Refining an alternative to the Merit-based Incentive Payment System (MIPS)

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MEDPAC

Background

- Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
  - Repealed SGR
  - Set statutory updates in perpetuity
  - Created 5% incentive payment for clinicians in A-APMs
  - Created new value-based purchasing program for clinicians remaining in Medicare FFS—the Merit-based Incentive Payment System (MIPS)
- Concerns about MIPS
  - We have raised concerns for the past two years
  - CMS delayed full implementation for first two years (2019 and 2020)
  - Providers, academics, others

Last month's discussion and today's presentation

- Last month
  - MIPS will not achieve goal of identifying and rewarding high-value clinicians, at significant burden to program and clinicians
  - General agreement to eliminate current MIPS—but desire to keep a value component for clinicians in Medicare FFS
  - Description of potential voluntary value program (VVP)
- Today
  - Interaction with Advanced-Alternative Payment Models (A-APMs)
  - Addressing questions on VVP

Availability of A-APMs

- CMS has taken some actions to make A-APMs more attractive to clinicians with which we agree
  - Prospectively attributing beneficiaries to ACOs
  - Allowing aggregation of smaller organizations to form a larger national entity
  - Making models available to any providers willing to meet the terms
  - Incorporating asymmetric risk
  - Allowing beneficiaries to be rewarded for using ACO providers
  - Defining risk as a share of revenue
- However, A-APMs need to be rigorous and lead to meaningful delivery system reform (e.g., guaranteed payments shouldn't exceed risk)

Interaction with A-APMs

- VVP would encourage clinicians to form voluntary groups and reward them for population-based outcomes
- Clinicians would be better positioned to form or join A-APMs
  - Familiar with groups
  - Familiar with measures
- Clinicians would continue to want to form or join A-APMs because:
  - VVP rewards would be limited
  - Still not eligible for 5 percent A-APM bonus

Policy option

- Eliminate the current Merit-based Incentive Payment System; and
- Establish a new voluntary value program in FFS Medicare in which:
  - Clinicians can elect to be measured as part of a voluntary group; and
  - Clinicians in voluntary groups can qualify for a value payment based on their group's performance on a set of population-based measures.

Voluntary value program (VVP)

- Withhold funds a pool of dollars for value payment
- Clinicians can:
  - Elect to be measured with a voluntary group and be eligible for value payment;
  - Join an A-APM and get their withhold back;
  - Not make any election and lose their withhold.
- VVP option would describe general framework, and provide illustrative policies
  - Would retain flexibility for Congressional, CMS, and stakeholder input on specific design
  - Remainder of presentation will discuss these policies in more detail in response to your questions

Size of the voluntary groups

- Minimum voluntary group size will depend on the specific measures, clinician specialties in each group, and attribution rules
- For example, a voluntary group of 10 or more clinicians would likely be sufficient to be measured on avoidable admissions or emergency department visits, if specialty mix is similar to MSSP ACOs
- How many clinicians are already in groups of this size?
  - 1/3 of Medicare-billing physicians work with 10 or more clinicians in the same practice in their immediate office location
  - 40 percent of Medicare-billing physicians are affiliated with a hospital or health system
  - ~190,000 clinicians are in MSSP Track 1 ACOs

Process for clinicians to join voluntary groups

- No restrictions on the size or makeup of the voluntary group, beyond minimum size
- CMS could provide technical assistance on referral networks to help clinicians form voluntary groups
- Potential fallback voluntary group?
  - CMS would establish groups for clinicians who wish to be in a group but don't have one they can join
  - Pros: Isolated or low-volume clinicians would have a voluntary group they could join
  - Cons: The value pool likely would be smaller (smaller rewards for high-performing voluntary groups)

Measures

- Criteria for measures
  - Focus on population-based outcomes, patient experience, and cost
  - Patient-oriented, encourage coordination across providers and time, and promote change in the delivery system
  - Not unduly burdensome for providers
- Measures should have scientifically acceptable properties
  - Reliable and valid using a defined minimum number of cases
  - Can distinguish meaningful differences among voluntary groups
  - Appropriate risk-adjustment for patient health risks
- Could use peer grouping to address social risk factor differences
- A-APM and VVP measures would be consistent by design

Attributing beneficiaries

- CMS uses several attribution methods, depending on the purpose of the program
  - Single (beneficiary attributed to one provider or group)
  - Multiple attribution (proportionally allocated to all providers involved in an episode of care)
- Multiple attribution results in more specialty clinicians being attributed per episode than single attribution
- Could use several attribution methods, multiple attribution could be the default

Specialists

- Specialist participation in A-APMs
  - Two-thirds of physicians in MSSP are specialists
  - Three out of seven of the A-APMs in 2019 focus on conditions largely managed by specialists
    - Comprehensive Care for Joint Replacement
    - ESRD Seamless Care Organization
    - Oncology Care Model
- Specialist connection to VVP measures
  - Avoidable emergency department and admissions measures: *Primary care, some outpatient medical specialties*
  - Readmissions, Medicare spending per beneficiary: *Surgeons, hospital-based clinicians*
  - Patient experience, cost: *Most clinicians*

Amount of the withhold and value payment

- 2% withhold is illustrative
  - Could compare to other Medicare value-based purchasing programs (Hospital value-based purchasing program is 2%)
  - Likely not sufficient to change behavior
- Could make withhold larger, or grow over time
- Total value payment would be capped, so less attractive than joining an A-APM

Potential loss of beneficial information in MIPS

- Policy would eliminate clinician-reported quality measures and clinician attestation process
  - Other organizations (ACOs, health systems, specialty societies) could measure and report individual performance to clinicians or the public
  - Currently, very few measures end up in Physician Compare
- More direct ways of pursuing EHR goals
- Registries could inform internal quality improvement

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