

CHAPTER

15

**Moving beyond the
Merit-based Incentive
Payment System**

R E C O M M E N D A T I O N

15 The Congress should:

- eliminate the current Merit-based Incentive Payment System; and
- establish a new voluntary value program in fee-for-service 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.

COMMISSIONER VOTES: YES 14 • NO 2 • NOT VOTING 0 • ABSENT 1

Moving beyond the Merit-based Incentive Payment System

Chapter summary

Recognizing that an enacted public policy is not fulfilling its intended goals and therefore calling for its elimination is complex and must be carefully considered. For example, the sustainable growth rate (SGR) system, which was intended to limit growth in Medicare fee schedule spending to a formula based on gross domestic product, started in 1999, was repeatedly overridden by the Congress between 2003 to 2014 and was not eliminated until the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The Commission supports the elements of MACRA that repealed the SGR and encouraged comprehensive, patient-centered care delivery models such as advanced alternative payment models (A-APMs).

Notwithstanding that specific support, the Commission has concluded that one part of MACRA, the Merit-based Incentive Payment System (MIPS), will not fulfill its goals and therefore should be eliminated. The Commission did not reach this conclusion hastily. We first examined options for improving MIPS as it was implemented, and we provided constructive feedback as CMS established rules for the first two years of the program (Medicare Payment Advisory Commission 2017a, Medicare Payment Advisory Commission 2016a, Medicare Payment Advisory Commission 2016b). However, as we continued to explore the issue in a deliberative process laid out in several Commission reports to the Congress, we determined that, from the Commission's perspective, the basic design of MIPS is fundamentally

In this chapter

- MIPS will not be successful
- MIPS should be eliminated
- A new direction for rewarding clinician quality: A voluntary value program
- Conclusion and recommendation
- Appendix: Design elements for a voluntary value program: An illustrative model

incompatible with the goals of a beneficiary-focused approach to quality measurement (Medicare Payment Advisory Commission 2017b, Medicare Payment Advisory Commission 2016c).

The basic design principle of MIPS is that clinician quality of care and payment adjustments for quality can and should be determined primarily at the individual clinician level, based on measures that clinicians themselves choose to report. But a system built on this design will be inequitable because clinicians will be evaluated and compared on dissimilar measures. In addition, many clinicians will not be evaluated at all because, as individuals, they will not have a sufficient number of cases for statistically reliable scores. (In fact, CMS estimates that over half of clinicians will be exempt from MIPS reporting and payment adjustments.) Further, the design is at odds with the fact that quality outcomes for patients—the principal objective of any value improvement program—are determined primarily through the combined efforts of many providers rather than by the actions of any one clinician.

It is this underlying conception of how best to improve quality that is most essential. It is a core Commission principle for value-based purchasing programs that clinical outcomes, patient experience, and cost must be evaluated together and that these measures are dependent on the totality of the delivery system that produces them. It can be difficult to put this principle in operation given the uncoordinated nature of fee-for-service (FFS) payment, but it can be done. However, MIPS, by design, does not satisfy this principle. The Commission believes that the MIPS program impedes the movement toward high-value care. MIPS will not succeed in helping beneficiaries choose clinicians, in helping clinicians collectively change practice patterns to improve value, or in helping the Medicare program to reward clinicians based on value.

Much of the design of MIPS is based on predecessor Medicare programs that have generally not been successful at improving population outcomes or substantively improving care processes. In addition:

- MIPS imposes a significant reporting burden on clinicians (estimated by CMS as over \$1.3 billion in the first year).
- MIPS scores are not comparable among clinicians because each clinician's composite MIPS score will reflect a mix of different, self-chosen, measures.
- MIPS is complex and inequitable, with different rules for clinicians depending on location, practice size, and other factors; it exempts more clinicians than will participate.

- MIPS-based payment adjustments will be small in the first years, providing little incentive, and then arbitrary and possibly very large in the later years, creating significant financial uncertainty for clinicians.

Moreover, MIPS will encourage clinicians to focus on selecting measures on which they expect to do well (rather than focusing on improving patient outcomes) and to remain in traditional FFS in bonus-only payment models that will increase their probability of getting high MIPS scores (instead of joining meaningful A-APMs with both risk and reward).

For these reasons, the Commission recommends that the Congress eliminate the current MIPS program as soon as possible. At the same time, the Commission believes that traditional Medicare FFS payment should have a value-based payment component. Thus, we recommend creating a new clinician value-based purchasing program—a voluntary value program, or VVP—to take its place. The VVP recommendation reflects a conceptual direction (not yet a detailed design) for rewarding clinician quality in Medicare FFS according to the core quality principle developed by the Commission; however, we are prepared to engage in a more detailed development of a VVP should the Congress pursue these recommendations.

Some have argued that a new program such as MIPS should be given a chance to succeed and that clinicians and CMS have already invested considerable resources in preparing for it. However, the Commission believes that MIPS cannot succeed in meeting the goal of reliably measuring and rewarding clinician quality, in part because it is based on predecessor Medicare clinician incentive systems and measures that did not work in the past and are not likely to work in the future. MIPS will continue to consume limited CMS and clinician time and resources, and the burden of MIPS will outweigh its value to Medicare beneficiaries, the Medicare program, and clinicians. Progress in a more useful direction is feasible. MIPS should be eliminated, and a VVP should be established to encourage clinicians to move in a more productive direction. ■

Background

From 1999 to 2015, payment updates under Medicare’s physician fee schedule were governed by the sustainable growth rate (SGR) system, which set updates so that total spending would not increase faster than a target—a function of input costs, fee-for-service (FFS) enrollment, gross domestic product (GDP), and changes in law and regulation. Because annual spending generally exceeded these SGR parameters, payments to clinicians were scheduled to be reduced by ever-growing amounts starting in 2002. The Congress overrode these negative cuts in all but the first year they were scheduled.

Because of these overrides and volume growing in excess of per capita GDP, the resulting potential update reduction grew to a scheduled 21 percent in 2015, carrying with it a significant budgetary cost of either a continued override or repeal. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repealed the SGR system and created a fixed set of statutory updates for clinicians, which relieved the uncertainty clinicians faced under the SGR system.

MACRA also created two new policies—an incentive payment for qualifying participants in advanced alternative payment models (A-APMs) and the Merit-based Incentive Payment System (MIPS). CMS refers to these two programs collectively as the Quality Payment Program (QPP).

MACRA’s incentive payments for clinicians participating in A-APMs were intended to encourage clinicians to move toward these models. A-APMs generally require participating entities to assume financial risk for their patients, which creates incentives for providers to improve care coordination and quality while controlling cost growth.¹ The Commission generally supports this and other elements of MACRA designed to move toward comprehensive, patient-centered care delivery models.

Under the QPP, clinicians remaining in traditional FFS Medicare (i.e., not joining an A-APM) are subject to additional reporting and payment requirements through MIPS. MIPS is a system that calculates individual clinician-level or group-level payment adjustments based on four areas—quality, advancing care information (ACI—or meaningful use of electronic health records), clinical practice improvement activities (CPIA), and cost. In MIPS, CMS assesses clinician performance for the first three MIPS categories using measures that clinicians themselves choose and report (Table 15-1, p. 450). Cost is calculated by

CMS. Performance scores are then used to adjust payments two years later. For example, each clinician (or group) will receive a composite score based on 2017 performance in these four areas (although cost will be weighted at zero), and that score will be used to adjust the clinician’s total Part B revenue for the 2019 payment year.

