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Understanding and evaluating deal considerations arising from MACRA

An update for private equity investors

Investments in health care providers and companies that provide services to health care providers require careful consideration. This issue explores certain strategic, financial, and tax issues that private equity investors should take into account when evaluating investments.

MACRA overview

The Medicare Access and CHIP Reauthorization Act ("MACRA") will dramatically change the way physicians will be compensated and will have far reaching effects. For example, the annual growth in Medicare physician compensation prescribed by MACRA is projected to be slower than the annual growth in health care costs. Physicians will have to outperform quality and cost benchmarks in order to receive additional compensation.

MACRA repealed the Medicare sustainable growth rate (SGR) methodology, which governed updates to the Medicare Physician Fee Schedule (PFS). The PFS is responsible for providing fixed, annual payment updates to SGR for all future years.

In addition, the Centers for Medicare & Medicaid Services' (CMS) final rule was released on October 14, 2016. This rule provides critical detail on the Merit-based Incentive Payment System (MIPS). MIPS is a new program for clinicians (physicians and certain other professionals paid under the Medicare Part B fee schedule) that adjusts updates based on clinicians' performance in four categories of measures, further outlined below. The final rule also provides detail on the criteria for incentives for clinicians to participate in certain Advanced Alternative Payment Models (APMs).

MACRA is expected to drive care delivery and payment reform across the US health care system for the foreseeable future. Congress intended for MACRA to transform the traditional fee-for-service payment model to new risk-bearing, coordinated care models. The law has ignited strategic discussions around new care, payment and delivery models and is creating new opportunities and risks for health care stakeholders.

MACRA overhauls Medicare's payments to clinicians by creating stronger incentives for them to participate in APMs that require financial risk sharing. In return, clinicians receive a broad set of health care services that are designed to improve quality of care and control health care costs.

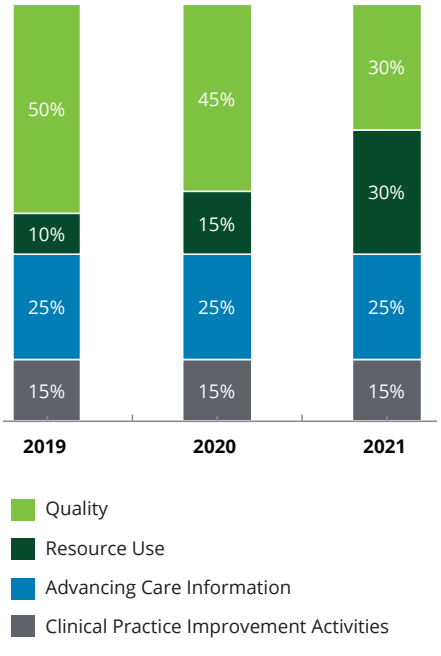
MIPS

CMS expects the vast majority of clinicians in 2019 to be subject to MIPS. Clinicians who do not achieve revenue or patient count thresholds for participation in APMs will need to report through MIPS. Their performance will be measured in four categories to determine payment adjustments:

- quality
- cost
- health information technology use
- clinical practice improvement

Over time, the performance formula will shift from a primary focus on quality measures to increasing focus on cost. The cost will be calculated by measuring the costs associated with clinicians' practice and referral patterns. Together, these policies are intended to encourage a much stronger focus on quality and total cost of care.

Components of MIPS CPS (2019-2021)



Source: Public Law 114-10 (April 16, 2015)

APMs

MACRA provides significant financial incentives for health care professionals to shift increasing proportions of their practices to risk-bearing, coordinated care models. Clinicians who receive significant shares of their revenue or patient counts through APM entities beginning in 2017 will be exempt from MIPS and qualify for incentive payments from 2019 through 2024. CMS has identified two types of eligible APMs: APMs and Other Payer APMs.

