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THE MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT: IMPLICATIONS FOR PHYSICIAN AGREEMENTS

Mark C. Herbers
AlixPartners, LLP
Chicago, IL

The Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA") creates powerful incentives for all physicians with more than 100 Medicare patients to report quality measures, improving care measures and advancing care measures, or else face a four percent fee reduction. The reporting requirements will be a new cost — one small practices will struggle to implement. Some may "go it alone" and others may finally "give up" and join a group or become employed. Independent contractor hospital-based professional ("HBP") groups may have to gain the cooperation of their hospital client to assist with collecting, compiling and reporting some of the measures for their practice. Large specialty groups will want to develop automated collection tools at each site while small groups may need to contract this service to an outside party. During 2017, data will need to be collected initially for a 90-day continuous period; subsequent periods may require full 12 month periods of data submission. As clinicians become more informed about MACRA, and the attendant new costs for data submission, hospital executives and larger group practice leaders can expect independent physicians, small group practices and hospital-based groups to approach them for help.

CMS announced in October 2016 the final MACRA[1] rule and transitional policies. This announcement softened language previously released in May 2016[2] and April 2015[3] and responded to thousands of comments received from concerned physicians, healthcare organizations, and elected officials. However, the new requirements will likely have a significant impact on agreements between physicians and others.

Overview of MACRA

MACRA implements the Merit-based Incentive Payment System ("MIPS") in what it calls its Quality Payment Program and replaces three current programs set to expire in fiscal year ("FY") 2018: the physician quality reporting system ("PQRS"), the value-based modifier program ("VBMP") and the Meaningful Use of electronic health records.[4] Licensed Medicare physicians and other licensed clinicians who elect to submit measures of patient quality outcomes from their practices for a continuous 90 day period in 2017 are eligible for incentive payment adjustments to their Medicare claims in FY 2019. CMS will review the submitted data, generate a score,[5] and award an incentive payment. MIPS Incentive payments vary by year (see Table 1 below) and exceptional performers may be eligible for an addition positive payment adjustment.[6]

CMS is requiring clinicians[7] to report data in CY 2017 as a basis for making incentive compensation adjustments to program claims in FY 2019. Clinicians choosing to not participate in MIPS, e.g. those who choose to not submit outcomes data, will receive no score and be subject to a four percent reduction in their program claim payments in FY 2019.[8] For a physician practice which expects to collect $250,000 from Medicare patients in FY 2019, a decision to not submit data in FY 2017 would amount to a projected $10,000 reduction in revenues in 2019.

Eligible clinicians have three flexible options to submit data to MIPS in 2017. Clinicians can choose to report to MIPS for a full 90-day period or, ideally, the full year, and maximize the MIPS eligible clinician's chances to qualify for a positive adjustment. In addition, MIPS eligible clinicians who are exceptional performers in MIPS, as shown by the practice information they submit, are eligible for an additional positive adjustment for each year of the first six years of the program.

1. Clinicians can choose to report to MIPS for a period of time less than the full year performance period 2017 but for a full 90-day period at a minimum and report more than one quality measure, more than one improvement activity, or more than the required measures in the advancing care information performance category in order to avoid a negative MIPS payment adjustment and to possibly receive a positive MIPS payment adjustment.
2. Clinicians can choose to report one measure in the quality performance category; one activity in the improvement activities performance category; or report the required measures of the advancing care information performance category and avoid a negative MIPS payment adjustment. Alternatively, if MIPS eligible clinicians choose to not report even one measure or activity, they will receive the full negative four percent adjustment.

Table 1: MIPS Incentive Compensation Range

CY	2019	2020	2021	2022
Incentive/Penalty	+/- 4%	+/- 5%	+/- 6%	+/- 7%

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3. MIPS eligible clinicians may be approved to participate in advanced alternative payment models ("APMs"), and if they receive a sufficient portion of their Medicare payments or see a sufficient portion of their Medicare patients through the Advanced APM, they will qualify for a five percent bonus incentive payment in 2019.[9]

MACRA also provides for "virtual groups", defined as solo and small practices that join together for reporting purposes.[10] CMS is not implementing virtual groups for CY 2017. This means that solo and small practices that choose to submit data may approach 1) larger groups to join, 2) employment with a hospital or health system, or 3) a third-party vendor to assist with the submission of their data. Those close to retirement may elect to not participate; others may decide after assessment of the costs vis-à-vis the incentive benefit.