The Bipartisan Budget Act of 2018 (BBA) made a number of changes to MIPS, including continued flexibility for CMS to set performance thresholds and adjust weights for the first five years of the program. The text below was drafted before the BBA was enacted and so does not reflect those changes.

The upward and downward MIPS payment adjustments are capped but grow over time, starting at +/- 4 percent in 2019 and increasing to +/- 9 percent by 2022. Payment increases may be larger than these percentages due to a scaling factor (to make the basic MIPS adjustments budget neutral) and an exceptional performance bonus. The basic MIPS adjustments are budget neutral, but MACRA also appropriated an additional \$500 million in annual funding for exceptional performance in MIPS.

MIPS repurposes the prior Physician Quality Reporting System (PQRS), physician value-based payment modifier (VM), and meaningful use of electronic health record (EHR) programs into one program. Specifically, the MIPS quality measures are largely the same as those used in PQRS and the VM, and MIPS’s ACI category is substantively similar to the prior EHR meaningful use program (Figure 15-1, p. 451). The Physician Quality Reporting Initiative (PQRI) and the EHR incentive payment programs were positive payment incentive programs. The e-prescribing and PQRS programs were initially payment incentives that became payment penalty programs. EHR meaningful use was a penalty program only. The value-based payment modifier was budget neutral.

MIPS will not be successful

A major effort is underway by CMS, clinicians, medical societies, quality improvement organizations, and EHR vendors to fulfill the MIPS requirements. But over the past two years, the Commission has come to the conclusion that MIPS is profoundly flawed. It will not succeed at its stated goals of increasing payment for high-value clinicians or reducing payment for low-value clinicians. Nor will it succeed as an incentive program designed to improve clinician practice patterns. With the sheer

**TABLE
15-1**

MIPS reporting requirements and weights in 2017 and 2018 reporting years

MIPS category	Required measures	Weight in 2017 (2019 payment year)	Weight in 2018 (2020 payment year)
Quality	6 measures chosen by clinician (from MIPS measure set of approximately 300 items) plus optional patient experience survey for large group practices	60%	50%
ACI	Clinician attestation of 11 to 15 activities done using certified EHR	25	25
CPIA	Clinician attestation of 4 activities (2 activities if certain circumstances apply)	15	15
Cost	Calculated from claims (Medicare spending per beneficiary, total per capita costs (plus 10 episode-based cost measures for 2017 only))	0 (Clinicians will receive feedback, but measures will not be used for payment)	10 (Medicare spending per beneficiary and total per capita costs)

Note: MIPS (Merit-based Incentive Payment System), ACI (advancing care information), CPIA (clinical practice improvement activities), EHR (electronic health record). The ACI category in 2018 includes a set of hardship exemptions, pursuant to the 21st Century Cures Act.

Source: Centers for Medicare & Medicaid Services. Quality Payment Program Year 2 final rule overview. <http://qpp.cms.gov>.

complexity of the system, MIPS will be unlikely to present a true, objective assessment of clinician quality and thus may be worse than no measurement at all. Nevertheless, MIPS will create significant costs for both clinicians and the Medicare program.

Our concerns about MIPS are shared by others. Clinician and provider organizations have requested delays of various MIPS requirements (American Medical Association 2017). Researchers and other observers have echoed the concern that MIPS will not ultimately improve care for beneficiaries (Frakt and Jha 2017, Ginsburg and Patel 2017, McWilliams 2017, Schneider and Hall 2017). With greater specificity below, the Commission concludes that MIPS will not be successful and because of its underlying design cannot be fixed.

MIPS replicates flaws of prior value-based purchasing programs in Medicare

The predecessor programs in Medicare repurposed for MIPS have generally not been successful at improving population outcomes or at substantively improving care processes. For example, two recent studies of the VM (which started applying to very large clinician groups

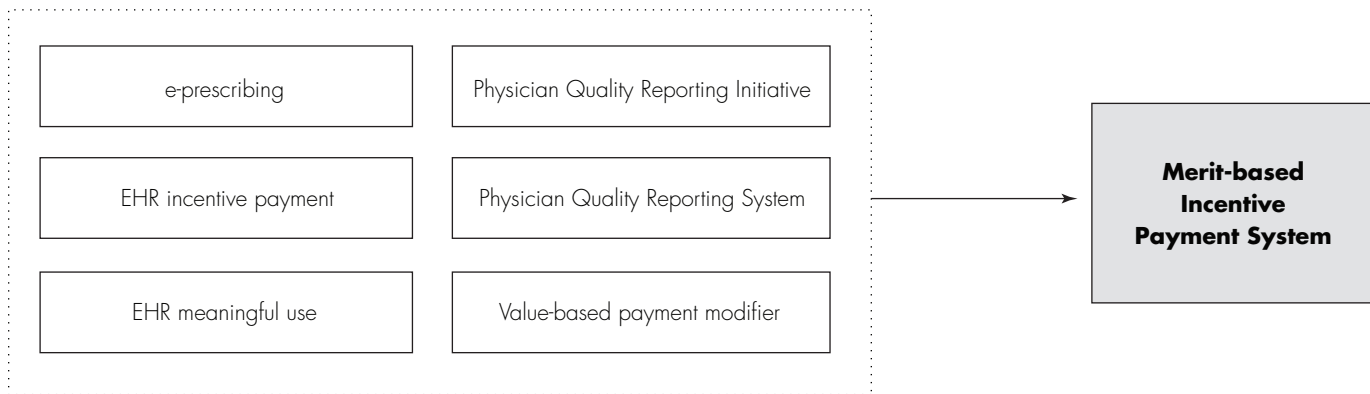
in 2015 and solo clinicians and groups of all sizes in 2017) found that its introduction was not associated with improvements in program measures (Joynt Maddox et al. 2017, Roberts et al. 2017).

A meta-analysis performed under contract to CMS's Office of the National Coordinator for Health Information Technology did not find persuasive evidence that the predecessor EHR meaningful use and EHR incentive payment programs led to quantifiably improved patient outcomes or reduced costs. Positive outcomes, when they occurred, were highly dependent on the type of information technology implemented and its functioning. Studies that evaluated EHR on the basis of efficacy (cost) were the least likely to find positive results (Rahurkar et al. 2015, Shekelle et al. 2014). On this basis, CMS does not assume that the MIPS requirements for clinicians to meet the ACI objectives will result in quantifiable improvements in quality or reductions in cost (Centers for Medicare & Medicaid Services 2017c).

CMS's estimate of clinician compliance costs with these predecessor programs is comparable with the first year of MIPS reporting—on the order of at least a billion dollars per year. But the effect on quality and cost were negligible.

**FIGURE
15-1**

Medicare's prior value-based purchasing programs for clinician services



Note: EHR (electronic health record).

Source: Centers for Medicare & Medicaid Services.

This negligible effect represents a significant outlay of expenditures and clinician time for programs that have not fundamentally improved the quality of care provided to Medicare beneficiaries.

It is unlikely that MIPS can succeed when prior efforts that used the same underlying structure have been unsuccessful. Further, none of the value-based purchasing program designs used in predecessor Medicare programs and repurposed for MIPS have been able to overcome the issue of small numbers of cases for measuring individual clinicians, a perennial issue in value-based purchasing for clinician services because it can make the results at the individual clinician level unreliable.

