Based Incentive System and Alternative Payment Models. While the rule is extremely complex, and not yet finalized, there are significant implications for nursing and advanced practice providers. This proposed rule intends to drastically change the

current provider payment system and reward providers who demonstrate better quality outcomes at a lower cost. It also aligns with the current administration's intention to reform the payment and delivery system to a value-based methodology. Within the proposed rule, there is much at stake and will likely transform the way in which providers are reimbursed for Medicare beneficiaries. Many strategies can help drive success within this new legislation. Among them are a renewed focus on quality outcomes, knowledge of clinical performance, care coordination, and deploying new models of care that address a lower cost structure. It is imperative that nurses and advanced practice providers are aware of this new legislation and its effects on their practice.

Are physicians ready for MACRA and its changes? Perspectives from the Deloitte Center for Health Solutions 2016 Survey of US Physicians

[By- Mitch Morris,]

This report studies the preparedness of the physician to the new payments system. It accesses their knowledge about MACRA. MACRA will fundamentally shift the US health care system to make major cost and quality improvements. It changes physicians' payment under Medicare and will likely influence other payers' physician payment strategies as well. MACRA's first performance reporting period is has started from January 1, 2017. Understanding the law, physicians' awareness about the law, and all the changes it will bring can help all stakeholders determine which strategies to implement to help succeed under MACRA.

The Deloitte Center for Health Solutions 2016 Survey of US Physicians sheds light on physicians' awareness of MACRA, their perspectives on its implications, and their readiness for change. They survey sample is of 600 primary care and specialty physicians who were asked about a range of topics on value-based payment models, consolidation, and health information technology (HIT). They found that many physicians are unaware of MACRA. Many physician realized that they likely would have to make changes to their practice to succeed under it, they will need to bear increased financial risk and they will require resources and support to develop the capabilities to do so.

2.3.3 Purpose of the study

Reason to choose MACRA project is because the first performance period opens on January 1, 2017 and closes on December 31, 2017. During 2017, physicians are required to report data on certain objectives and measures by MACRA and their payment by Medicare will depend on it.

MACRA puts significant revenue at stake for hospitals, health plans, and other organizations that employ clinicians who are paid through the Medicare PFS. In addition, the law's incentives for clinicians to enter risk-bearing, coordinated care models could create opportunities for health systems and health plans to enter into new arrangements with clinicians under Medicare. Thus understanding this model will help al the stakeholders of healthcare. The physicians will know what path to follow according to the resources available and what capacity to build to improve their incentives.

For firms like Deloitte, understanding the requirement of MACRA will provide them an opportunity to build a platform for physicians, to help them to be compliant with this act

Thus this study will cover all aspects of the act, along with understanding physician's awareness level about the model.

2.3.4 Objectives of the study

1. **To understand the Quality payment program of MACRA**

   To study different pathways provided by the new act and the details of each parameter.

2. **To understand the Medicare Payments of Physicians**

   to study in detail the payment models under MACRA and the incentives, penalties and the timelines in which it will be applicable.

3. **To study the awareness of Physicians about MACRA**

   Analyse the understanding of physicians regarding the new act and their acceptance level towards it.

2.4 Methodology

Study Design: **Descriptive study -** A **document review** was done, as last two years data was reviewed from various articles, reports and journals to understand " MACRA" and the different payment models, how will it improve the current scenario and physicians level of understanding and acceptability.

The first and the second objectives are accomplished by understanding the requisites of the act, mentioned on Government online portals cited in bibliography. It describes the various method by which the physicians will receive the payments from Medicare B payment.

After review, the research's third objectives are met by analyzing the awareness levels from the reviewed data of the physicians related to MACRA. It elaborates a study done by Deloitte to analyze their understanding and the acceptance level towards this act.

Type of Data: Secondary Data collected by reviewing documents and reports of the studies done to understand this act.

Collection Method: Qualitative .

Duration of the Study: 6th Feb to 12th May 2107

Analysis tool: SWOT Analysis.

2.6 Data Analysis

Objective 1: To understand the Quality payment program of MACRA

Findings

The Quality Payment Program aims to do the following:

(1) Support care improvement by focusing on better outcomes for patients, decreased provider burden, and preservation of independent clinical practice

(2) Promote adoption of Alternative Payment Models that align incentives across healthcare

Stakeholders

(3) Advance existing efforts of delivery system reform, including ensuring a smooth transition to a new system that promotes high quality, efficient care through unification of CMS legacy programs

Quality Payment Program (QPP) is a new reimbursement system and it consists of two tracks: the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models.

Merit-based Incentive Payment System (MIPS)

The Merit-based Incentive Payment System (MIPS) consolidates three existing quality-reporting programs: the Physician Quality Reporting System (PQRS), the Value-based Payment Modifier (VBPM), and meaningful use (MU). The system also adds a new performance category, called improvement activities (IA). Scores from the four categories are combined to establish a final score (0-100) that is composite performance score (CPS).CPS will be compared against a threshold. The physician payment adjustments done by using the final score. The categories that make up the MIPS final score are:

Quality—based on PQRS

Resource use—based on VBPM

Advancing Care Information (ACI)—based on MU and

Clinical practice improvement activities—new performance category.

Eligibility: If Physician bill more than $30,000 to Medicare, and provide care to more than 100 Medicare patients per year.

It also applies to the:

- Physician
- Physician assistant
- Nurse practitioner
- Clinical nurse specialist
- Certified registered nurse anaesthetist

Note: Physician means doctor of medicine, doctor of osteopathy (including osteopathic practitioner), doctor of dental surgery, doctor of dental medicine, doctor of pediatric medicine, or doctor of optometry, and, with respect to certain specified treatment, a doctor of chiropractic legally authorized to practice by a State in which he/she performs this function.

