

Policy BRIEF

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Repeal and Replace, Part II: Improving Pay-for-Performance in Medicare

The fate of the Affordable Care Act and the possibility of “repeal and replace” dominated political and health policy discussions in 2017. Less heralded during this time was the roll-out of a new nationwide pay-for-performance program for Medicare-enrolled clinicians: the Merit-based Incentive Payment System, or MIPS.

Over the past year, the focus of repeal and replace has shifted to MIPS. In January, the Medicare Payment Advisory Commission (MedPAC), the body that advises Congress on payment policies for Medicare providers, voted to recommend scrapping MIPS and replacing it with an alternative approach, the sooner the better. At 14-2, the vote wasn’t close, yet it did not reflect consensus on the path forward. Repealing one big new program like MIPS and replacing it with another big new program that has not been adequately tested carries substantial risks. A more incremental approach will put Congress and the Centers for Medicare & Medicaid Services (CMS), the agency responsible for implementing MIPS, in the best position to get it right.

WHAT IS MIPS?

MIPS is a new pay-for-performance program created by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). It assesses how well physicians and certain other clinicians perform in terms of the quality and cost of the care they provide to Medicare beneficiaries, their use of electronic health record (EHR) technology, and their completion of practice improvement activities. MIPS is part of the larger Quality Payment Program enacted under MACRA.

Begun in 2017, the program ties higher quality and efficiency to higher rewards—and poorer performance to higher penalties—under the

Medicare fee-for-service payment system.

Clinicians who choose not to participate in MIPS despite being required to do so suffer the largest possible penalty, equal to 4 percent of Medicare revenues beginning in 2019 (based on performance in 2017) and rising to 9 percent by 2024. Maximum rewards for strong performance similarly increase over time.

Not all professionals billing Medicare are subject to MIPS. Although CMS recently expanded the set of non-physician practitioners included, a few, such as certified nurse midwives, remain exempt. So are clinicians who treat relatively few Medicare beneficiaries. For those subject to MIPS, CMS has made special accommodations for non-physician

practitioners, clinicians practicing in Health Professional Shortage Areas or rural areas, small practices, clinicians who do not typically treat Medicare beneficiaries in face-to-face encounters (for example, pathologists), and hospital-based clinicians.¹

Importantly, clinicians participating in risk-bearing Medicare Accountable Care Organizations (ACOs) and certain models currently being tested by the Center for Medicare & Medicaid Innovation (CMMI) are not required to participate in MIPS. The alternative approaches to fee-for-service payment—known as alternative payment models, or APMs—have the potential to improve the quality of health care provided to Medicare beneficiaries at the same or lower cost, or to reduce costs without compromising quality. APMs meeting MACRA's requirements, including a requirement that clinicians participating in the model bear more than nominal risk for spending, are Advanced APMs. Clinicians who derive a large enough share of their Medicare revenue from participation in Advanced APMs are exempt from MIPS.

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HOW DID WE GET HERE?

Indeed, it is striking how *un*popular MIPS has proven to be for an initiative that has barely been launched and about which so many clinicians know so little. When CMS released its initial proposed regulations governing MIPS for public comment, the reaction was overwhelmingly negative. Clinicians and other commenters registered their objections to a program they viewed as too complex, too burdensome, too unfair, and too unlikely to drive change. Data published in that proposed rule implying that MIPS would be especially likely to penalize smaller practices further fueled these concerns.

In response, CMS dramatically slowed implementation of the program and exempted a significantly larger set of clinicians. Clinicians reacted positively to the expanded exemptions,

but initial rewards proved small, and support for the methodology underlying the performance assessments has remained tepid at best.

The lack of strong support for MIPS is even more striking considering the environment it was conceived in. Unlike the Affordable Care Act, which was beset by furious partisan wrangling from birth, MACRA enjoyed broad bipartisan support within Congress, along with the backing of the American Medical Association (AMA) and other medical societies. Initial attempts to pass MACRA foundered in the wake of disagreements over how to pay for it. The overall approach to incentivizing clinicians, though, built on existing pay-for-performance programs and engendered less disagreement: at a high level, the methodological approach changed little through successive versions of the bill.

Yet on closer observation, it was far from clear that MACRA would solve the problem of rising Medicare costs and uneven quality, nor are the growing concerns over MIPS since then—culminating with MedPAC's call for repeal—a surprise. There are two reasons for this. First, MIPS was not adequately tested. Second, the requirements detailed for MIPS in MACRA were too specific to give CMS the latitude it needed to implement an effective program of MIPS' scale and complexity.