MIPS is burdensome and complex

MIPS requires clinicians to report multiple quality measures, in addition to attesting to their activity in two categories: ACI and CPIA.² Clinicians can report to MIPS using five different reporting tools (plus an optional survey tool).³

The burden of this reporting on clinician practices is significant and quantifiable. For 2017, CMS estimated a total cost burden of \$1.3 billion for clinicians (Centers for Medicare & Medicaid Services 2016).⁴ For 2018, CMS first estimated a burden of \$857 million and finalized

a burden estimate of \$694 million (primarily because more clinicians will be exempt from MIPS) (Centers for Medicare & Medicaid Services 2017c, Centers for Medicare & Medicaid Services 2016). In other words, in the first two years of the program, clinicians will spend \$2 billion implementing MIPS. And the burden will continue as long as MIPS is in place because it will continue to require substantial clinician reporting. This burden is especially notable because CMS has adopted a phased approach for QPP reporting in 2017 and 2018 that allows clinicians to report minimal amounts of quality, ACI, or CPIA data to avoid a penalty.

The Commission's quality principles hold that quality reporting for the Medicare program should not be burdensome for providers. But all measures used in MIPS for the quality, ACI, and CPIA categories require clinicians to report information to CMS; no data are extracted from claims.

Coupled with the burden for clinicians are the administrative requirements for CMS to collect and validate this information, calculate benchmarks, apply multiple special rules, apply special scoring, combine performance across multiple categories, reweight MIPS categories if necessary, and derive a composite performance score for each of the half a million clinicians subject to a MIPS adjustment each year.

MIPS information is unlikely to be meaningful

The Commission believes that Medicare's value-based purchasing programs should address three areas of concern for the Medicare program: clinical quality, patient experience, and cost/value. The measures should be patient oriented, encourage coordination across providers and over time, and promote change in the delivery system. The measures used in MIPS do not meet these criteria. (The Commission believes that providers may choose to use more granular measures to manage their own quality improvement.)

The measures in MIPS are variable in their clinical appropriateness, their association with meaningful outcomes, and their emphasis on patient experience of care. In the MIPS measure set, only 31 percent of the measures and reporting method combinations are outcome measures, whereas 65 percent are process measures (4 percent are structure or efficiency measures). Many measures (of all types) have compressed performance—of the 403 total MIPS measures and reporting method combinations in 2017, 113 meet CMS's definition of topped-out measures (Centers for Medicare & Medicaid Services 2017a).⁵ But because in MIPS every clinician must report at least six measures, CMS has generally been reluctant to remove topped-out measures.

As an example, CMS will address only six topped-out measures in 2018 (by adjusting the scoring for these measures). CMS is proposing a four-year process for removing the remaining 107 topped-out measures from the MIPS measure set. This long time line is meant to avoid disadvantaging certain clinicians who would be reporting these measures. But in the meantime, additional clinicians can elect to report these measures.

In addition to the problem of topped-out measures, 145 of the 403 measure and reporting combinations have no benchmarks at all, meaning that clinician performance on these measures cannot be compared with a baseline performance level (Centers for Medicare & Medicaid Services 2017a). Furthermore, the MIPS measure set does not include many important aspects of quality. For example, the set lacks comprehensive measures assessing low-value care. And while Medicare beneficiaries face a particular vulnerability in transitioning across providers and settings, few quality measures used by the prior Medicare programs (and replicated in MIPS) assess these

transitions (Medicare Payment Advisory Commission 2012).

Finally, the measures that clinicians have been reporting to Medicare do not help patients choose among clinicians. Although CMS has been collecting self-reported quality data from clinicians for over a decade, Medicare's Physician Compare website contains very little quality information available to the public at the individual clinician (or group) level.

For the new category, CPIA, clinicians can choose from a list of 93 activities that clinicians attest to doing to get full credit. Some of the CPIA activities reflect basic standards of care (e.g., training in care coordination) or lack evidence to demonstrate that they will improve quality of care. Some activities also overlap with the quality component of MIPS. For example, one of the activities is participation in the Consumer Assessment of Healthcare Providers and Systems[®] (CAHPS[®]) patient experience survey.⁶ As a result, clinicians could use some activities to satisfy multiple MIPS requirements. Other activities such as participating in a medical home have mixed evidence on their effectiveness (Friedberg et al. 2014, Schwenk 2014).

MIPS performance scores will not be easily interpreted or comparable across clinicians

CMS will derive composite performance scores for each measure in each category based on the distribution of performance scores only for other clinicians who reported the same measure using the same method (subject to a minimum case size for calculating the benchmark and the performance score). In other words, clinicians who achieve the same performance level on the same quality measure can receive a different score based on the method with which they choose to report (e.g., by means of a registry or EHR). In addition to being inequitable, this design further exacerbates the small-numbers problem for any given measure and adds to the overall complexity of the program. Each clinician will get a composite MIPS score reflecting a mix of different measures because clinicians choose which six measures to report. By construction, the composite quality score will not be comparable across clinicians.

MIPS contains many special rules, and a significant share of clinicians are exempt

CMS has established special rules for how many measures must be reported (and the resulting scoring of those

measures) for the following clinicians and clinician groups:

- participants in certain Center for Medicare & Medicaid Innovation (CMMI) models deemed to be “MIPS Alternative Payment Models (APMs),”⁷
- small practices (15 or fewer clinicians),
- practices in health professional shortage areas,
- non-patient-facing clinicians,
- clinicians in rural areas,
- clinicians practicing primarily in facilities,
- clinicians who report measures without benchmarks, and
- clinicians who report measures below the minimum size threshold.

Separately, CMS has also established policies to increase total performance scores for clinicians:

- with complex patients (measured by both average hierarchical condition category (HCC) score and the share that are dually eligible for both Medicare and Medicaid);
- in rural areas;
- in small practices (15 or fewer clinicians);
- who improve their composite quality or cost performance score over time (which can be achieved by reporting different quality measures each year); and
- who report high-priority quality measures, use certain EHR technology, report to public health agencies or clinical data registries, or are in certain types of medical homes.

While there may be good reasons to consider the issues raised above, we believe that the effect of all of these special rules and performance increases will be a MIPS score that has very little connection to value and is not comparable across clinicians.

In addition, clinicians in certain categories are exempt from MIPS reporting: clinicians in the first year of Medicare participation, clinicians in certain specialties that have been excluded from prior value-based purchasing programs (such as podiatrists), and clinicians meeting a

low-volume threshold. CMS has used this low-volume threshold to exempt a significant share of clinicians from MIPS reporting and payment adjustments altogether. In total, a higher number of Medicare-billing clinicians are exempted in the second year as compared with the first (Table 15-2, p. 454). In other words, some clinicians who would have been required to report in 2017 may no longer be required to report in 2018.

MIPS scores will be very high for most clinicians, limiting CMS’s ability to differentiate performance

Under the current MIPS scoring mechanism, clinicians have an incentive to select quality measures that they believe can maximize their score. Although the details of the scoring methodology vary by year, this maximizing could be accomplished, for example, by reporting topped-out measures, reporting measures through relatively less commonly used reporting methods, or reporting measures with no benchmarks.⁸ CMS has also made explicit decisions elsewhere in the program to help clinicians receive very high performance scores. For example:

- For clinicians who report more than six quality measures, CMS will count the six highest-scoring measures.
- For clinicians who could qualify for facility-based scoring, CMS will allow clinicians to see their scores first and then elect whether to use the facility scoring.
- CMS will select the higher of the two scores for participants reporting through two group practices (for example, a clinician billing under two taxpayer identification numbers).
- The MIPS scoring methodology allows points to total over 100 percent in three out of four MIPS categories in 2018 (and CMS will cap each MIPS category score at 100 percent).