Exemptions for MIPS

- Physicians newly enrolled in the Medicare program.
- Physicians with less than or equal to $30,000 in Medicare charges and less than or equal to 100 Medicare patients annually.
- Physicians who are already involved in an advanced APM through their hospital systems.

Reporting methods for individuals include claims, qualified clinical data registry (QCDR), qualified registry, and electronic health records (EHR). The ACI and IA categories will include attestation options. There is no data submission for the cost performance category, as the Centers for Medicare & Medicaid Services (CMS) will calculate this for ECs based on Medicare claims data.

Reporting methods for groups include QCDR, qualified registry, EHR, CMS Web Interface, and CMS-approved survey vendor for the Consumer Assessment of Health Providers and Surveys (CAHPS) for MIPS. Groups will also be able to attest for the ACI and IA performance categories. The CMS Web Interface option is only available to groups of 25 or more ECs.

2.6.1 MIPS timeline

2017	2018	JULY		2019
Performance period (Jan-Dec) 1st Feedback report (July)	Reporting and data collection	2nd Feedback report (July)	Targeted review based on 2017 MIPS performance	MIPS begins to Pay for quality

(5)

Scoring system

Quality Score + Resource use score +Clinical practice improvement activities score+ Advancing care information score**= CPS (composite performance score)**

Quality score: Worth **60%** of total **MIPS CP**. Clinicians should choose six measures to report. Zero point awarded to those who fail to report anyone of them. CMS will add in the scores from two or three measures that it computes for the clinician or group (each worth 10 points); **Total Possible Points** will be either 60 or 70.

ACI score: Worth **25%** of total **MIPS CPS**, it replaces Meaningful Use for non-hospital clinicians for Medicare only, ACI performance category score caps at 100 points.

CPIA score: Worth **15%** of total **MIPS CPS**, most improvement activities are medium-weight activities, and are worth 10 points. There are a few high-weight improvement activities, and those will be worth 20 points. Physicians can use any combination of medium and high-weight activities.

Resource use score: worth **10%** of total **MIPS CPS**, it measures Total Per Capita, Medicare spending per beneficiary and episode measures. It Assign 1-10 points based benchmark. These benchmarks based on deciles, and based on performance period (rather than baseline period) .(4)

2.6.2 Summary of MIPS performance category

Performance category	Maximum possible points per performance category	Percentage of overall MIPS score (Performance Year 1 - 2017)
Quality: Clinicians choose six measures to report to CMS that best reflect their practice. One of these measures must be an outcome measure or a high-priority measure and one must be a crosscutting measure.	80 to 90 points depending on group size	50 percent
Advancing Care Information: Clinicians will report key measures of interoperability and information exchange.	100 points	25 Percent
Clinical Practice Improvement Activities: Clinicians can choose the activities best suited for their practice; the rule proposes over 90 activities from which to choose. Clinicians participating in medical homes earn "full credit" in this category, and those participating in APMs will earn at least half credit	60 points	15 percent
Resource use: CMS will calculate these measures based on claims and availability of sufficient volume. Clinicians do not need to report anything.	Average score of all resource use measures that can be attributed	10 percent

APM (Alternative Payment Model)

An Alternative Payment Model (APM) is a payment approach, developed in partnership with the clinician community, which provides added incentives to clinicians to provide high quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.

Revised key terms of APM include the following:

"Eligible" APM replaced by "Advanced" APM

The defining criteria for an APM are unchanged and CMS is the payer for all Advanced APMs

APMs for which CMS is not the payer are termed "Other Payer APMs"

"APM entity" defined as any entity participating in an APM

"Eligible alternative payment model entity" replaced by "Advanced APM entity"

The defining criteria for an alternative payment model entity are unchanged "Advanced APM entity" is one participating in an APM determined to be an Advanced APM by CMS

"Medical homes" are APM entities that are associated with their respective APMs; such APMs are termed "medical home models"

"Medicaid Medical Home Model" is a type of "Other Payer APM".

A model approved by CMS, considered as an Advanced APM when it meets following four criteria:

Approved by the CMS Innovation Center, part of Medicare Shared Savings Program, a federal demonstration.

It must require at least 50 percent of its participants to use Certified EHR Technology. Any hospital within the APM must also use Certified EHR Technology.

It must tie at least some payments to performance on one or more quality measures comparable to those under the MIPS program, including one outcome measure.

It must accept financial risk—that is, it must assume financial consequences for failing to meet cost and/or quality metrics. These could be lower payments, deductions, or repayments.

Advanced APM – Certified Electronic Health Records Technology (CEHRT)

Eligible practitioners to meet the Meaningful Use objectives and measures in specific years must use CEHRT. In the final rule, CMS recognizes the need for MIPS eligible clinicians and Advanced APM participants to use the same EHR systems.

Advanced APM - Quality Measures "Comparable" to MIPS Measures In the final rule

CMS recognized that for Advanced APM measures to be comparable to MIPS measures, the measures should have evidence-based focus and, as appropriate, target the same priorities (for example, clinical outcomes, use and overuse). Advanced APMs must include at least one of the following types of measures if they have an evidence-based focus and are reliable and valid:

- Any of the quality measures included on the proposed annual list of MIPS quality measures
- Quality measures endorsed by a consensus-based entity
- Quality measures developed under the CMS quality measures development plan
- Quality measures submitted in response to the MIPS call for quality measures
- Any other quality measures that CMS determines to have an evidence-based focus and be reliable and valid.
- Advanced APM – Nominal Financial Risk

CMS finalized its financial risk standard as proposed. To be an Advanced APM, an APM must provide that, if actual expenditures for which an APM entity is responsible under the APM exceed expected expenditures during a specified performance period. CMS can withhold payment for services to the APM entity or the APM entity's eligible clinicians; reduce payment rates to the APM entity and/or the APM entity's eligible clinicians; or require the APM entity to reimburse CMS.