Clinicians can qualify for the APM incentive track for 2019 and be exempted from MIPS in one of two ways:

1. receive at least 25 percent of Medicare Part B revenue through APM entities, with the threshold increasing to 50 percent in 2021 and 75 percent in 2023
2. have at least 20 percent of eligible Medicare beneficiary patients attributed to an APM entity, with the threshold increasing to 35 percent in 2021 and 50 percent in 2023

Strategic considerations

MACRA is most likely to directly impact physicians, clinicians, health systems, Ambulatory service centers, urgent care providers (collectively, "Provider Organizations"), and health plans. However, the law may affect other stakeholders along the health care continuum, including post-acute providers, regulatory officers, health care suppliers, and information technology companies. MACRA's intent is to reduce health care spending and overall utilization by rewarding providers for improved quality and outcomes. Cost measures and APMs may increase already heightened scrutiny on inputs: hospitalizations, medical technology and devices, drugs covered under Medicare Part A and Part B, and post-acute care. As CMS incorporates Medicare Part D spending into cost measures, organizations may see greater pressure on outpatient drug spending, as well, which may have downstream pricing impacts to pharmaceutical, medical device, and other life science companies.

Provider organizations

Providers that employ physicians will need to consider how to succeed under MIPS and whether to pursue an APM arrangement. This may not be an either / or decision. Even if systems invest in APM initiatives, not all of an organization's clinicians may be able to take part in an APM initiative. Also, smaller physician practices may be more interested in becoming part of a health system if they are not well-positioned to adapt to the new MACRA payment arrangements.

Investment in technology and business practices

Both APMs and MIPS will require provider organizations to invest in technology and business practices. For example, there are interoperability requirements that may have significant implications to vendor relationships, and information systems. CMS requirements will change over time, so systems and processes will need to change with them. Under MIPS, clinicians and provider organizations billing on their behalf will need to analyze quality and cost performance against the national benchmarks and, if needed, change practice patterns to avoid payment reductions and public reporting about substandard performance. Provider organizations also will need to review and appeal inaccurate CMS information and prepare for CMS audit processes to validate clinician-submitted performance data. If organizations have not already accredited their clinicians as Patient Centered Medical Homes (PCMH), they should consider doing so or investing in other practice improvement activities to receive credit under the MIPS clinical practice improvement measures.

Special requirements under APMs
Under APMs, provider organizations will need to confirm that their initiatives qualify for and conform to the CMS definition and that the initiatives succeed in managing financial risk. Provider organizations may need to build or acquire special capabilities to succeed under APMs. Among these could be:

- managing risk (including reserving capital and purchasing stop-loss coverage)
- building networks (including post-acute care providers);
- integrating health information technology across clinicians and provider organizations to support collaboration
- investing in analytics to identify high-cost enrollees and work efficiently with clinicians to reduce costs and improve quality

Health plan implications; working with clinicians

Health plans should consider identifying strategic business opportunities to support clinicians and hospitals as they change the way they practice medicine and adapt to new payment and risk arrangements. Health plans may see pressure from clinicians and hospitals to align quality and reduce utilization, and to identify high-performing clinicians using Medicare's new measures. In addition, health plans using narrow-network strategies may see pressure from businesses or consumers to include clinicians that are identified as high-performing based on publicly reported scores.

Consolidation

Greater consolidation among clinician practices and clinician practices with provider organizations to meet MACRA requirements may put pressure on health plan payment rates. Clinicians may pressure health plans to enter commercial contracts with accountable care organizations, other APMs and PCMHs that align with programs under MACRA. Doing so may reduce clinicians' burden and help them qualify for higher payment updates and temporary bonuses for APMs under the Other Payer policies.

Financial considerations

Physician fee schedule updates

MACRA repealed and replaced the Medicare SGR methodology, which was intended to tie PFS updates to the growth of health care costs and the economy overall. However, negative updates to the PFS dictated by the SGR formula were allowed to take effect only once, and Congress then intervened 19 times to block the cuts from taking effect, including a 24 percent cut at the time MACRA was enacted. MACRA provides for nominal increases of 0.5 percent to the PFS through 2019, with the PFS flat between 2020 and 2025. Beginning in 2026, clinicians achieving the APM threshold will receive annual updates of 0.75 percent and those participating in MIPS 0.25 percent. Investors should expect nominal Medicare rate increases below the historic growth rate in health care spending as they model future cash flows. In order to qualify for additional payment adjustments or other financial incentives, clinicians will need to perform better than quality and cost benchmarks through MIPS or reduce costs and achieve quality goals through APMs.