Low thresholds in the first two years of the program will result in minimal payment adjustments

Despite the significant effort involved to report (and the resulting complexity of CMS’s calculation of MIPS scores), most clinicians in 2017 and 2018 will receive minimal payment adjustments. This result is attributed to two factors: the maximized performance scores and CMS’s decision to set the MIPS performance threshold

**TABLE
15-2****Estimated number of clinicians subject to and exempt from MIPS, 2017 and 2018 reporting years**

	2017	2018
Total number of Part B–billing clinicians	1,380,000	1,548,000
Exempt: Low volume	384,000 <i>(Less than \$30,000 in Medicare payments per year or fewer than 100 patients)</i>	540,000 <i>(Less than \$90,000 in Medicare payments per year or fewer than 200 patients)</i>
Exempt: A–APM-qualifying participants	70,000 to 120,000	185,000 to 250,000*
Exempt: Other reasons	285,000	315,000
Required to participate in MIPS	600,000 to 640,000	445,000 to 510,000*

Note: MIPS (Merit-based Incentive Payment System), A–APM (advanced alternative payment model). This table has been updated to reflect CMS’s final rule for the 2018 reporting year. By statute, clinicians in the first year of Medicare participation and clinicians in certain specialties are exempt from MIPS.
*In the regulatory impact analysis included in the 2018 final rule, CMS estimates that 71,000 clinicians would be exempt because they are A–APM participants in 2018 but states that, based on future administrative action, it expects the number of A–APM-qualifying participants in 2018 to total 185,000 to 250,000 clinicians. Therefore, the number of clinicians required to participate in MIPS in this table is calculated from other numbers in the table and differs from the figure shown in CMS’s regulatory impact analysis.

Source: Centers for Medicare & Medicaid Services 2017c; Centers for Medicare & Medicaid Services 2016.

at a very low level for the first two years (i.e., 3 and 15 points, respectively, out of 100), well below where most clinicians’ scores are expected to be.

As a result, almost everyone—95 percent in 2017 and 97 percent in 2018—in the first two years of the program will receive either a neutral or positive adjustment (Table 15-3) (Centers for Medicare & Medicaid Services 2017c, Centers for Medicare & Medicaid Services 2016). Because the basic MIPS adjustments are budget neutral, if there is a small penalty pool that must be spread across a significant number of clinicians who cleared the bar, the overall positive increases will be minimal—much less than 1 percent.

In later years, small differences in performance will be magnified into large differences in payment adjustments

In subsequent years, small differences in MIPS scores will be magnified into substantial differences in payment adjustments. The statute requires that CMS set the MIPS performance threshold at the mean or median in the 2019

reporting year—that is, much higher than the levels in the first two years. In addition, the maximum negative adjustment rises from –4 percent in the 2017 reporting year to –9 percent in the 2019 reporting year. As a result, many more clinicians will pay a penalty, and the penalty will be larger. Because the base MIPS adjustments are budget neutral and proportionally fewer clinicians will receive positive adjustments than in the first two years, the positive adjustments will also increase.

Given that many clinicians are likely to have extremely high MIPS scores, small differences in MIPS performance scores will result in large differences in payment adjustments. For example, if the mean or median MIPS performance score is 90 points out of 100, clinicians with a score of 90 points would receive no payment adjustment, and clinicians with a score of 100 points would receive the maximum MIPS payment adjustment (in 2019) of 7 percent, plus the maximum MIPS exceptional performance bonus. In other words, a clinician with a score just 10 points higher than average could receive a payment adjustment that could be as high as 22 percent, including the exceptional performance bonus.⁹

**TABLE
15-3**

Performance thresholds and estimated impact for MIPS clinicians, 2017 and 2018 reporting years

	2017	2018
Regulatory performance thresholds (points out of 100)		
MIPS performance threshold	3 points	15 points
MIPS exceptional performance threshold	70 points	70 points
Estimated impact for MIPS clinicians		
Share receiving a negative adjustment	5%	3%
Share receiving a neutral or positive adjustment	95	97
Share of those receiving a positive adjustment also receiving MIPS exceptional performance bonus	N/A	74

Note: MIPS (Merit-based Incentive Payment System). CMS did not publish an estimate of the share of MIPS participants receiving the exceptional performance bonus in 2017. CMS did not release an estimate of clinicians receiving positive versus neutral adjustments.

Source: Centers for Medicare & Medicaid Services 2017c; Centers for Medicare & Medicaid Services 2016.

Because of the way that MIPS adjustments are to be derived and calculated after 2018, small changes in performance that are clinically irrelevant could result in large changes in payment. This feature also raises a significant policy concern: The potential for positive adjustments in MIPS may be so high that staying in FFS appears more attractive for clinicians than moving to A-APMs. This concern is not theoretical. Under Medicare’s current value-based payment modifier, certain clinician practices received very large payment adjustments; in 2017, 69 practices received payment bonuses equivalent to over 77 percent of their FFS payments.

MIPS should be eliminated

The Commission concludes, based on this analysis, that MIPS impedes the movement toward high-value care (Medicare Payment Advisory Commission 2017a, Medicare Payment Advisory Commission 2017b, Medicare Payment Advisory Commission 2016a, Medicare Payment Advisory Commission 2016b, Medicare Payment Advisory Commission 2016c). MIPS will not succeed in helping beneficiaries choose clinicians, helping clinicians change practice patterns to improve value, or helping the Medicare program reward clinicians based on value.

Our critique of MIPS should not be misinterpreted. The Commission understands the importance of individual-level clinician performance measurement and the importance of process measures. Process improvement activities can have a significant impact on overall health outcomes. There continues to be a role for process measures, individual-level performance assessment, and measures that vary by clinician practice or specialty. All these elements are key to quality improvement programs run by clinician groups and others, and they can help patients choose a clinician consistent with their preferences.

However, we do not believe that individual-level process measures should be used by the national Medicare program to move trust fund dollars among individual Medicare clinicians. There is a different standard for data completeness, comparability, lack of bias, and universality if the measures are being used for internal quality improvement, confidential reporting, or public reporting. But when measures are used to allocate funding, they must be comparable, statistically robust, and universal. MIPS fails to meet these standards. More fundamentally, from the Commission’s perspective, the central tenets of MIPS are fundamentally incompatible with the goals of a beneficiary-focused approach to quality measurement. MIPS assumes that clinician quality can and should be

determined primarily at the individual clinician level. This orientation sends the wrong signals about quality and value. It treats quality of care as isolated and siloed, rather than what it generally is today—the result of the combined efforts of multiple clinicians.

The Commission does not come to this conclusion lightly. After MACRA was passed, we raised concerns about MIPS and spent a significant amount of time attempting to identify ways to substantively improve the system within its current framework (Medicare Payment Advisory Commission 2017a, Medicare Payment Advisory Commission 2016a, Medicare Payment Advisory Commission 2016b). However, as CMS has issued regulations implementing the first two years of the program, the true complexity and unworkability of MIPS has become clear.

As a result, the Commission recommends that the current MIPS be eliminated. This recommendation addresses only MIPS—not the other parts of MACRA that repealed the SGR, established statutory updates, and created an incentive payment for A-APM participation.