Only AAPMs (Advanced APMs) are eligible for the 5% bonus. The following APMs apply to primary care and are Advanced APMs (AAPMs) for the performance period beginning in 2017

Comprehensive Primary Care plus (CPC+)

Medicare Shared Savings Tracks 2 and 3

Next Generation ACO Model.

MACRA mandates that Qualifying APM Participants (QPs) who participate in eligible Advanced APMs or Other Payer Advanced APMs receive incentive payments. The final rule confirms much of the proposed criteria for the incentive payment program and finalizes the definitions, requirements, procedures, and thresholds of participation governing the program. In addition to defining the structure of Advanced APMs and Other Payer Advanced APMs, the rule finalizes the criteria required of MIPS APMs, as well as Physician Focused Payment Models.

Qualifying for APM Participant and Partial QP determination is based on whether an entity with a group of individual eligible clinicians participate in an Advanced APM based on the finalized proposal; of CMS.

MACRA does not change how any particular APM rewards value, APM participants who are not "QPs" will receive favorable scoring under MIPS. Only some of these APMs will be eligible APMs to get additional rewards for participation in APMs, Most physicians and practitioners who participate in APMs will be subject to MIPS and will receive favorable scoring under the MIPS clinical practice improvement activities performance category. Those who participate in the most advanced APMs may be determined to be qualifying APM participants ("QPs").

As a result, QPs:

Are not subject to MIPS

Receive 5% lump sum bonus payments for years 2019-2024

Receive a higher fee schedule update for 2026 and onward.

Objective2: To understand the Medicare payments to physicians under Quality Payment Program.

Findings

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) makes sweeping changes to how Medicare pays to physician services. The legislation repeals the Medicare physician sustainable growth rate (SGR) formula and instead provides predictable payment increases. The law also requires the Centers for Medicare & Medicaid Services (CMS) to implement, by 2019, a new two-track payment system – the Quality Payment Program (QPP) – for physicians and other eligible clinicians. The two tracks of the QPP seek to tie an increased percentage of physicians' Medicare fee-for-service (FFS) payments to outcomes through the new Merit-based Incentive Payment System (MIPS) and to encourage the adoption of "alternative payment models" (APMs). APMs move payment away from fee-for-service reimbursement, and instead pay providers based on the quality and cost of care for particular episodes (e.g., bundled payment), or defined patient populations (e.g., accountable care organizations (ACOs).

If physicians decide to participate in traditional Medicare, rather than an Advanced APM, then they will participate in MIPS where they earn a performance-based payment adjustment to their Medicare payment. CMS estimates approximately 500,000 clinicians will be eligible to participate in MIPS in the first year of the program. In MIPS, physicians earn a payment adjustment based on evidence-based and practice-specific quality data. Based on their performance in 2017, they will see a positive, neutral, or negative adjustment of up to 4% to your Medicare payments for covered professional services furnished in 2019. This adjustment percentage grows to a potential of 9% in 2022 and beyond.

Composite performance score depends on four categories

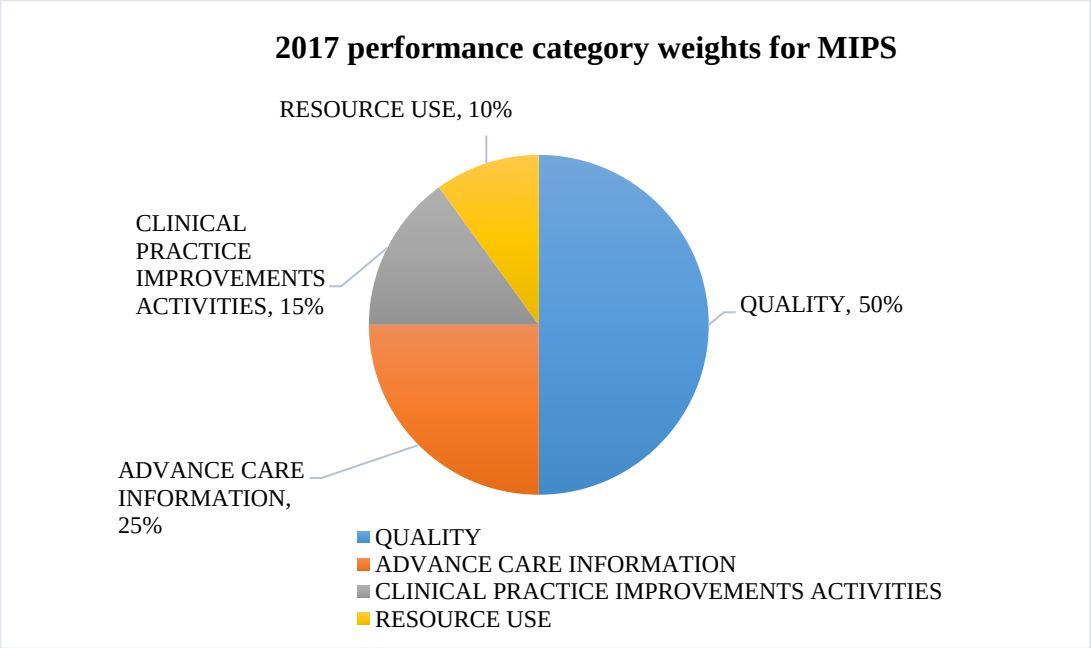
Quality (related to PQRS and VM)

Resource Use (cost)

Clinical Practice Improvement Activities

Meaningful Use (MU) of Certified EHR Technology (CEHRT).

