Advising the Congress on Medicare issues

Next steps for the Merit-based Incentive Payment System (MIPS)

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Today's presentation

- Overview of MIPS
- Commission's concerns with MIPS
- Policy alternative
- Discussion

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MIPS overview

- MIPS adjusts Medicare FFS clinician payment up and down based on clinician performance
- It builds on and repurposes measures and processes used in seven predecessor quality and EHR incentive programs in Medicare
- MIPS applies to clinicians who are in most specialties, are above a low-volume threshold, and are not substantively participating in Advanced Alternative Payment Models (A-APMs)
- The first year of MIPS payment adjustments will occur in 2019, clinicians are reporting now
- The base MIPS adjustments are budget-neutral, and there is an additional $500 million per year for exceptional performance

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MIPS performance areas

Area	Measures	Weight in 2019
Quality	6 measures chosen by clinician (from ~300 MIPS measure set) plus patient experience (for large group practices)	60%
Advancing care information	Clinician attestation of 11 to 15 activities (based on EHR technology certification)	25%
Clinical practice improvement activities	Clinician attestation of 4 activities (2 activities if rural/underserved area)	15%
Cost	Calculated from claims (MSPB, total per capita, and certain episode costs, reporting only)	0%

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MSPB: Medicare spending per beneficiary

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MIPS: burden and complexity

- Significant burden on clinicians: CMS estimates over $1 billion in reporting burden in 2017
- MIPS extremely complex (and CMS emphasis on flexibility and options has increased complexity)
  - Exemptions (~800,000 clinicians exempt)
  - Special scoring and rules (e.g., for facility-based clinicians, clinicians in certain models)
  - Multiple reporting options (e.g., EHR, web interface, registry)
  - Score dependent on actual reporting method (e.g., whether clinician reported through EHR or registry)

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MIPS measures and scoring concerns

- Measures not associated with high-value care
  - Process measures
  - Attestation/check the box
  - Minimal information on Physician Compare
- Statistical limitations
- MIPS is structured to maximize clinician scores, leads to score compression, limited ability to detect performance
  - 2019-2020: High scores combined with low performance standard result in minimal reward
  - Later years: Minimal differences result in big payment swings
- Clinicians can choose their own measures, thus resulting MIPS score is inequitable across clinicians

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New approach needed

- MIPS will not achieve goal of identifying and rewarding high-value clinicians, but there should be a value component in Medicare FFS
- Statute requires quality measures to be comparable between MIPS and A-APMs
  - MIPS: Silo-based measures not working for FFS, unsuitable for A-APMs
  - Alternative: Population-based measures

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Goals of new approach

- Align quality and value signals across the health care delivery system
- Equitably measure aggregate clinician performance in FFS
- Limit bonuses available in traditional FFS
- Reduce clinician burden

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Policy option: Eliminate MIPS and create new voluntary value program

- 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, building on June 2017 Report to the Congress

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Voluntary value program

- 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)

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Illustrative measures

Clinical quality	Patient experience	Value
• Avoidable admissions/ emergency department visits • Mortality • Readmissions	• Ability to obtain needed care • Able to communicate concerns to clinician • Clinicians coordinated with other providers	• 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

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Conclusion

- MIPS is not sustainable
  - Significant burden
  - Will not identify high- or low-value clinicians
- CMS will start making MIPS adjustments in 2019, therefore action is needed now
- Option will encourage clinicians to join with other clinicians to assume responsibility for the outcomes of their patients
- Would allow Medicare to adjust funding based on population-based outcomes, would allow others (ACOs, specialty societies, health systems) to collect and report individual clinician performance

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Policy option

- Eliminate MIPS and its reporting requirements; and
- Establish a new voluntary value program in which:
  - Clinicians can elect to join with other clinicians in a sufficiently large entity to be eligible to receive a value payment;
  - CMS will assess the performance for each entity using a set of population-based measures comparable to those in A-APMs;
  - CMS will make the same value payment adjustment to all clinicians in each entity; and
  - The downward adjustment is set as a withhold ahead of time and the value payment is capped.

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