Time is of the essence for eliminating MIPS. Clinicians are reporting and participating in activities in 2018 that will affect the 2019 and 2020 payment years, and more clinicians may be subject to its requirements in future years. And while CMS has used its flexibilities to phase in requirements for the first two years, provider groups have requested that these flexibilities continue for an additional three years (American Medical Association 2017). But CMS will still be calculating scores and making payments during this time (although the base MIPS adjustments would likely be smaller on average than they would be otherwise, as they are in 2017 and 2018).

If history is any guide, once the apparatus for MIPS is established and up and running, the process will have its own momentum, and it will become even more difficult to substantially change or improve the program. Furthermore, the longer the program continues, the signals that MIPS sends will continue. We do not agree with those signals: that clinicians should pick measures to report on which they expect to do well (rather than focusing on the totality of patient care), that quality measures should emphasize processes (instead of outcomes), that clinicians should join bonus-only payment models that would increase their possibility of scoring highly (rather than joining meaningful models with risk and reward), and

that completing check-the-box activities is a reasonable performance measure (instead of adopting meaningful practice improvements that work for clinicians' practices and improve care for their patient populations).

A new direction for rewarding clinician quality: A voluntary value program

The Commission has determined that MIPS should be replaced by a value component for clinician services in Medicare FFS. Such a program should conform to the Commission's principles for measuring quality: It should encourage coordination across providers and time, promoting change in the delivery system; include population-based measures such as outcomes, patient experience, and value; and give rewards based on clear, absolute, and prospectively set performance targets. In addition, the program should not be overly burdensome for providers.

The Commission believes that all parties in the health care delivery system have a role in improving the quality of care provided to Medicare beneficiaries. In addition, there should be a value component at every level of Medicare payment so that all providers—including clinicians—face an aligned set of signals across the program. Consistent signals are especially important in FFS payment, which emphasizes the individual activities that providers engage in and places less emphasis on the totality of patient outcomes, cost, and experience.

Yet the very nature of Medicare's payment system for clinician services complicates the creation of a value-based purchasing program. To a unique extent in traditional Medicare, clinician services are isolated, with, in most cases, no single decision maker (such as an accountable care organization (ACO) governing board or large multispecialty practice) assuming responsibility for the totality of the patient's experience. (By contrast, within institutional episodes, a single entity does assume responsibility for the discrete episode of care for a patient.)

Recognizing these challenges, the Commission's approach is to allow clinicians to self-organize into groups that collectively assume responsibility for their patients' outcomes. This voluntary value program (VVP) is based on the premise that patient outcomes rely on the combined

contributions of clinicians and emphasizes that quality improvement is a collective effort. A VVP would reorient incentives so that all clinicians (of all specialties) would face an incentive to improve population-based outcomes. There is precedent for assessing clinician performance at the group level—many clinicians already participate in MIPS as a group.

A VVP would measure all clinicians based on the same set of measures: clinical quality, patient experience, and value. Since these measures assess the health care of a population (and generally do not make sense at the individual clinician level), the program would encourage clinicians to address care across time and across settings.

A VVP's penalties and rewards might not be significant enough to meaningfully change clinician behavior. However, the intent is to get clinicians comfortable with being measured in a manner similar to the way they would be in A-APMs. With that experience, clinicians would be positioned to form or join robust A-APMs, under which the risk and reward is more meaningful and the potential for true delivery system reform is within reach. Over time, if additional incentives are needed to help clinicians move to A-APMs, the parameters of a VVP could be modified.

A VVP is an illustrative policy; its goals could be achieved in a number of ways

The Commission's recommendation is an illustrative policy that emphasizes that clinicians should be subject to the same quality incentives as the rest of the Medicare program, and that, in reality, most clinicians are part of a system of care (formal or informal) that has responsibility for the entirety of a patient's experience across time and settings and through the care continuum.

However, the recommendation language for a VVP is broad and conceptual because there are a number of ways that the goals outlined above could be achieved. Some design elements in a VVP are the ability of clinicians to self-organize for the purposes of quality measurement; the measures (in the categories of clinical quality, patient experience, and cost); the minimum voluntary group size (sufficient to detect meaningful differences in performance); and the form and size of the payment adjustments. Appendix 15-A (p. 460) illustrates one approach for defining these elements.

However, no matter how the VVP is structured, there would be three important features that would distinguish it from MIPS:

- Clinicians would be eligible to receive a payment adjustment at a voluntary group level. A VVP would require only minimal administrative structure (clinicians would just elect to be measured as a voluntary group) and would entail less risk and reward than is required in A-APMs.
- These voluntary groups would be assessed on a uniform set of population-based measures that align with the Commission's quality principles.
- Clinicians would no longer need to report quality data to Medicare because all measures would be calculated by CMS from claims and surveys.

A VVP could incorporate certain policy elements designed to further the effectiveness of the program as an incentive and ameliorate the risk of unintended consequences. For example, to minimize the uncertainty of downward and upward payment adjustments and remove the possibility of inappropriate windfalls or significant penalties, a VVP policy could include a cap on the negative payment adjustment and a cap on the total payment increase (so that it is less attractive than the A-APM incentive payment).

Consistent with other value programs in Medicare, a VVP could be designed to be budget neutral. Payment reductions for poorly performing voluntary groups of clinicians and for clinicians who do not participate would be used to finance payment increases for high-performing voluntary clinician groups.

Two key benefits would arise from using claims-calculated and centrally administered survey information to calculate performance. First, as the program evolves, CMS could, through notice and comment rulemaking, modify the measures, scoring, or payment adjustment calculation without requiring clinicians to change their reporting process. Thus, this approach would be flexible, allowing Medicare to react in a timely way to changes in clinical practice, input from stakeholders, and the needs of the Medicare population. Second, relying on claims-based measures removes a significant, demonstrable cost and time burden of clinician reporting. Further, using established and uniformly applied measures would remove the incentive for clinicians to measure (and report on)

things they do well, instead of areas of quality needing improvement. Infrastructure requirements for a VVP are minimal; that is, clinicians would only need to elect to be measured as a voluntary group. However, if groups then wished to substantively improve performance, they would likely need to make additional investments to achieve that goal.

Medicare would no longer require tools for reporting such as registries, EHRs, and other quality-data reporting methods. However, these tools could be used for internal quality improvement at the voluntary group level to improve performance and by other payment models such as A-APMs. Efforts to improve quality measures could continue, including developing methods to add clinical data (such as lab values) to claims, enhancing interoperability between registries and EHRs, and improving claims-calculated measures. To the extent that Medicare pursued policies regarding EHRs (such as interoperability), those requirements could either be addressed by the Office of the National Coordinator for Health IT or be considered as a condition of participation in Medicare.

Under a VVP, the Medicare program could provide feedback to the voluntary groups on their performance relative to others. Other parties in the health care system (e.g., a group practice, ACO, or specialty society) could measure individual clinician performance as desired using individual quality measures for public reporting purposes as well as individual quality improvement efforts.

Transitioning to a new voluntary value program

Although it is urgent to eliminate MIPS as soon as possible, a VVP could be phased in over time. If policymakers decided to phase in a VVP, this process could occur in several ways while building confidence in the measures and results and building support from the clinician community. The flaws of MIPS should not be replicated in a VVP. The Commission would engage in more detailed development of a VVP should the Congress pursue this recommendation.

Operational details would be developed in notice and comment rulemaking, which would leverage CMS expertise on technical issues and give stakeholders a chance to respond. Other policy considerations (such as calculating the voluntary group's composite score, weighting measures and domains, and setting benchmarks)

could leverage CMS's experience with other value-based purchasing programs in Medicare.