Figure no. **2.6.3**



Performance category - 2017	**Points need to get a full score**	**Maximum possible points per performance category**
Quality: Clinicians choose six measures to report to CMS that best reflect their practice.	80 to 90 points depending on group size	50%
Advancing Care Information: Clinicians will report key measures of interoperability and information exchange.	100 points	25%
Clinical Practice Improvement Activities: Clinicians can choose the activities best suited for their practice; the rule proposes over 90 activities from which to choose.	60 points	15%
Cost: CMS will calculate these measures based on claims and availability of sufficient volume. Clinicians do not need to report anything**.**	Average score that can be attributed to all resource measures.	10%

Quality performance category score

Measures requirements :Eligible physicians to submit 6 measures, including 1 high priority measure (outcome, appropriate use, patient safety, efficiency, care coordination or patient experience) and at least 1 crosscutting measure (if EP is patient facing) , If a required measure is not reported then EP receives 0 points for that measure

Resource use performance category score

Measures: Total per capita, Medicare spending per beneficiary, Episode measures

CPIA Performance Category Score

Six Measures: Expanded practice access, population management, beneficiary management, patient safety and practice assessment, care coordination, participation in an APM

In general: each activity in the CPIA activity list is worth a certain number of points Most are worth 10 points (medium weight), Some activities have high weight, and are worth 20 points To get maximum credit, must achieve 60 points . Physician can achieve the points by selecting any combination of activities: High- and medium-weight, all high-weight and all medium-weight activities.

Total points for high-weight activities + Total points for medium-weight activities =Total CPIA points.

Total CPIA points /Total possible CPIA points = CPIA performance category score[8]

Advancing care Information performance category

100 percentage points is the max score in performance category (out of a possible 155 percentage points), 50 percentage points for the base score, which consists of reporting privacy and security. 90 percentage points for the performance score, which is determined based on achievement above the base score requirements for three objectives - Patient electronic access, coordination of care through patient engagement, health information exchange, 15 “bonus” percentage point for Public Health and Clinical Data Registry Reporting. [3]

Quality Measures +Resource Measures +CPIA activities +Advancing care information=Composite Performance Score

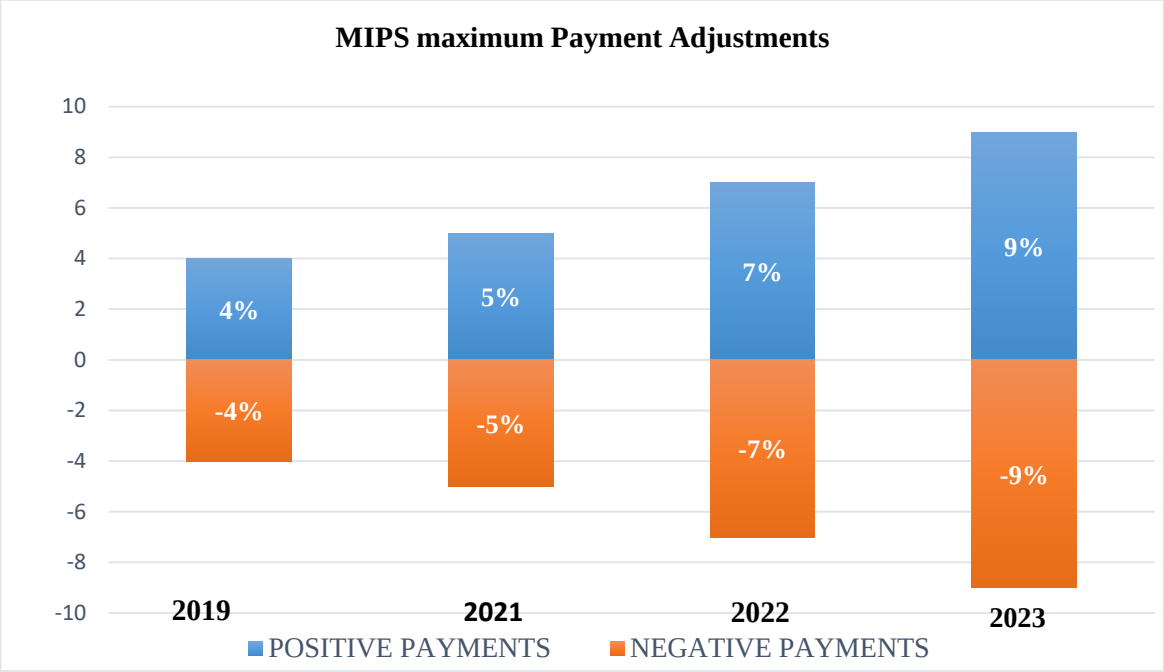
Payment under MIPS

Beginning in 2019, physicians participating in MIPS will be eligible for positive or negative Medicare Part B payment adjustments that start at 4% and gradually increase to 9% in 2022. Distribution of payment adjustments are budget neutral and are on a sliding scale. Payment adjustments depends on the following: [3]

- Physicians with a final score at the threshold will receive a neutral payment adjustment.
- Physicians with a final score above the threshold will receive a positive payment adjustment on each Medicare Part B claim in the payment year.
- Physicians with a final score below the threshold will receive a negative payment adjustment on each Medicare Part B claim in the payment year.
- Physicians with a final score will be automatically in the lowest quartile and adjust to the maximum negative adjustment on each Medicare Part B claim in the payment year.