The celebration accompanying the passage of MACRA owed at least as much to MACRA's repeal of the wildly unpopular Sustainable Growth Rate (SGR) as it did to the installation of its replacement, MIPS. For most of its existence, the SGR had required deep annual cuts in Medicare payments unless overridden by an act of Congress (also required annually), and repealing it had long been a priority for physicians and politicians alike. It is possible that legislators would have scrutinized MIPS with a more critical eye—considering the potential effectiveness of pay-for-performance generally and potential unintended consequences of the legislation—if it had been considered independently of the SGR repeal.

Although the MIPS methodology draws on CMS's experience with preceding pay-for-performance initiatives, including the Value-Based Payment Modifier, even this experience is limited. Physicians nationwide were subject to the Value Modifier for only two years; neither the program's overall effectiveness at scale during

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this period nor the longer-term effects of Value Modifier policies over the full duration of the program have been formally evaluated. Thus, not only is MIPS itself untested, but strong evidence of effectiveness is not available from the programs it was built upon.

In the absence of such thorough vetting, legislators might have specified only the broad parameters of a new MIPS program instead of the detailed requirements in MACRA. This is the second problem with the legislation: MACRA's specificity limited CMS's flexibility to thoughtfully develop effective incentives.

Specifying the weight MIPS must attach to performance on cost measures prominently illustrates the law's lack of flexibility. MACRA originally placed significant weight on cost measures (equal to that of quality measures) beginning in 2019. However, the development of reliable cost performance measures that are widely acknowledged as valid continues to be a work in progress, and attaching too much weight to relatively new or unproven measures risks introducing significant error into performance measurement. Buying time for development required adding language to the Bipartisan Budget Act of 2018. Even so, this simply put off the equal weighting of cost and quality until later. The larger issue of whether cost and quality *should* be weighted equally at any time is debatable, but MACRA's specificity foreclosed such a debate.

A less prescriptive law also would have spared CMS the considerable time needed to accommodate many specific mandates of unproven value, such as the requirement to develop patient relationship codes that might or might not ultimately support more accurate patient attribution. (It is noteworthy that MACRA's requirements for MIPS span nearly 30 pages of text, in contrast to the Value Modifier, which required only 2 pages in Section 3007 of the Affordable Care Act.)

MEDPAC PROPOSES ANOTHER WAY

By establishing a major program with an incomplete evidence base and a lot of specifics, MACRA has made MIPS an unhappily accessible target for critics, and MedPAC's critique of it has been broad and unsparing. On the one hand, MedPAC noted its numerous exemptions: CMS estimates that fewer than

two in five clinicians will be subject to MIPS in 2018.² On the other, for those who *are* required to participate in MIPS, MedPAC decried the program's complexity and echoed clinicians' concerns that fulfilling the requirements of MIPS will be costly and time-consuming. CMS estimates the burden of information collection in 2018 to be \$694 million.³

Moreover, MedPAC questioned why anyone should expect the EHR and practice improvement activity requirements to drive higher value care, and noted the paucity of quality measures assessing outcomes of interest. MedPAC also expressed concern about evaluating individual clinicians who had small samples of available data, grading different clinicians on different measures, and using topped-out measures (where measured performance is uniformly high) that do not discriminate sufficiently between high and low performers.

MedPAC ultimately concluded that MIPS is "inequitable, burdensome, and will not improve care for beneficiaries nor move the Medicare program and clinicians toward higher value care."

In its place, MedPAC has proposed a Voluntary Value Program, which would withhold a percentage of the clinician's fee-for-service reimbursements during the relevant performance period. The withheld amounts would be returned if the clinician participated in an Advanced APM. Alternatively, the clinician could choose to join a large voluntary group, which CMS would assess on population-based outcome measures computed from administrative claims. These would measure such concepts as low value care, mortality, hospital readmissions, and relative resource use, among others. Strong performers would earn back part or all of their withheld reimbursements. The voluntary group may be clinician-determined or CMS-defined, but it would have to be large enough to ensure adequate sample sizes for the performance measures.