Table 2: Reporting Measures and Incentive Compensation Potential

Option #	Reporting Period	Quality	Improving Care	Advancing Care	Incentive/Penalty
1	90 days, 1 year preferable	6	4	5	Up to maximum
2	90 days	1	1	5+	No negative incentive, possible positive incentive
3	90 days	1	1	5	No negative incentive, no positive incentive
4	None	0	0	0	-4% penalty
# Measures Table A		128	43	31	

For full participation in MIPS, and to achieve the highest possible final scores, MIPS eligible clinicians are encouraged to submit measures and activities in all three integrated performance categories: quality, improvement activities, and advancing care information. For full participation in the quality performance category, clinicians will report on six quality measures, or one specialty-specific or subspecialty-specific measure set. For full participation in the advancing care information performance category, MIPS eligible clinicians will report on five required measures. For full participation in the improvement activities performance category, clinicians can engage in up to four activities, rather than the proposed six activities, to earn the highest possible score of 40.

CMS Analysis of Submission Associated Costs to a Physician Practice[11]

CMS estimated the impact by clinical specialty, utilizing 2014 data as a surrogate for 2017 performance. Its analysis identified the number of clinicians, their allowed Part B charges and the estimated percent of clinicians that would have a negative adjustment to their payment rates (See Table 3). A number of the clinical specialties are commonly contracted with hospital providers as independent contractors, coverage agreements or employment agreements.

Some clinicians in each specialty shown in Table 3 are expected to see negative adjustments under MACRA. Four of the top five specialties, chiropractic, optometry, podiatry, and dentist, are generally not contracted with hospital providers and have little activity outside of their office practice. General practice, psychiatry, plastic surgery, physical medicine, allergy/immunology and oral/maxillofacial surgery are common professional services agreements with hospitals for on-call and coverage agreements. Activities associated with their services rendered in the hospital/clinic setting may require coordination with the hospital/clinic for data collection. Clinical nurse specialists and nurse anesthetists are commonly employed by hospitals, although they may be employees of a physician or physician group. Data collection and submission for these clinicians will require new processes by their employer(s).

CMS also reported the expected impact of implementing MACRA by

Table 3: CMS Projection of Impact of MACRA by Clinical Specialty[12]

Provider Type	# Clinicians	Allowed Charges	% with negative Adjustment
Chiropractic	20,572	$585	98.40%
Optometry	18,394	$945	79.70%
Podiatry	15,310	$1,882	78.00%
General Practice	3,598	$273	69.40%
Dentist	915	$26	68.90%
Psychiatry	20,854	$1,143	68.80%
Plastic Surgery	3,691	$287	65.40%
Physical Medicine	7,295	$918	57.90%
Allergy/Immunology	3,031	$199	57.10%
Oral/Maxillofacial Surgery	200	$7	55.00%
Clinical Nurse Specialists	1,681	$57	54.70%
Nurse Anesthetist	31,737	$826	51.00%
Hospital Based Services			
Radiology	34,998	$4,165	49.20%
Anesthesia	34,233	$1,904	47.40%
Emergency Medicine	41,728	$2,626	35.40%
Pathology	7,302	$593	43.30%
Internal Medicine (includes Hospitalists and intensivists)	89,257	9,327	40.30%

size of clinical practice[13] (See Table 4). Groups of less than 10 clinicians are most at risk for negative adjustments and are estimated by CMS to bear more than 70 percent of the total aggregate negative adjustment payments — $579 million of aggregate negative adjustments compared to $105 million of aggregate positive adjustments. Larger group practices are expected to be more favorably impacted — $539 million aggregate positive adjustments compared to $57 million aggregate negative adjustments.

Operational Implications: Cost/Benefit Analysis

A recent study reported that from a survey of 523 non-paediatric speciality physicians "nearly three-quarters (71 percent) say they would accept value-based payment models, mostly shared savings, for a five percent guaranteed increase in payment."[14] It follows that many clinicians serving the Medicare population will want to evaluate their participation in MIPS.

Solo Practice Example

For a solo internal medicine physician who collects annually ~$200,000 from Medicare for patient services (Part B allowed charges), the certainty of a four percent reduction in CY 2019, if the physician elects to not submit any data, would result in an $8,000 reduction in revenues. The trade-off for this physician is the cost of reporting to Medicare in 2017 and 2018 to participate in a potential zero to four percent increase in 2019. CMS estimated[15] that the annual cost per physician approximated $24,000 (hours multiplied by a weighted average cost/hour). Using nominal dollars, and assuming 1) the annual incremental cost of reporting to the physician approximates $24,000 (outsourcing the collection, compilation and submission of data for 90 days in FY 2017 and FY 2018 ~25 percent or $6,000); and 2) the physician earns a full four percent

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Table 4: CMS Projection of Impact of MACRA by Practice Size