One approach would be to begin with current measures and easily defined groups. For example, CMS could build on several of its proposals for defining groups. CMS could leverage its work on facility-based measurement and tie all clinicians with a facility site of service on their claims to that facility (for example, all clinicians with either inpatient or outpatient claims from a given hospital). That clinician group could then be scored on quality measures used in Medicare's hospital quality programs, such as mortality, readmissions, patient experience, and Medicare spending per beneficiary. This approach would accustom the clinicians to considering themselves part of a group that influences patients' health outcomes and to using those measures. At first, no money would be attached to the scores; they would be strictly informative.

Similarly, clinicians participating in Medicare Shared Savings Program Track 1 ACOs and other models that are not A-APMs could be measured as groups on the quality measures for their APMs. Those measures would be fully transitioned to include more population measures over time. Any clinicians involved with A-APMs would have access to their measure results and other groups connected with the A-APM. Because no money would be at stake, participating in multiple groups would not be an issue and could inform clinicians as to which groups they would want to eventually choose to be associated with. CMS, through the Quality Improvement Organization Program or similar tools, could provide technical assistance to groups on understanding their results and how to affect their performance. Yet other clinicians could choose to form voluntary groups and be measured on population outcomes, again for their information and without any monetary outcomes.

Through these processes, CMS would gain experience with the measures and be able to derive reliability and other factors to set minimum voluntary group size requirements. Because the measures would not require clinician reporting, CMS would have the ability to modify the measures as necessary. At that point, clinicians could start forming voluntary groups, payment could be attached, and a VVP could start in earnest. The size of the penalties or rewards could be increased over time as confidence in the program increased, as long as the maximum amount did not encourage clinicians to stay in a VVP rather than progress to A-APMs.

Conclusion and recommendation

The Commission, based on our analysis, concludes that MIPS will not succeed in helping beneficiaries choose clinicians, in helping clinicians change practice patterns to improve value, or in helping the Medicare program reward clinicians based on value. MIPS is based on predecessor Medicare programs that have generally not been successful at improving population outcomes or substantively improving care processes. In addition, MIPS imposes a significant reporting burden on clinicians; scores are not comparable across clinicians; it is administratively complex and produces inequitable results; and its small payment adjustments in the first years will be followed by subsequent arbitrary and possibly very large payments in later years, creating financial uncertainty for clinicians.

At the same time, the Commission believes that, consistent with the policy goals of MIPS, all clinicians operating in traditional FFS Medicare should be subject to a value-based payment component, and we recommend a path forward for that component—a voluntary value program. The program could be designed to emphasize the role of all clinicians in quality improvement and to align incentives for providers across the Medicare FFS delivery system as well as with A-APMs.

RECOMMENDATION 15

The Congress should:

- **eliminate the current Merit-based Incentive Payment System; and**
- **establish a new voluntary value program in fee-for-service 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.**

Spending

- Payment increases would be designed to offset payment decreases in a VVP. In any given year, if the maximum positive payment adjustments were capped and the targets set prospectively, a VVP could incur a small cost or small savings but would be designed to be budget neutral in every year.

A VVP would thus produce savings over current law. Under MIPS, an additional \$500 million is appropriated each year from 2019 to 2024 for exceptional performance (or \$3 billion over that time frame). However, the Commission's current intent is not to produce budget savings but to consider policies that would reinvest these funds elsewhere in Medicare clinician payment so that, in total, the policies together would be budget neutral.

Beneficiary and provider

- The recommendation would be unlikely to affect beneficiaries' access to care. It would significantly reduce provider burden by eliminating all quality measures and ACI and CPIA reporting to the Medicare program.
- Providers could incur some administrative cost in creating or joining voluntary groups, but the burden would be significantly less than current policy. In designing a process for clinicians to elect voluntary groups, CMS could leverage the infrastructure they have been developing for both facility-based measurement and virtual groups.
- The recommendation would eliminate extremes in payment by setting lower and upper bounds on adjustments. Overall, a VVP would be budget neutral (in contrast to the current MIPS program). Some clinicians would see a payment reduction; others, a payment increase. ■

15-APPENDIX A

**Design elements for a
voluntary value program:
An illustrative model**

**TABLE
15-A1**

Key differences between current-law MIPS policy and an illustrative voluntary value program

	Current-law MIPS	Illustrative voluntary value program
Covered clinicians	All clinicians except those in the following groups: qualified A-APM participants (or partial-qualifying A-APM participants); clinicians in certain specialties; those below the low-volume threshold; or those in their first year of Medicare participation	All clinicians not participating in an A-APM who choose to participate
Maximum negative adjustment	Set in statute for clinicians who do not report any MIPS information and for very low performers (reaches 9% by 2022)	Set at a fixed amount as a prospective withhold (e.g., 2%)
Maximum bonus	Potential upside reaches 37% by 2022 (scaling factor of 3 times maximum bonus of 9%, plus 10% exceptional performance bonus)	Capped so that the maximum bonus is smaller than potential from participating in A-APMs
Measures that clinicians need to report	If subject to MIPS, report at least 6 quality measures (plus voluntary CAHPS®), all ACI information, and 6 (or 9) CPIA activities (option for hospital-based assessment if hospital-based specialty; special reporting rules for MIPS APM participants)	None
Clinician election	Clinicians can elect either hospital-based assessment (if hospital-based specialty) or virtual group measurement	Clinicians can elect to be measured with a voluntary group sufficiently large for performance assessment on all measures
Level of performance measurement	Individual clinician (TIN/NPI) or group (TIN) level	Voluntary group level
Performance assessment based on:	Self-selected quality measures, attested ACI and CPIA measures, cost (starting in 2021)	Uniform set of measures in three categories: outcomes, patient experience, and value (cost/value); measures would be patient centered, comparable with measures used to assess A-APM performance and to assess quality across time and the delivery system
Application of quality score	TIN/NPI (or TIN if group reporting)	Each clinician in voluntary group, same score across group

Note: MIPS (Merit-based Incentive Payment System), A-APM (advanced alternative payment model), CAHPS® (Consumer Assessment for Healthcare Providers and Systems®), ACI (advancing care information), CPIA (clinical practice improvement activities), MIPS APM (Merit-based Incentive Payment System Alternative Payment Model), TIN/NPI (taxpayer identification number/national provider identifier).

As stated in the chapter, the Commission’s recommendation outlines the broad policies of a value component in fee-for-service (FFS) Medicare. However, during the Commission’s deliberation, many design elements were discussed in some detail, and this appendix gives a detailed illustration of one potential design for a voluntary value program (VVP) (Table 15-A1).

For example, a VVP could entail a withhold applied to all clinicians’ payments to fund a pool of potential value payments. An alternative policy is to make upward and downward payment adjustments concurrently. At this point, clinicians would make one of three choices:

- voluntarily elect to be measured with other clinicians in a group of sufficient size to be measured on

population outcome measures and be eligible to receive a value payment;

- join an advanced alternative payment model (A-APM) and have their full withhold refunded (in addition to any payment adjustments under the A-APM design); or
- make no election and lose their withhold.

The most salient design elements in a VVP would include selection of measures that focus on clinical quality, patient experience, and cost; size and formation of the voluntary groups; the role of specialists; the withhold and value payment; and attribution of beneficiaries to the group.