The 2017 MACRA final rule designated 2017 a transition performance year and set the performance threshold at three points. As a result, any level of participation through the Pick Your pace program will protect an EC from the 2019 negative payment adjustment. Since physicians in the lowest quartile will receive the maximum negative adjustment, to maintain budget neutrality, physicians with higher final scores may be eligible for a positive payment adjustment up to three times the baseline positive payment adjustment for a given year. For example, the baseline positive payment adjustment for 2019 will be 4%, so higher performers may be eligible for a positive payment adjustment of up to 12% (4% x 3).For 2019 through 2024, an additional sliding scale for a positive payment adjustment of up to 10% will be available to "exceptional performers." For transition year 2017, the threshold for "exceptional performers" is 70 points. This additional positive payment adjustment does not fall under the budget-neutrality requirements. Beginning in 2026, all physicians participating in MIPS will be eligible for a 0.25% increase in their Medicare Part B physician fee schedule (PFS) payment. [3]

2.6.4 Payment Adjustment



Do not submit data	**Negative payment:** Not participating in the Quality Payment Program i.e., if physician do not send any 2017 data, then they receive a negative 4% payment adjustment.
Submit something	**No negative payment** If Physician submit a minimum amount of 2017 data to Medicare (for example, one quality measure or one improvement activity), they can avoid a downward payment Adjustment**.**
Submit a partial year	**Positive payment** Partial: If physician submit 90 days of 2017 data to Medicare, they may earn a neutral or small Positive payment adjustment.
Submit a full year	Full: If you submit a full year of 2017 data to Medicare, you may earn a moderate positive Payment adjustment.

Reporting system as an individual, group and small groups

Reporting as an individual

If physician send MIPS data as an individual, their payment adjustment depends on the performance. The definition of an individual is single National Provider Identifier (NPI), tied to a single Tax Identification Number. They will send their individual data for each of the MIPS categories through a certified electronic health record, registry, or a qualified clinical data registry. They may also send in quality data through their routine Medicare claims process.

Reporting as a Group

If, they send their MIPS data with a group, the group will get one payment adjustment based on the group's performance. A group is defined as a set of clinicians (identified by their NPIs) sharing a common Tax Identification Number, no matter the specialty or practice site. Physician group will send in group-level data for each of the MIPS categories through the CMS web interface or a third-party data-submission service such as a certified electronic health record, registry, or a qualified clinical data registry. To submit data through CMS web interface, physicians must register as a group by June 30, 2017.

Payment changes of APM

The APM scoring standard applies to APMs that meet these criteria:

APM Entities participate in the APM under an agreement with CMS they include one or more MIPS eligible clinicians on a participation list and APM bases payment incentives on performance (either at the APM Entity or at eligible clinician level) on cost/utilization and quality measures.

APM Scoring Standard applies to

- Shared Savings Program (all tracks)
- Next Generation Accountable care organization(ACO) Model
- Comprehensive ESRD Care (CEC)
- Comprehensive Primary Care Plus (CPC+)
- Oncology Care Model (OCM)
- All other APMs that meet criteria for the APM scoring standard
- Qualified APM participants must have at least 25 percent of their Part B payments tied to Advanced APMs beginning in 2019. That percentage grows to 50 percent in 2021 and 75 percent in 2023.

QP patient thresholds start at 20 percent in 2019 and then grow to 50 percent beginning in 2023. The patient threshold identifies the percentage of patients that must be Medicare enrolees in order to satisfy QP requirements. Satisfying these requirements exempts QPs from MIPS and makes them eligible for the 5 percent Advanced APM incentive payment. The QP performance period will run from January 1 through August 31 of the calendar year. During the QP Performance Period, CMS will make QP determinations three times, each of which would be a final determination for eligible clinicians who are determined to be QPs. CMS modified its proposed policy that would give Partial QPs the option to choose whether to report MIPS data and thereby be subject to a MIPS-related payment adjustment. In order to qualify for the 5% APM incentive payment for participating in an Advanced APM during a payment year, QPs must receive a certain percentage of payments for covered professional services or see a certain percentage of patients through the Advanced APM during the associated performance year.)

Table 2.6.6 APM Scoring Standard for Shared Savings Program

Measure	**Reporting Requirement**	**weight**
Quality	Shared savings program ACOs submit to the CMS web interface on behalf of their MIPS eligible clinicians.	50%
Resource use	Not applicable	0%
CPIA	All MIPS eligible clinicians submit through ACO participant TINS according to the MIPS requirements.	20%
ACI	All MIPS eligible clinicians submit through ACO participant TINS according to the MIPS requirements.	30%

Table 2.6.7 APM scoring standard for all other APMs under the APM Scoring Standard

Measure	Reporting requirement	Weight
Quality	No assessment for the first MIPS performance year. APM-specific requirements apply as usual.	0%
Resource use	No reporting requirement.	0%
CPIA	All MIPS eligible clinicians submit individually according to the MIPS requirements.	25%
ACI	All MIPS eligible clinicians submit individually according to the MIPS requirements.	75%

Objective 3- To study the awareness perspectives and readiness of physician regarding the changes in payments due MACRA

Introduction

The primary goal of MACRA is to move away from fee-for-service reimbursement toward a value-based payment system, thus with a goal of 85 percent of all Medicare payments being tied to quality or value. It plans to focus on three areas: physician incentives, care delivery, and information sharing.

A study conducted by Deloitte to analyze the awareness of the physician about MACRA and the changes it will bring in their practice.

Findings

600 physician surveyed and questions were asked to analyze their understanding and readiness regarding MACRA.