It is not yet clear whether the Voluntary Value Program is the best replacement for MIPS. Like the program it is designed to replace, the Voluntary Value Program has yet to be carefully vetted. One commissioner who voted in favor of it as a replacement to MIPS stated, "There hasn't been any support from the physician community around this, and we should be cautioned by

that fact.” The Medical Group Management Association and the American Medical Association have come out against replacing MIPS with the Voluntary Value Program.

Aside from concerns that another large program shift would further burden clinicians just as they begin to adapt to MIPS, there are other reasons to ask whether the Voluntary Value Program would be the best path forward. One is that some of MedPAC’s criticisms of MIPS could be addressed within MIPS without implementing a whole new program. For example, CMS could address concerns about measure reliability by specifying adequate (measure-specific) sample size minimums based on careful testing and by assigning zero weight to a clinician’s performance category score whenever no measures applicable to that clinician in that category meet the minimum. To more effectively discriminate between the performance of individual clinicians, CMS could take a more aggressive approach to deprioritizing and removing topped-out measures, as they have begun to do in the latest finalized regulation. And CMS could further accelerate the development of meaningful outcome measures and the retirement of measures with weak links to outcomes.

There are other concerns about the Voluntary Value Program. For example, administrative claims lack detailed clinical information that would offer a complete picture of a patient’s health and the context in which a provider furnished care. Relying on administrative claims alone, then, could make it challenging to distinguish low-value care from necessary care with confidence in a broad range of circumstances, and consequently limit the information available to effectively risk-adjust resource use measures.

A bigger challenge is that it is not obvious that the Voluntary Value Program will incentivize clinicians in ways that would necessarily lead to better and more efficient health care. As MedPAC acknowledges, the new program would represent a shift toward measuring system-level performance. Yet, although the voluntary groups that many solo practitioners and small practices will join might offer sample sizes large enough to allow more accurate assessment, they would lack an obvious administrative structure, or perhaps even a

logical set of clinical relationships, to drive performance improvement. This would be especially true if the Voluntary Value Program allowed participation in CMS-defined, area-based groups such as hospital service areas, as MedPAC initially contemplated. Most of the proposed measures would not be directly applicable to, say, a diagnostic radiologist’s work, and a small primary care practice’s incentive to improve its own performance or its ability to impact the performance of its larger voluntary group would be minimal. The most important missing piece is a series of validated links between the program’s proposed structure, its transformation of clinician practice, and improved outcomes over time.

Moreover, MedPAC acknowledges that a 2 percent withhold might be too small to incentivize behavioral change, and suggests an alternative goal of using a modest incentive that would make providers more willing to start accepting joint accountability and risk-taking. This approach could pave the way nicely to participation in Advanced APMs with their heightened risk, although several Advanced APMs already offer such a pathway, including, for example, Track 1, or Levels A and B of the new Basic Track of the Shared Savings Program.

DON’T JUST STAND THERE, DO SOMETHING SMALL

To repeal MIPS and replace it today with the Voluntary Value Program or any other large but relatively untested program risks repeating the mistakes of the past—namely, continuing the practice of implementing substantial nationwide reforms without doing enough pilot testing, experimentation, or formative evaluation of key program components, either before or during early implementation of the reforms. As policymakers continue to struggle with improving quality and reining in spending, it has proven to be much easier to criticize successive approaches than to fix them. Critiques of MIPS from MedPAC and others, along with their concerns that the program’s effect on health care delivery will be minimal or harmful, should be taken seriously. There is little evidence to suggest that MIPS in its present form—with its myriad requirements, options, and exceptions—will lead to higher quality and more efficient care, and the costs of compliance and reporting will be significant.

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Doing nothing, then—that is, implementing MIPS as currently specified in statute—is unlikely to be the best solution, and the legislation limits CMS’s discretion to make the program more effective. Yet any major alternative Congress might consider needs adequate review and testing to ensure it will be better than just implementing the next MIPS or the next SGR. Upon such review, MedPAC’s proposal might be proven worthy, and careful design and testing could help overcome the concerns raised here. Alternatively, careful review could transform the Voluntary Value Program or MIPS into something stronger, or a third and better alternative might emerge. Thus, if Congress must do something soon, the next steps should be smaller, not bigger.

Higher value health care is urgently needed, but truncating this debate in the interest of time risks saddling the physician community with another large set of changes that have an uncertain future but will nonetheless require practice reform to accommodate; hence the importance of proceeding incrementally. The principles below are intended to guide Congress and CMS in taking these incremental steps.