Practice Size	Eligible Clinicians		Part B Allowed Charges ($ Mil)	% Eligible with payment adjustment		Aggregate Adjustment ($Mil)			
	#	%		Negative	Positive	Negative	%	Positive	%
Solo	102,788	13.5%	$12,458	87.0%	12.9%	($300)	36.1%	$105	7.9%
2-9	123,695	16.2%	$18,697	69.9%	29.8%	($279)	33.5%	$295	22.1%
10-24	81,207	10.8%	$9,934	59.4%	40.3%	($101)	12.1%	$164	12.3%
25-99	147,976	19.4%	$12,868	44.9%	54.5%	($95)	11.4%	$230	17.3%
100+	305,676	40.1%	$18,648	18.3%	81.3%	($57)	6.9%	$539	40.4%
Total	**761,342**	**100.0%**	**$72,605**	**45.5%**	**54.1%**	**($832)**	**100.0%**	**$1,333**	**100.0%**

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incentive payment; as shown in Table 5 below, the "investment" doesn't pay off until year eight, or FY 2024.

If this same physician elects to not report and forego participation in MIPS, the reduction increases from –four percent to –seven percent (see Table 1) such that by 2022, the fourth year of non-eligibility, this same $200,000 of Medicare payments would be reduced to less than $163,000. (($200,000 x 96%) x 95%) x 94%) x 93%)). In nominal dollars, six years of "investing" $6,000 would be $24,000 compared to the loss of revenues of $41,224 for non-participation, a difference of $17,224. This loss approximates $0 if the incentive earned by submitting data is two percent.

Small Group Practice Example

A three-person group, with similar performance statistics, i.e. three physicians each generating $200,000 of Part B Medicare allowable charges may achieve some economies of scale in collecting and reporting practice data and incur less cost proportionately than a solo practitioner. CMS's estimate of an annual cost of $24,000 would approximate $6,000 per quarter per physician or $18,000. Assuming a small economy of scale, Table 6 assumes this three-person group can collect and report 90 days of data for a total cost of $15,000 in 2017 and that the reporting requirements for FY 2018 thru FY 2023 remain at a single 90 consecutive day period; the investment "pays off" in FY 2022 if the full four percent incentive is earned.

It is important to note the cost associated with collection, compiling and reporting (the investment) is required to avoid the four percent penalty. The physician or group could expend the investment to report and not qualify for the full four percent incentive. This group would spend $90,000 over six years to potentially receive $96,000 of MIPS; a three percent earned incentive would approximate a cumulative loss of $15,000. If this group elected to not participate, and its Medicare business remained steady, the group could expect to have its payments adjusted downward each year as shown in Table 1 — a revenue shortfall of $121,540 compared to an "investment" of $90,000 for a positive cost/benefit of $31,640 if the four percent MIPS incentive is earned. A three percent incentive would result in a negative cost/benefit of $18,000.

Small groups of less than 25 clinicians and solo clinician practices may likely seek assistance with the reporting requirements of MACRA from an accountable care organization, a larger physician group, or one of their hospital affiliates. Any such assistance will have to comply with the Stark laws[16] (regarding incentivizing physician referrals) when an agreement is reached and be provided at fair market rates.

Table 5: Solo Practice Primary Care Example, $200,000 of annual Part B allowable charges

Calendar Year	2017	2018	2019	2020	2021	2022	2023
Investment	($6,000)	($6,000)	($6,000)	($6,000)	($6,000)	($6,000)	($6,000)
Incentive earned			$8,000	$8,000	$8,000	$8,000	$8,000
Cumulative Impact	($6,000)	($12,000)	$(10,000)	$(8,000)	($6,000)	($4,000)	($2,000)

Table 6: Three Person Primary Care Practice, $600,000 of annual Part B allowable charges

Calendar Year	2017	2018	2019	2020	2021	2022	2023
Investment	($15,000)	($15,000)	($15,000)	($15,000)	($15,000)	($15,000)	($15,000)
Incentive earned			$24,000	$24,000	$24,000	$24,000	$24,000
Cumulative impact	($15,000)	($30,000)	($21,000)	($12,000)	($3,000)	$6,000	$15,000

Provider Agreements

Provider contracts with physicians typically take one of four basic forms:

Type of Agreement		Common Features
1	HBP services	Independent contractor with exclusivity for contract term; may have supplemental fee arrangement to cover services provided to self-pay/charity patient encounters
2	Employment agreement	Frequently (though not exclusively) primary care physicians with office-based practices
3	Medical directorship	Administrative services/oversight to support medical services in facility including the Medical Executive Committee functions
4	Physician coverage	Typically specialty physicians to treat patients who have no identified physician and require treatment while in facility

The reporting requirements of MACRA and the changes in compensation beginning with CY 2019 may stimulate discussions between the parties as contracts are reviewed and/or renewed.