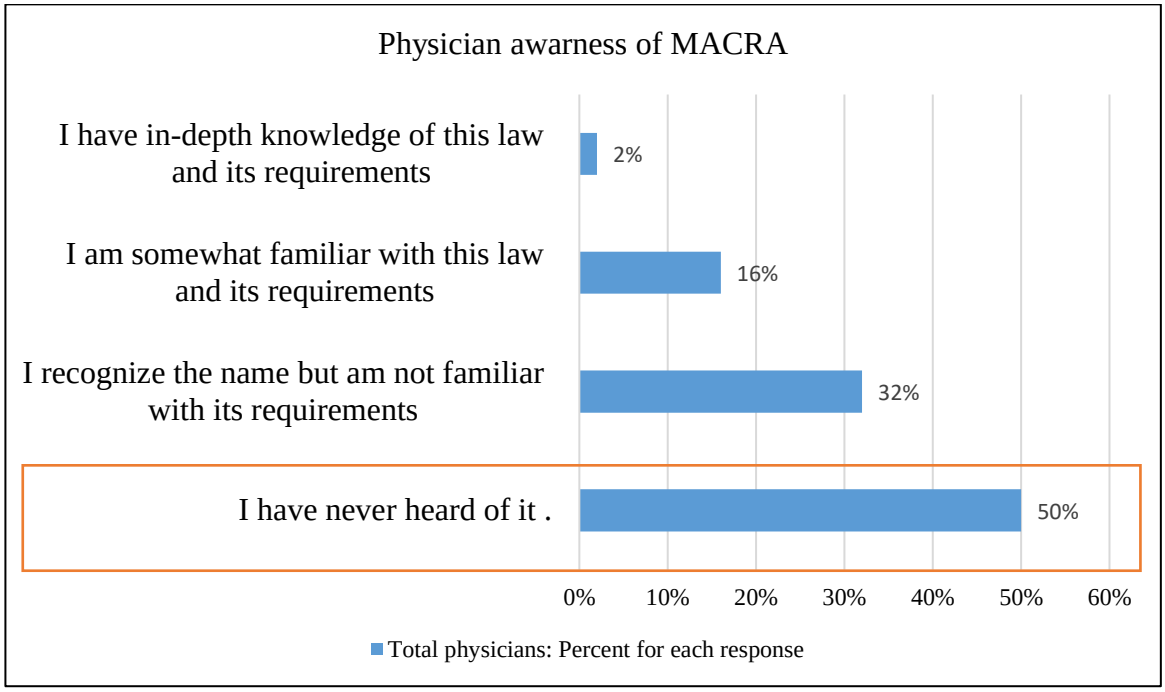
Few questions are as follows –

- How familiar are you with MACRA and its requirements?

- Which of the criteria would make physicians more likely to accept risk-based compensation?
- Questions to understand their acceptance level regarding the quality reporting under MACRA.

The findings are as follows -:

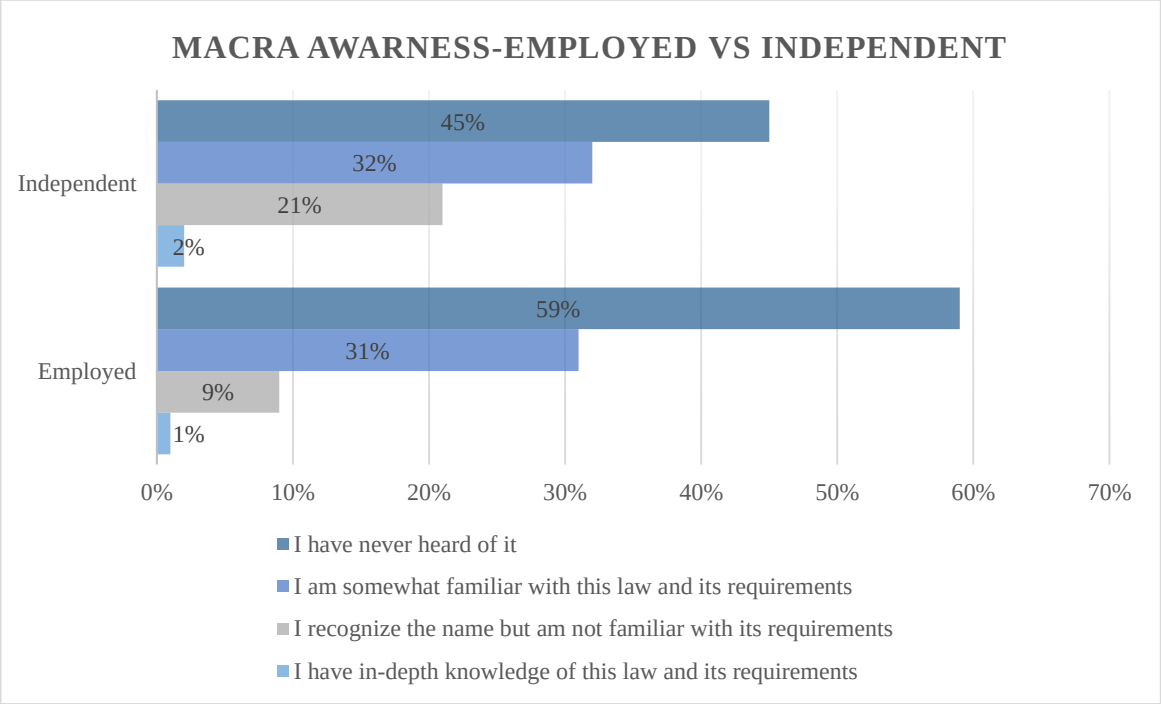
Figure 2.6.8 Physician awareness



Source: Deloitte Center for Health Solutions 2016 Survey of US Physicians.

The data shows that 50% of the physicians were unaware of MACRA and did not hear about it and only 2% of physician had in-depth knowledge about rules of MACRA and changes it would bring in their Medicare payment.(6)

Further, the report tries to analyze the awareness level between independent Vs the employed physicians. The data shows that independent physicians are somewhat more aware about the laws about MACRA.



Source: Deloitte Center for Health Solutions 2016 Survey of US Physicians.

According to the researchers, the possible reason for this awareness can be that the self-employed and independent physicians has more direct responsibility for their business requirements compared to other providers, which contributed to more awareness of the program.