Measures

Consistent with the Commission’s quality principles, VVP measures should focus on population-based outcomes, patient experience, and value and would be patient oriented, encourage coordination across providers and time, and promote delivery system change. In addition, measures should not be unduly burdensome for providers (e.g., would use claims or survey data), and they would have scientifically acceptable properties such as:

- reliability and validity, using a defined minimum number of cases and beneficiaries;
- ability to distinguish meaningful differences among groups; and
- ability to adjust appropriately for patient health risks.

Also deriving from the Commission’s principles, a VVP should reward performance based on clear, absolute, and prospectively set performance targets. Rates for all measures would be risk adjusted for beneficiary health characteristics (e.g., by using hierarchical condition categories).

Separately, the payment adjustments resulting from the population-based measures in a VVP should take into account, as necessary, differences in the social risk factors for each voluntary group’s population. This process could include using a peer-grouping approach or other approaches as necessary so that a voluntary group of clinicians who treat a disproportionate number of low-income or otherwise high-risk patients is not unduly

financially disadvantaged, but under which there is still incentive to improve.

CMS also has significant experience creating composite quality scores and setting benchmarks in other value-based purchasing (VBP) programs and in A-APMs. The measure concepts presented in Table 15-A2, meant to be illustrative, follow our general principles and are used in other Medicare VBP programs and in A-APMs.

Size and formation of voluntary groups

Under the VVP, CMS would determine the minimum size of a voluntary group so that each group could be scored on all of the population-based outcome measures. Beyond this technical requirement, there could be no limit on the shape or size of clinician entities for assessing value.

Many clinicians already are in some kind of group that could meet the definition of a voluntary group: clinicians affiliated with hospitals or health systems, independent practice associations, local medical societies, large multispecialty practices, and accountable care organizations (ACOs). Forty percent of clinicians are presently in practices with hospital or health system affiliation (Medicare Payment Advisory Commission 2017b). CMS could also provide technical assistance to clinicians by identifying virtual referral networks consisting of other clinicians that their patients see. In general, voluntary groups would need to include a range of clinicians to have a sufficient number of attributed beneficiaries for all the population-based measures on which they would be assessed.

The formation of and administrative process for voluntary groups could build on the work CMS has done thus far to develop virtual groups for the Merit-based Incentive Payment System (MIPS), which allows groups of clinicians without a formal financial arrangement to elect to be measured as a group. CMS’s proposal to allow certain clinicians to request that their performance be assessed using their hospital’s VBP score also could provide a foundation for forming some groups and assessing performance using population-based measures. The population-based measures used in the hospital VBP, as described by CMS, show a meaningful distribution of performance scores (Centers for Medicare & Medicaid Services 2017b). In the Commission’s September 2017

**TABLE
15-A2**

Illustrative VVP measures and their use in other Medicare VBP programs and A-APMs

Domain	Measure	Used in VBP programs	Used in A-APMs
Clinical quality	Readmissions	HRRP, physician VM	All ACOs (ESCOs, NG, MSSP)
	Mortality	Hospital VBP	ESCOs
	Inpatient hospitalization use ^a	Physician VM	CPC+, OCM, All ACOs (ESCOs, NG, MSSP)
	Emergency department use ^b	N/A	CPC+, OCM
Patient experience	Consumer Assessment of Healthcare Providers and Systems ^{®c}	Physician VM, hospital VBP	All A-APMs (CCJR, CPC+, ESCOs, NG, MSSP, OCM ^d)
Value	Medicare spending per beneficiary	Physician VM, hospital VBP	N/A
	Total cost of care per beneficiary	Physician VM, QRURs	Similar to shared savings benchmarks CPC+, OCM, All ACOs (ESCOs, NG, MSSP, OCM)
	Relative resource use (episodes) ^e	Physician VM, QRURs (no longer used)	Similar to CCJR episode cost
	Low-value care	N/A	N/A

Note: VVP (voluntary value program), VBP (value-based purchasing), A-APM (advanced alternative payment model), HRRP (Hospital Readmissions Reduction Program), VM (value-based payment modifier), ACO (accountable care organization), ESCO (ESRD [end-stage renal disease] Seamless Care Organization), NG (Next Generation [ACO model]), MSSP (Medicare Shared Savings Program [Tracks 2 and 3]), CPC+ (Comprehensive Primary Care Plus), OCM (Oncology Care Model), CCJR (Comprehensive Care for Joint Replacement [payment model]), QRURs (Quality and Resource Use Reports).

^aRisk-adjusted or standardized measures of observed-to-expected acute inpatient discharges or proportion of patients with hospital admissions. This concept can include the Prevention Quality Indicator (PQI) ambulatory sensitive condition acute composite (acute and chronic) measures. PQI measures were initially used in the VM but are not included in MIPS.

^bRisk-adjusted measures of observed-to-expected emergency department visits or proportion of patients with an emergency department visit.

^cConsumer Assessment of Healthcare Providers and Systems[®] (CAHPS[®]) is a registered trademark of the Agency for Healthcare Research and Quality. CAHPS is a standardized survey tool used to evaluate patient experiences with health care. CAHPS surveys are designed for a specific setting (e.g., hospitals, clinician groups, dialysis facilities), but incorporate the same core elements (e.g., rating of care, communication) across the survey types.

^dOCM collects patient-reported experience of care results based on the CAHPS core elements.

^eCMS is presently developing a new set of episode-based resource use/cost measures.

Source: Centers for Medicare & Medicaid Services.

comment letter, we commended CMS’s efforts to develop both policies as providing a foundation for future iterations of clinician value-based payment (Medicare Payment Advisory Commission 2017a).

A key question is how large a voluntary group would have to be for CMS to detect performance on the types of population-based measures envisioned in a VVP. First, the set of measures would need to be selected. Then, the size of the voluntary group required would be determined

by the measure requiring the largest minimum number of cases or beneficiaries.

For each measure, CMS would have to determine a minimum number of beneficiaries or cases to represent an accurate estimate of the group’s performance and to reliably detect the group’s performance as distinguishable from the performance of other groups.¹⁰ CMS has made such determinations for prior programs. Often there is a trade-off between setting a smaller number—thus

**TABLE
15-A3**

Minimum cases or beneficiaries for selected illustrative measures

Measure	Minimum cases or beneficiaries
Clinician Group–CAHPS®	750 patients (to get 300 surveys)
Value-based payment modifier: MSPB	125 cases
Value-based payment modifier: 30-day all-cause readmissions	200 cases
Value-based payment modifier: All other measures	20 cases
Potentially preventable admissions/ED visits	1,000 beneficiaries
MSSP total spending benchmark	5,000 attributed beneficiaries
Next Generation/Pioneer total spending benchmark	10,000 attributed beneficiaries

Note: CAHPS® (Consumer Assessment for Healthcare Providers and Systems®), Medicare spending per beneficiary (MSPB), emergency department (ED), Medicare Shared Savings Program (MSSP).

Source: Centers for Medicare & Medicaid Services, Agency for Healthcare Research and Quality, 3M.

including more providers in the program—and setting a larger number—thus achieving greater confidence in accuracy and reliability.

This policy trade-off will be influenced by the VVP’s design. For example, under a VVP, each measure’s score could be a function of how much observed performance diverges from baseline performance. Scores from each measure could then be combined and an overall score calculated. The overall score would move a small amount of payment.

