OPTING OUT: THE ULTIMATE MACRA ALTERNATIVE

If yours is one of the small clinical practices with less than $30,000 in Medicare revenue or fewer than 100 unique Medicare patients per year, October 2nd, 2017 will be just another Monday for you. However, for most Medicare-participating healthcare practitioners, October 2nd will mark the day that their practice becomes subject to significant reporting requirements and financial risk under the Quality Payment Program of the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA").

REPORTING REQUIREMENTS AND PAYMENT REDUCTIONS

MACRA's Quality Payment Program is a value-based payment regime for Medicare-participating clinicians. MACRA-covered clinicians may choose one of two tracks, both of which add yet another acronym to the crowded healthcare lexicon. Clinicians feeling confident in their ability to control costs may choose to participate in the Alternative Payment Model ("APM") track, in which they will directly bear upside and downside risk. Alternatively, clinicians may participate in the Merit-Based Incentive Payment System ("MIPS") track, under which they will be scored on activity reporting measures related to Quality, Improvement Activities, Advancing Care Information, and Cost.

MACRA-covered clinicians who do not elect a track by October 2, 2017 will be assigned to the MIPS track, and will receive a 4% reduction in Medicare payments for fiscal year 2018. Those who choose the MIPS track but do not properly perform and report will also receive up to a 4% payment reduction. Each year thereafter, the activity and reporting requirements increase, along with the negative adjustments for non-compliance. In fact, by 2022, non-compliance will bring a full 9% payment reduction.

Given the significant financial implications of non-compliance, it may come as a surprise that, less than a month before MACRA's implementation, CMS is still concerned that around 40% of clinicians are unaware of the MACRA requirements. What should come as no surprise, however, is that 46% of physicians plan to accelerate their retirement, cut back on patients or seek non-clinical roles as a result of MACRA's implementation.[1]

UNINTENDED CONSEQUENCES

The history of healthcare is the history of unintended consequences. The full measure of MACRA's unintended consequences will reveal themselves over time; however, some can be easily predicted. For example, MACRA is being implemented at the same time that several members of the United States Senate, including some anticipated 2020 presidential candidates, are proposing Medicare-for-All legislation. While leaders of one of our nation's main political parties are proposing to expand Medicare to all Americans, CMS is implementing an unprecedented reporting and reimbursement program for Medicare that is causing nearly half of physicians to accelerate their retirement. This does not bode well for our national physician shortage, particularly among the Primary Care Physicians that serve as the gatekeepers for our nationwide experiment in data-driven healthcare.

Further, if Medicare-for-All gains traction, which it may be expected to do given that support for a single payor is greater among younger voters, the thought of all-MACRA-all-the-time may increase the rate of early physician retirement far above the 46% originally reported. Those who remain will increasingly be younger physicians who have never known anything but a 7-minute patient encounter spent typing into the EMR. This does not bode well for the quality of care that MACRA is supposed to increase.

Another unintended consequence of MACRA may be a spike in the number of physicians who refuse to take new Medicare patients, or who opt out of Medicare entirely. Many clinicians are now refusing to accept patients with ACA insurance plans, due the propensity for the high deductibles to go unpaid. An increasing number of clinicians are simply disenrolling from all third-party payment plans entirely. Given the rise in co-pays and deductibles that have turned many commercial insurance plans into the equivalent of catastrophic coverage plans, consumers may find that a visit to a "private pay" practitioner costs them no more than a visit to a practitioner who is enrolled in the consumer's insurance plan.

THE RISE OF ALTERNATIVE PRACTICE MODELS

As documented in numerous studies, practitioner satisfaction is at an unprecedented low. A 2017 survey of 14,000 physicians confirmed four primary causes for this dangerous level of burnout: too many bureaucratic tasks, spending too many hours at work, feeling like just a cog in a wheel, and increased computerization of practice.[2] Why anyone thinks that MACRA will do anything but pour gasoline onto this very real problem of burnout is beyond comprehension. MACRA is the antithesis of what our healthcare system needs at this critical moment.

Simultaneously, many healthcare markets have aggregated into an oligopoly of large, institutionally-led systems at the same time that the justification for those large systems is eroding. Unsurprisingly, aggregation has led to the increase in costs that commonly accompanies increased market share. It has also been shown to have been accompanied by an increase in ancillary service cost and utilization, and it has decreased clinicians' ability to refer to non-affiliated providers. In today's information-based economy, individuals increasingly see themselves as empowered decision-makers in a consumer-centric marketplace. With EMR interoperability looming over the horizon, the balance of power in the healthcare infrastructure is poised to shift away from institutional healthcare systems and toward the empowered consumer. From the point of view of the healthcare consumer, the rise of healthcare oligopolies has been part of the problem, not part of the solution.

In response, entrepreneurial physicians and other clinicians are building new practice models that mix traditional and alternative care options in a manner that responds to the desires of today's healthcare marketplace. Innovation is creating a new healthcare landscape, ranging from freestanding retail clinics and emergency rooms to private-pay practices that allow clinicians to give their patients that most precious of all resources: time.

Further, these entrepreneurs are not keeping their success to themselves. Whether through franchising, management services organizations, or other collaborative efforts, healthcare innovators are creating practice models that can be branded and replicated. Clinicians seeking to reverse the shift in their job duties from patient care provider to data entry clerk are being met by a growing number of practice support entities tailored to various models of personalized healthcare delivery. Many of these involve a complete opt-out of all government and third party payor programs, meaning that rather than spend time trying to avoid reimbursement cuts under MACRA, clinicians can generate the same or greater revenues while spending more time with each patient. With luck, the rise of these alternative practice models will reduce the MACRA-induced onslaught of early retirement by our nation's most experienced physicians. These alternative practice models may also provide employment opportunities for young clinicians looking for a more meaningful and satisfying way of delivering care.

Hopefully, we will someday find a way to make these alternative practice models available to those who must rely on governmental payors. Until then, October 2nd awaits.

[1] *Bruce Jaspen,* More Doctors To Retire As MACRA And Value-Based Pay Hit, *FORBES, Sept. 23, 2016, avail. at: https://www.forbes.com/sites/brucejapsen/2016/09/21/more-doctors-to-retire-as-macra-and-value-based-pay-hit/#67912e949f97.*

[2] *Troy Parks,* Report reveals severity of burnout by specialty, *AMA WIRE, Jan. 31, 2017 (citing "Medscape Lifestyle Report 2017), avail. at: https://wire.ama-assn.org/life-career/report-reveals-severity-burnout-specialty.*

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