There are two-payment modes in MACRA: MIPS and APM

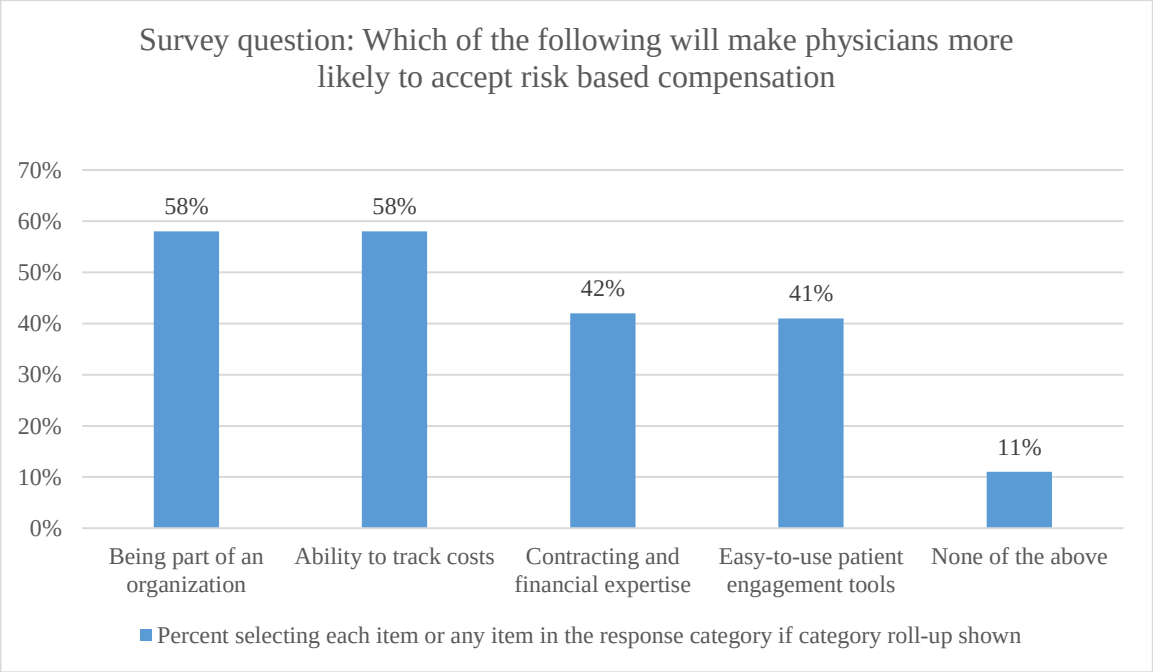
MIPS, Medicare will consolidate and expand upon all three of clinicians, pay-for-performance programs—Meaningful Use, the Value-Based Payment Modifier, and the Physician Quality Reporting System—into a single revenue-neutral program. Under this program, CMS will score clinicians and groups on their performance in four categories: **Quality, Cost, Improvement Activities (IA), and Advancing Care Information (ACI).**

Starting in 2019, physicians in this track will face a range of payment adjustments, starting with potential penalties of -4% and bonuses as high as 12% in 2019. These penalties and bonuses will grow to payment reductions as much as 9% and increases of up to 27% after the first few years of the program. On the other hand, those that qualify for the Advanced APM payment track can earn favorable financial rewards. However, only clinicians or groups who are part of risk-based payment models will qualify, thus incentivizing a shift toward risk.

Clinicians or groups that participate in Advanced Alternative Payment Models, as defined by CMS, and are able to convert a large enough share of their Medicare and/or other payer reimbursement to risk-based payment models, will earn a 5% annual payment bump from 2019-2024. They will also be exempt from the MIPS requirements.

Thus, one of the biggest changes for physicians under MACRA will be the need to bear increased financial risk, although the surveyed physicians indicated they feel increased financial pressures in general. For this reason, most surveyed physicians (80 percent) expect MACRA to drive increased physician consolidation, either by joining larger organizations or networks. Moreover, half of those surveyed say financial pressures are the number one driver of consolidation.

The survey analyzed factors, which can lead to the acceptance of the physician towards risk-based compensation. Out of the physician, interviewed 58% of physician wanted to be part of an organization, to reduce individual physician risk and bear financial risk collectively under alternative payment models. The organization will also provide full range of resources for both clinical and non-clinical activities. (6)



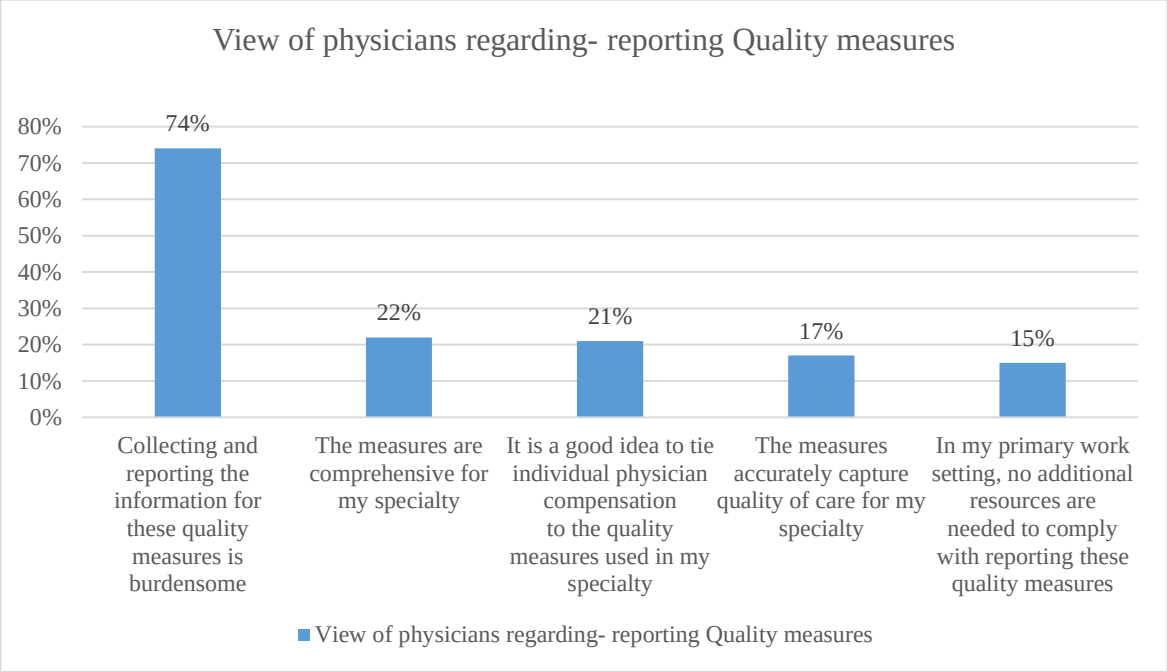
(Source: Deloitte Center for Health Solutions 2016 Survey of US Physicians, n=600)