In contrast, for an ACO, the difference between actual spending and the benchmark can translate directly to a dollar-for-dollar payment change. Much greater accuracy and reliability of performance is thus required in the ACO case. Table 15-A3 gives some examples of the minimum number of cases or beneficiaries CMS and others have determined is necessary for some measures. Under CMS’s value modifier, there appears to have been a preference for small minimum case sizes to include as many clinicians as possible; under a VVP, these minimums could be increased to improve reliability. Two measures—Medicare Shared Savings Program (MSSP) total spending benchmarks and Next Generation/Pioneer total spending benchmarks—are used in ACOs and would not be used in the same manner (e.g., for calculating precise shared

savings or losses) for a VVP. They are given to provide a reference for other minimums.

An added benefit of using claims-calculated measures over clinician-reported measures is the ability to replace samples of clinicians’ performance (e.g., self-reported process measures for selected cases over a limited time period) with a full census of clinicians’ Medicare FFS performance because the program would use data from all claims for the full year.

The creation of an incentive for clinicians to join voluntary groups has the potential to increase the trends toward consolidation, although the effect may be modest. First, the market for clinician services has already consolidated considerably (clinician practices have merged and hospitals and health systems have purchased clinician practices) (Medicare Payment Advisory Commission 2017b, Neprash et al. 2017). Second, clinician groups consolidate (or pursue vertical integration) for several reasons, including more favorable payment policies, more flexibility in accommodating lifestyles and schedules, greater efficiency, and greater negotiating power with private payers. Third, clinicians in our focus groups have cited quality reporting and electronic health record requirements repeatedly as a reason for joining a

practice owned by a hospital or health system (Summer et al. 2017). In other words, the requirement to report MIPS quality, advancing care information, and clinical practice improvement activities information can make being acquired by a hospital or health system look more attractive to clinicians. The elimination of these requirements for Medicare (by eliminating MIPS) could lessen that factor.

The role of specialists

A VVP could include a mix of measures with direct relevance to a range of specialties. For example, readmissions or a measure assessing 30-day resource use after a hospitalization would link to surgical or hospital-based specialties. Patient experience and total per capita cost measures would link to all specialties. And avoidable hospitalizations or emergency department visits would link to clinicians involved in seeing patients in the outpatient setting (e.g., clinicians specializing in internal medicine, family practice, cardiology, or endocrinology).

Many specialists are currently involved in alternative payment models. For example, based on our analysis of the 2015 ACO public use file, about twice as many specialists as primary care providers were in MSSP ACOs—even though attribution to MSSP ACOs is predominantly dependent on primary care visits.¹¹ In addition, three out of seven models identified by CMS as A-APMs for the 2017 reporting year focused on conditions generally treated by specialists (other than primary care).

Amount of the withhold and the value payment

For illustrative purposes, we have described a VVP with a withhold. The amount of the withhold or penalty is a policy decision; it could be larger or smaller or could grow over time. A relatively small withhold could be appropriate if a VVP's goal were to get clinicians comfortable with the idea of joining with others to be accountable for population outcomes. Keeping the withhold and rewards relatively modest would also help address the criticism that these population outcome measures are the result of

a variety of factors (including, but not solely, clinician behavior).

A 2 percent withhold, for example, is likely not large enough to motivate comprehensive clinician practice redesign. A larger withhold might be enough to motivate behavioral change but could end up replicating the A-APM structure if the risk and reward grew too large. Another option is a withhold that ramps up over time as clinicians grow familiar with joining voluntary groups.

Attributing beneficiaries

CMS currently uses several methods to attribute cost and quality outcomes to clinicians. For example, the attribution process used in many ACO models attributes beneficiaries to clinicians based on the plurality of a subset of evaluation and management (E&M) visits. There are two key variables with respect to attribution: whether the measure is attributed to one clinician (or group) or multiple clinicians (or groups) and whether attribution is based on all claims or a subset (e.g., only E&M claims).

Single attribution, in which an outcome of interest is attributed to one clinician (or group), implicitly identifies a key decision maker for all the care provided related to that outcome. Multiple attribution acknowledges that a variety of unrelated clinicians contribute to the patient's care. A common multiple attribution method is to allocate the measure proportionally, based on each clinician's relative frequency of visits or amount of spending for the patient.

In prior work by the Commission on attribution methodologies, we have found that no one attribution method was statistically superior to others, but each had characteristics that could be desirable in certain contexts. We found that multiple attribution (based on total dollars) resulted in more episodes being attributed to specialty clinicians than did single attribution based on E&M spending (Medicare Payment Advisory Commission 2009). Therefore, a multiple attribution approach might be most appropriate in a VVP to emphasize that each clinician in a voluntary group is jointly accountable with all other clinicians involved in a patient's care for that patient's outcome. In contrast, single attribution may be more appropriate in the context of ACOs because the ACO takes responsibility for all of a beneficiary's spending. ■

Endnotes

- 1 A–APMs are a subset of CMS payment models that must meet certain criteria set out in the MACRA statute. CMS reviews all potential models for A–APM eligibility on a rolling basis. In 2017 (the reporting year for the 2019 payment year), the seven A–APMs are the Medicare Shared Savings Programs, Tracks 2 and 3; the Comprehensive Care for Joint Replacement model; the ESRD [end-stage renal disease] Seamless Care Organization model (risk-bearing track); the Oncology Care Model (risk-bearing track); the Comprehensive Primary Care Plus model; and the Next Generation ACO (accountable care organization) model.
- 2 ACI examples include electronic prescribing (e-prescribing) and immunization registry reporting. CPIA examples include depression screening, co-location of primary care and mental health services, and patient coaching practices between visits.
- 3 CMS supports six tools for MIPS quality reporting, plus the collection of ACI and CPIA information. The six reporting methods include no-pay claims, qualified registries, Qualified Clinical Data Registries, EHR, web interface, plus a CMS-approved survey vendor for the Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) if group practices elect to conduct the CAHPS.
- 4 The total burden estimated by CMS for the 2017 reporting year (\$1.311 billion) includes \$805 million for the six ways of reporting quality information, \$308 million for ACI, and \$198 million for CPIA.
- 5 For the first year of the QPP (2017), CMS defines “topped-out measures” as follows: “For each process measure, a measure is topped out if the median performance rate is 95 percent or higher (non-inverse measure) or is 5% or lower (inverse measures). For each non-process measure, a measure is topped out if the truncated coefficient of variation is less than 0.10 and the 75th and 95th percentiles are within 2 standard errors.”
- 6 CAHPS is a registered trademark of the Agency for Health Care Research and Quality.
- 7 The current list of MIPS APMs includes Track 1 Medicare Shared Savings Program ACOs, the bonus-only ESRD [end-stage renal disease] Seamless Care Organization model, the bonus-only Oncology Care Model, the Vermont Medicare ACO initiative, and the Medicare–Medicaid Accountable Care Organization Model. In addition, all seven approved A–APMs are also classified as MIPS APMs.
- 8 For the first two years of QPP, each clinician’s performance is set relative to all other clinicians that reported that measure, even for topped-out measures. Therefore, a clinician reporting 100 percent for a topped-out measure with a median performance score of 100 percent would still score 10 points out of 10 for that measure.
- 9 MACRA appropriated an additional \$500 million each year for exceptional performance in MIPS from the 2019 through the 2024 payment years. *Exceptional performance* is defined as performance at or above the 25th percentile above the mean (or median) of performance scores. The maximum total bonus is capped at 22 percent in 2019, 25 percent in 2020, 31 percent in 2021, and 37 percent in 2022 and later.
- 10 The size could also depend on the makeup of the voluntary group (e.g., the mix of primary care, specialist, or non-patient-facing clinicians).
- 11 The ratio could be slightly less if many specialists participate in multiple ACOs. File available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/SSPACO>.

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