WHERE TO GO NEXT

Moving to a more effective Medicare pay-for-performance program requires thinking about (1) where to go next and (2) how to get there. The first involves thinking carefully about whether any purely pay-for-performance approach would be likely to substantively advance CMS’s goal of incentivizing high-value care. If so, which particular approach would complement CMMI’s deployment of current and future APMs most effectively in the absence of any constraints to implementation? The second involves determining the most effective way to implement the new program in the presence of legacy programs and technological, political, and other constraints.

1. Build on experience and the literature to develop evidence-based program principles.

Evidence of the effectiveness of pay-for-performance in U.S. health care has been mixed at best, leading some to call for scrapping pay-for-performance altogether and prompting a growing chorus of experts to recommend major revisions separately from MedPAC. The lack of strong evidence from rigorous studies is

the strongest argument for proceeding cautiously with large-scale pay-for-performance initiatives and for requiring proof of a design’s effectiveness on a limited scale before scaling it broadly.

Happily, Congress and CMS do not need to work from a blank slate when they think about how to proceed. Some proposed alternatives, including the Voluntary Value Program, are already available for consideration, in addition to any others that policymakers or stakeholders might conceive of. Moreover, CMMI’s entire mission is to develop and test novel approaches to payment. CMS has incorporated elements of pay-for-performance into major initiatives such as the Next Generation ACO and Comprehensive Primary Care Plus models, and relevant evidence from those programs should inform future pay-for-performance designs. Any new pay-for-performance model not only should be successful when tested on a limited scale; it should also demonstrate the potential for broad generalizability to a diverse provider population before it is scaled nationally.

Program designers also should pay close attention to lessons in the literature on which elements of pay-for-performance are effective in which contexts, and why. Research has suggested, for example, the critical importance of transparent processes and enough supportive resources to generate provider buy-in and the possibility that too many choices or options could actually discourage physicians from engaging with a new program.

2. Engage clinicians to address the heterogeneity of practice structures, specialties, and conditions.

In addition to building on experience and evidence, the development of a new pay-for-performance program must incorporate substantial input from the physician community.

Any nationwide pay-for-performance program will need to accommodate a large number of specialties and subspecialties and a variety of organizational structures—from integrated delivery systems and academic medical centers to rural practices and solo practitioners. Much of MIPS’ complexity reflects the need to present a flexible approach to measurement in the hope that at least one will prove appropriate for each practice or individual subject to assessment,

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including hospital-based clinicians, clinicians who don't interact directly with patients, and small and rural practices.

Whether Congress decides to continue with an all-physician, all-condition approach to pay-for-performance or provides the latitude to focus initially on a subset of priority conditions or specialties, any program must work for all clinicians included in it, regardless of their specialty, role, practice structure, or degree of experience with pay-for-performance. This will require engaging with clinicians and specialty societies and making them partners in program design. This engagement should include both (1) clinician researchers who can advise on how to assess the performance and accommodate the constraints of a wide variety of practice structures and specialties, and (2) practitioners representing the variety of specialties and roles who will need to buy in to a new program. In developing confidential feedback reports under the Physician Feedback Program, for example, CMS both convened multispecialty technical expert panels to advise on methodology and separately interviewed practitioners of different specialties on the usefulness of proposed approaches. Partnering with physicians in design and testing will lead not only to a stronger program but to greater buy-in among those subject to it.

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HOW TO GET THERE

Operationally, moving from the status quo to a new or modified program involves two phases: (1) the period during which the new approach is being developed, and (2) the implementation period that follows.

1. Minimize physician burden and risk while developing the next alternative.

Developing evidence-based design parameters and testing model concepts will take time, and while it is going on, CMS should continue striving to minimize the burden of information reporting and financial risk to clinicians subject to MIPS to the extent possible. In their latest finalized regulation, CMS has taken steps in this direction by introducing additional flexibility for clinicians furnishing services to Medicare beneficiaries and streamlining reporting requirements relating to the use of EHR technology. At the

same time, any congressional modifications to MIPS in the near term should reduce the burden of compliance. Reducing burden and risk will weaken near-term incentives to join Advanced APMs, but it will also reduce the risk of deploying too soon a full-blown MIPS program in which participation is too expensive and desired outcomes too elusive, and this is a trade-off worth making.