HBP Services

The HBP physician/group's ability to report data for eligibility in the MIPS program necessitates cooperation of the provider facility. Other measures may require a change in the contract terms during any measurement period. For example, one of the measurements addresses the availability 24/7 of MIPS eligible physicians. To affect this measure, coverage requirements between the physicians and facility may need to change or be augmented. The hospital with professional services agreements for these hospital-based services should prepare for the group(s) to initiate discussions about "being made whole." For example, if the impact in 2019 is a four percent reduction in their professional fees, the group(s) will likely want to discuss some stipend arrangement to make up for this shortfall. In addition, if the data submitted with the assistance of the provider hospital/clinic, and the MIPS incentive earned is less than expected by the physicians, it is likely that discussions will ensue between the parties to adjust any current agreements. Existing agreements may not contain any language regarding responsibility for collection and submission of quality data to regulatory agencies.

Employment Agreements

The receipt of incentive compensation in CY 2019 and later may enter into the conversation with employed clinicians, especially if some portion of the total compensation includes a factor for collections. The hospital/clinic employer will likely be responsible for the collection and submission of data to participate in MIPS. The "pass through" of MIPS incentive earnings to the employed clinician will likely be a point of discussion and/or contract amendment. Independent solo or small group practices may be more open to employment arrangements with a hospital provider in order to participate in MIPS without the investment to collect and report data.

Medical Directorship Agreements

The existing agreements between clinicians and hospitals/clinics may not contain language addressing the responsibilities for development of systems and processes to collect and report quality measures for participation in the MIPS program. These agreements may require amendment to incorporate these responsibilities (and adjust the compensation).

Physician Coverage/ On-Call Agreements

These agreements are generally straightforward and involve compensation for coverage of the clinician's specialty to the broader medical staff and emergency department patient demands. The existing agreements may not contain language addressing the responsibilities for collecting and providing clinician data reports of quality measures supporting the clinician's participation in the MIPS program. These agreements may require amendment to incorporate these responsibilities (and adjust the compensation).

Conclusion

MACRA establishes a "pay for performance" formula by incenting defined quality, care improvement and advancing care measures as part of the patient-clinician relationship. CMS is allowing clinicians to ramp up to the ultimate goal of full year reporting and publishing clinician practice behaviors. Wanting to avoid a four percent annual reduction in Medicare Part B fees, clinicians will likely seek partners/sponsors/employers to bear this cost. Hospital-based physicians will have to work with their hospital provider to collect data for submission to CMS; solo practice physicians who elect to participate may seek direction and assistance from their peers and hospital leaders. New performance management

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programs will require a close review and modifications of existing agreements.

Mark Herbers is a director at Alix Partners in Chicago and leads healthcare organizations through restructuring processes aimed at improving cash flow, financial performance, and strategic alignments with market conditions. He has nearly three decades of experience as a senior executive in all provider settings covering both for profit and not for profit, and expertise in improving revenue cycle performance, addressing regulatory issues and reimbursement, financing, strategic planning, and physician relations. He has worked extensively with academic medical centers and residency and fellowship program management. He has an MBA from Washington University in St. Louis and is a certified public accountant. He may be reached at *mherbers@alixpartners.com*.

Endnotes

1 Federal Register, October 16, 2016, 81 Fed. Reg. 77008 (11/4/2016), https://federalregister.gov/d/2016-25240.

2 Federal Register, May 9, 2016 pages 28162-28586.

3 Public Law 114-10 April 16, 2015: "Medicare Access and CHIP Reauthorization Act of 2015."

4 Note that MACRA does includes a second avenue in its Quality Payment Program: the advanced alternative payment model ("advanced APM"), such as a Medicare accountable care organization, which provides additional incentives for the delivery of high quality patient care. This avenue will initially affect fewer physicians and other clinicians.

5 Table 13, Federal Register May 9, 2016 page 28243.

6 Section 1848(q)(6)(B) of the Act, Federal Register May 9, 2016 page 28273.

7 Clinicians newly joining the Medicare program, and clinicians with less than or equal to $30,000 of Medicare Part B allowed charges or less than or equal to 100 Medicare patients will be excluded from MIPS.

8 Section 1848(q)(6)(E) of the Act, Federal Register May 9, 2016 page 28275.

9 Section II.F.5.b of the Act.

10 Section 1848(q)(5)(I) of the Act, Federal Register May 9, 2016 page 28179.

11 Tables 46-64, Federal Register May 9, 2016 pages 28350-28375.

12 Table 63, Federal Register May 9, 2016 Page 28372.

13 Table 64, Federal Register May 9, 2016 Page 28375.

14 "Are physicians ready for MACRA and its changes?" Karen Lamb, PhD, The Deloitte Center for Health Solutions 2016 Survey of US Physicians, Page 7.

15 Table 53, Federal Register May 9, 2016, page 28359.

16 For more information about the Stark law, go to: https://cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/index.html.

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