As MIPS, practice hassles get harder, pay-for-performance gets more attractive

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PBN Perspectives

Discouraging bonuses and ever-increasing requirements under the Merit-based Incentive Payment System (MIPS), along with other hassles of modern fee-for-service life, may be driving some providers out of business — or into new payment models, where CMS would prefer to see them.

On Aug. 1, CMS published an updated listing of MIPS scores for 2017, the first reporting year. You'll recall that CMS reduced the final score needed to avoid a payment penalty that year to three points — making it almost impossible to fail.

The new figures show that out of 22,659 eligible groups, 8,007 scored a zero; and out of 413,233 eligible individuals, 31,592 scored a zero. Percentage-wise, that's not bad for the individual filers, about 93% of which qualified — though only 65% of the eligible groups beat the tiny spread. These numbers are slightly lower than the preliminary 2017 MIPS results trumpeted by CMS Administrator Seema Verma in a Nov. 8, 2018, CMS blog post.

The numbers are encouraging in a way, and preliminary CMS reports for 2018 show even more providers at least avoiding a MIPS penalty. But the pressure is ratcheting up in year four: For 2020, participants will have to score 45 points just to break even, according to a CMS proposal — and the exceptional performance bonus threshold goes up to 80 points. Plus the potential penalty for missing the 45-point target goes up to 9% of your Medicare charges (PBN blog 7/29/19).

Industry groups have begun to push back on the hassle of keeping up with changes in the program. The Medical Group Management Association (MGMA), for example, responded to CMS' recent Patients Over Paperwork RFI with a long list of MIPS-related suggestions, requesting that the agency "simplify" MIPS with fewer measures and clearer performance standards.

The "Pathways" model that CMS proposes for MIPS in 2021 seems geared to address some of these problems (PBN 8/15/19). But as the MIPS program matures into a major factor of practice life, it's worth asking what the long-term result will be on stressed providers and practices.

"Given the increasing collective financial risk and impact, there are potentially multiple 'straws'" that could break the proverbial camel's back, "not just MIPS, [and] that could force more physicians into difficult choices," says Tom Lee, former CEO of Ignite SA and now strategic advisor to SPH Analytics in Alpharetta, Ga.

Low bonuses persist

True, putting in the work to succeed in MIPS means your practice may do better than break even and score a bonus, which by law can go up to a maximum of 9%. But the revenue neutrality of the program, and the small number of MIPS "losers" whose penalties would feed the bonus kitty, suggests it will be far less.

"Based on 2017 performance data, MIPS 2019 payment adjustments are less than 2%, even for top performers, as the program requires budget neutral payments. This well-intentioned program is costing practices money to comply, with little promise for financial reward," reported the MGMA's Mollie Gelburd and Drew Voytal in a January 2019 MGMA STAT blog post.

Also, incentive bonuses are not a gift: if a practice made incentive money on MIPS, it still has to pay tax on it — or rather the recipients do, depending on your tax structure. (See sidebar, "To IRS, MIPS penalties are a breed apart," p. 6.)

No tax relief in sight

In fact, the financial environment for practices isn't stellar. True, physician salaries are generally up, but the provider tax environment isn't so hot. That's despite the Trump tax cuts instituted via the Tax Cuts and Jobs Act of 2017 Act, which are commonly thought to be great for high earners, a category to which most observers would assign doctors. Actually, for many doctors, "this has turned out to be a severe negative change, because of the loss of deductions," says David Gair, a tax partner at the Gray Reed firm in Dallas, Texas.
One example Gair cites is the loss of entertainment expenses: "The medical profession got hit particularly hard because some business-friendly aspects of Trump's tax reform specifically excluded doctors." Another new deduction a lot of doctors can't take: the qualified business income (QBI) deduction, also known as the section 199A deduction, which Gair says "gives a potential 20% deduction to individuals who have business income (not wages) that are not specified to

service businesses and who earn over $315,000/$415,000," which Gair observes leaves out many physicians.

"Some physicians have seen a decrease in their tax burden," says Delia Daw, a tax attorney with offices in San Diego and Los Angeles. "However, because of the elimination of the alternative minimum tax and caps on property tax deductions, many doctors in states with high state taxes have seen an increase in the amount they have to pay."

Next stop: Value-based care

These may be among the factors that, along with other administrative hassles of modern medicine of which MIPS is a part, are driving many physician-run practices to shut down, sell out or let themselves be absorbed by larger facilities. In 2017, for the first time, more doctors were employed by practices than owned them (PBN 3/1/17, PBN blog 5/31/17).

Janet Bliss, a partner in The BDO Center for Healthcare Excellence & Innovation, also cites electronic medical records and HIPAA compliance "as well as declining reimbursement and the need to improve profitability" among the big practice stressors. "Many of the smaller practices that were struggling financially and didn't have the resources to manage MIPS and other programs have already joined hospitals or other larger groups," she says.

While some doctors are inarguably shifting to an employment model, there are signs that MIPS may be driving many participants in the direction of full-on quality reporting models — such as the Advanced Alternative Payment Models (APMs) that some providers use as an alternative to the largely fee-for-service-based MIPS program.

According to Administrator Verma, the number of Qualifying APM Participants (QP) in Advanced APMs doubled from 2017 to 2018, increasing from 99,076 to 183,306. Certainly CMS is setting out lures for physicians to get into pay-for-performance models, such as its new Direct Primary Cares model, which sets a low barrier for entry to primary care physicians (PBN 4/25/19). And those who already have toes in the water of value-based payment at the lower-risk levels of the Shared Savings ACO program are being pushed into the deep end by CMS with its new Pathways to Success standards that make them take on more risk more quickly (PBN 6/13/19).

"The cause-effect is not so clear," cautions Theresa Hush, CEO of Roji Health Intelligence in Chicago. In the case of the doctors shedding ownership, for example, the motivation may be less MIPS and more that "they can spend less time on administration and have more resources," Hush says. "These are financial decisions that will happen with or without MIPS."
But Hush acknowledges that "Medicare is hoping that APMs and its risk-based payment will be the winning scenario that will draw physicians away from FFS." Medicare is providing incentives to do that and making it clear that it will be tough to continue in FFS as it is now, she says. "MIPS penalties and incentives are only part of that mix. The 2020 MIPS financials are more difficult, and it will help nudge them toward APMs. É I think that is likely, especially given more options available to physicians, that they will go in this direction over time." — Roy Edroso (redroso@decisionhealth.com)

Resources:

MIPS group scores: https://data.medicare.gov/Physician-Compare/Physician-Compare-2017-Group-Public-Reporting-Over/vh77-fha8

MIPS individual scores: https://data.medicare.gov/Physician-Compare/Physician-Compare-2017-Individual-EC-Public-Report/j79y-bz9t

CMS blog posts: www.cms.gov/blog/quality-payment-program-qpp-year-1-performance-results, www.cms.gov/blog/quality-payment-program-releases-2017-physician-compare-data-and-sees-increases-clinician

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