A full and immediate repeal of MIPS is not advisable, however. It is conceivable that future program requirements will include some level of reporting and feedback: the infrastructures that CMS and many physician practices have invested in to capture, report, and analyze performance data should be maintained at some minimum level. One way to do this would be for Congress to authorize a "MIPS Light" approach in the near term, similar to the proposal of Fiedler et al., that would require minimal participation to avoid a penalty and would not impose performance-based penalties.

Even if Congress were to decide to repeal MIPS immediately, it would not be necessary to simultaneously replace it with a new incentive program at scale. While a new program is being tested, Congress could authorize CMS to simply keep paying clinicians according to established Medicare fee-for-service prices, with no or minimal annual updates for clinicians who do not participate sufficiently in Advanced APMs.

2. Emphasize broad program principles over detailed parameters in legislation.

Once a new or updated program has been agreed on, Congress must authorize it. To give policymakers in CMS and other agencies the flexibility they need for effective implementation, future legislation should articulate a high-level design framework and broad program rules and parameters. A collaborative effort by CMS and the provider community should then fill in the details as CMS gains experience with what works and what doesn't, recognizing that the inherent complexity of the problem (as well as experience) ensures that the most successful program will be not the one initially deployed but the one that will evolve over time. MedPAC's approach, with its emphasis on broad program principles for the Voluntary Value Program, nicely illustrates how this should work.

It is unlikely that any new pay-for-performance program will work as intended from the outset. Thus, bringing a new program to scale prematurely would magnify any errors and unintended consequences present in the initial approach before CMS has the opportunity to correct them and improve the program during more limited testing.

Avoiding too prescriptive a law is important due to the relative immaturity of many aspects of pay-for-performance methodology as it currently applies to individual clinicians and practices. A consensus has not yet formed on effective approaches to attributing beneficiaries to fee-for-service providers, the relative weight to assign to different classes of measures, the proper size of incentives, or how best to benchmark performance. The continued research on methodological topics called for above will narrow gaps in these areas of inquiry but is unlikely to close them entirely in the near future. Too fine a specification of parameters related to these or other dimensions of the methodology risks locking a new program into an approach that will fail to produce the desired improvements by clinicians and practices.

3. Plan to evaluate the program on an ongoing basis.

Because the literature lacks a blueprint for the “best” pay-for-performance design, CMS should formally evaluate any new or modified pay-for-performance program on a regular and ongoing basis. This will be challenging for a variety of reasons. One is that CMS cannot wait until the program is complete, or even for long-term trends to emerge, before evaluating it. Starting a program with a limited evidence base means policymakers will need to perform evaluations early in the implementation cycle to generate evidence that can be used to tweak and improve the program over time. Another challenge is that valid control groups can be difficult to construct for a nationwide program, or when alternatives to participation are other models that are themselves being tested (in the present case, Advanced APMs).

These challenges are not insurmountable, however. For example, the use of rapid-cycle evaluation approaches and factorial and orthogonal testing designs can help overcome them. More frequent evaluation will permit CMS to make incremental, evidence-based improvements to its measures and incentive structure over time.

4. Avoid scaling up too early.

An incremental approach that builds and expands incentives at a measured pace as more evidence is gathered also will mitigate the potentially harmful effects of path dependence:

once a large program becomes established and clinicians have made substantive adjustments and investments to comply with its rules, it becomes increasingly difficult to make large-scale changes. Such changes impose additional costs on program participants and risk losing the provider buy-in critical to long-term success. It is expensive, for example, to invest in new or different EHR tools, or to hire and train staff to comply with reporting requirements. The bigger the changes, the more certain we should be that we’re getting them right.

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CONCLUSION

MedPAC’s call for an immediate repeal of MIPS reflects the recognition that as time passes, MIPS will become more entrenched. Yet for exactly this reason, we shouldn’t rush into the Voluntary Value Program. Effective clinician payment reform that incentivizes high value care continues to be badly needed in Medicare. The costs of delaying reform are real. The potential costs of moving forward with large, untested alternatives are much higher.

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ENDNOTES

¹ CMS estimates in Table 64 of the *Quality Payment Program 2017 Proposed Rule* indicated that among clinicians subject to MIPS, 87 percent of solo practitioners and 70 percent of clinicians in practices with fewer than 10 eligible clinicians would receive negative payment adjustments.

² See Table 75 of the *Quality Payment Program 2018 Final Rule*.

³ See Table 74 of the *Quality Payment Program 2018 Final Rule*.

⁴ Fiedler et al. propose a similar approach focused on offering small, targeted incentives for high-value activities.