MIPS payment adjustments

MIPS payment adjustments will start in 2019 based on performance measured in 2017. Healthcare organizations will have to be very thoughtful on the necessary investment and operational changes needed to track, monitor and enhance performance measures in the relatively short period between now and 2017 when the performance measures will impact payments adjustments in 2019. Distribution of payments generally is required to be equally divided between negative adjustments and positive adjustments based on relative performance measurements. Clinicians will have to continue to invest in optimizing their performance measures relative to their peers to receive positive payment adjustments.

APM payment adjustments

Under the APM incentive track, qualifying clinicians can expect temporary incentive payments of five percent beginning in 2019. However, to participate in the APM incentive track, APMs are required to assume downside financial risk for increasing percentages of their practices. If that risk is not managed appropriately, the benefits of the incentive payments may not be realized.

*For 2019 through 2024, the highest performing MIPS eligible clinicians who receive a positive payment adjustment will be eligible to share up to $500 million each year for "exceptional performance" payments. This upside is limited by the statute to +10% of Medicare charges.

Source: Public Law 114-10 (April 16, 2015)

Tax considerations

Tax overview

In an effort to enhance reimbursements under MACRA, it is likely that new entities will be formed, existing entities will be involved in restructurings, and clinicians subject to changes in reimbursement may be transferred between entities or enter into new compensation arrangements.

Formation of new entities

Consideration should be given as to the tax classification of any newly formed entities (e.g., a C or S corporation, a partnership, a disregarded entity, exempt, or taxable). The most appropriate tax classification may vary depending on the specific facts and circumstances. It should also be noted that entities entering into certain risk bearing arrangements (as described in special requirements under APMs above, for example) could be viewed as insurance companies for federal income tax purposes. Entities that are classified as insurance companies for federal income tax purposes are required to be taxed as C corporations. A failure to properly classify an insurance company as a C corporation can result in significant tax exposures.

Restructuring of existing entities

CMS will use taxpayer identification numbers ("TINs") to group clinicians who choose to report as a group for purpose of evaluating various quality metrics that may impact reimbursement levels. It is possible that organizations will elect to combine or separate existing entities in an effort to align clinicians by entity/TIN in a manner that enhances reimbursement. For example, an organization may want to group high performing clinicians together to increase reimbursement levels for that group. There may be tax consequences associated with legal entity restructurings and consideration should be given to such tax consequences before any restructuring is implemented (i.e., it may be possible to structure movements or combinations of clinicians through a series of tax-free transactions rather than a series of taxable transactions).

Corporate practice of medicine tax considerations

Consideration should be given to MACRA's impact on the complex legal entity structures and distinctive acquisition steps that may be required to comply with corporate practice of medicine laws. There are often unique tax considerations when implementing such structures. Further, when corporate practice of medicine laws result in complex legal entity structures, various contractual arrangements are commonly utilized, such as a management fee paid by a physician practice to an investor owned management company in return for non-medical services. To the extent that the overall performance of the physician practice is impacting reimbursement under the MIPS or APM models, care must be exercised to structure the terms of the management fee to comply with arm's length principles.

Payroll tax considerations

The movement of individuals between entities either in an effort to enhance reimbursements or simply to comply with MACRA could result in payroll tax reporting requirements. For example, many states require employee transfers between entities be reported to, and approved by, the state. Also, consideration should be given to the appropriate state unemployment tax rates that should apply to the transferred employees to avoid possible penalties under the State Unemployment Tax Act ("SUTA"). For instance, shifting employees from an entity with a high state unemployment tax rate to an entity with a low state unemployment tax rate could be considered SUTA dumping.

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