Physician Practice Burden and the Merit-based Incentive Payment System (MIPS)

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MEDPAC

MACRA

- Repealed the SGR
- Created two payment tracks for physicians-both to reward "value"
  - APMs (later A-APMs) for "organized practices"
  - MIPS for other physicians-consolidating previous reporting and bonus/penalty approaches (and adding a few more)

MIPS Performance Areas

Area	Weight in 2019 (2020)
Quality	60% (50%)
Advancing care information	25%
Clinical practice improvement activities	15%
Cost	0%(10%)

MSPB: Medicare spending per beneficiary

MIPS Reporting is Burdensome and Complex

- Significant burden on clinicians: CMS estimates over $1 billion in reporting burden in 2017; 800M per year thereafter
- MIPS extremely complex (and CMS emphasis on flexibility and options has increased complexity)
  - Exemptions (~850,000- 57% of non-A-APM clinicians exempt)
  - Multiple reporting options (e.g., EHR, web interface, registry)
  - Score dependent on actual reporting method (e.g., whether clinician reported through EHR or registry)
- Many physicians will be confused and unhappy as MIPS rolls out over the next few years

MIPS Measures, Scoring and Rewards/Penalties are Problematic

- Measures may not be associated with true high-value care- poorly linked to outcomes
- There is the statistical problem of small numbers
- Physicians choose their own measures, thus the resulting MIPS scores are inequitable among physicians, especially when used for payment purposes
- MIPS is structured to maximize clinician scores. This will lead to score “compression”, and a limited ability to detect performance differences
  - In 2019-2020: High scores combined with low performance standard result in minimal reward for anyone, but….
  - In later years: Minimal differences result in big payment swings: -9% to +9% (or higher) by 2022

Policy Option: Eliminate MIPS and Create a New Voluntary Option

- Eliminate MIPS and its related reporting requirements
  - Eliminate clinician reporting of quality measures, Advancing Care Information, and Clinical Practice Improvement Activities
  - Eliminate CMS's support of EHR reporting, no-pay claims, web interface
- Create a new "Voluntary Value Program" (VVP), building on MedPAC's June 2017 Report to the Congress

Voluntary Value Program (VVP)

- All clinicians would have a portion of fee schedule payments withheld (e.g., 2%)
- Clinicians could:
  - Elect to be measured with a sufficiently large entity of clinicians (and be eligible for a value payment)
  - Elect to join an A-APM (and receive withhold back); or
  - Make no election (and lose withhold)
- Entities would be collectively measured on population-based measures assessing clinical quality, patient experience and value (similar to A-APMs)

Illustrative VVP Measures

Clinical quality

- Avoidable admissions/ emergency department visits
- Mortality
- Readmissions

Patient experience

- Ability to obtain needed care
- Able to communicate concerns to clinician
- Clinicians coordinated with other providers

Value

- Spending per beneficiary after a hospitalization
- Relative resource use
- Rates of low-value care

- Calculated from claims (or surveys)
- Aligned with A-APM measures
- Combination of measures to balance incentives

Conclusion

- MIPS is not sustainable
  - Significant burden on physicians
  - Will not identify high- or low-value clinicians
- CMS will start making MIPS-based physician payment adjustments in 2019, therefore action is needed now
- Our policy option will encourage clinicians to join with other clinicians to assume some level of collective responsibility for the outcomes of their patients
- And it will allow Medicare to adjust physician payment based on population-based outcomes that have statistical validity at the voluntary entity level