The physicians also agreed to enter successfully the increased risk arrangements, their practices would need new capabilities.

The top needed supporting capability was standardization of quality measures (42 percent), followed by analytics and other monitoring tools to track high-cost patients (29 percent) and standardization of cost measures (28 percent).

Overall, the surveyed physicians preferred traditional compensation models to most value-based payment models. Nearly 8-in-10 physicians surveyed said they prefer FFS or salary-based compensation arrangements. However, 71 percent, said, they would participate in value-based payment models if offered financial incentives to do so and 52 percent would opt for shared savings.

The survey found that majority of physicians, around 70 percent, believe that the performance of the U.S. health care system can be improved by measuring care outcomes ,processes and measuring resource utilization and costs, but, conversely, the survey found most physicians believe performance reporting to be burdensome (74 percent), while 79 percent don't support tying compensation to quality.



Source: Deloitte Center for Health Solutions 2016 Survey of US Physicians

The researcher gave physicians a brief explanation of MACRA. Then they again tried to assess their acceptance regarding MACRA and value based payment model. The findings indicate sharp difference between physicians who are willing to participate in value-based payment models and those who are unresponsive to incentives.

Of those surveyed physicians willing to participate in value-based payment models with financial incentives:

23 percent indicate that the law would reduce costs; 19 percent indicated it would improve quality and 47 percent believe that value-based payment models can improve the performance of the U.S. healthcare system.

Many healthcare stakeholders believe the impact of MACRA implementation will percolate the entire healthcare industry, not just Medicare physicians. New incentives created by MACRA are likely to drive payment and care delivery reform across all payers.

Therefore, all physicians, even non-believers in value-based care, have to familiarize their practices with MACRA legislation before the January 2017 launch.

Table. 2.7 SWOT Analysis of MACRA

STRENGTH	WEAKNESS
• High-quality patient-centred care • Continuous improvement • Improve data collection and information sharing	• Low physician awareness. • Requires capacity building e.g. For IT/Analytics, financial capacity which requires investments • Noncompliance can result in penalties
OPPORTUNITY	**THREAT**
• Physician can earn incentives by adhering to any one pathways out of the two. • Changes in the system and use of IT in healthcare creates opportunity for Health IT	• Frequently changing regulations. • Data security

Strength-

MACRA emphasize on high quality treatment to patients and incentives are given to physicians who report these parameters. Specials incentives for physicians who want to participate in alternate payment model hence motivating physicians to develop their capabilities and resources like use of certified electronic health record system.

MACRA if flexible as it provides two pathway for the physicians to choose from, depending on their capability. Initial the physicians have to report for 90 days starting from 2017 to avoid any penalties.

It provides incentives to the physicians to continuously work to improve on data collection and information sharing, thus acknowledging their effort and motivating others to improve.

The payment model adjusts for the different case mixes different physicians and group practices experience, thereby paying comparatively more for sicker patients that require more services.

Weakness

It's a new act and so many physicians are yet not much aware about its requisites and thus this can lead to penalties as the reporting period starts from 1 January 2017.

As parameters require use of certified EHR, information sharing and sharing of financial risks in APM model. The independent physicians are finding it difficult to be compliant to the new act as it will require them to upgrade to new technologies resulting in higher investments.

Opportunities

Now physicians will have more opportunity to earn through Medicare.

MACRA require the physicians to upgrade their technologies capability, thus creating an opportunity for the health IT and consultants to help the physicians to meet the requisites to earn better incentives.

Threats

Change in government can bring in new rules and policies thus overshadowing the efforts and investment by physicians to follow this act.

MACRA promoted data sharing although data security is still a big concern.

2.8 Suggestions

- Effort should be made to reduce the reporting so that the physicians are able to concentrate more on giving quality treatment to patients.
- Special educative classes for physicians to improve their knowledge about MACRA
- Special incentives for independent physicians and helping them to develop their capacity.

2.9 Conclusion

MACRA presents physicians with a unique opportunity to embrace the paradigm shift toward improving medical quality and value, and take the lead in collaborating with CMS to shape the future of health care reimbursement hence physicians should be proactive, and lead the effort to improve medical quality and control health care related costs, the primary goals of MACRA.

MACRA will change the way Medicare rewarded the clinicians for **value over volume**, it covers issues like data reporting, new practice models, evolving clinical standards, and physician evaluations, and the bonuses depends on the quality of treatment and criteria mentioned in the act. Not adhering to the rules or not participating in this program can result in penalties to the physician. This study also helps us to understand about the physician's level of awareness and acceptance for MACRA. It reveals that Fifty percent of the physicians have never heard of the law. So most of the physicians still prefer traditional fee-for-service (FFS) or salary-based compensation as opposed to value-based payment models. To meet all the criteria is of MACRA they would have to develop more capabilities and would need investments. This can result in physician joining larger organizations or working in-group so that they can share risk.

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