MIPS is dead, MIPS is dead…Well, not quite!

On January 11, 2018, the Medicare Payment Advisory Commission (MedPAC) voted 14 to 2 to replace MIPS with the Voluntary Value Program (VVP). So, who is MedPAC, why would they make such a recommendation, what could go wrong, what is the impact of their recommendations, and when is MIPS gone? Oh, and why would we want the VVP? important questions to answer before you pull up your MIPS folder on your computer, hit "Delete All" smile, and think "Good riddance."

So, what and who is MedPAC? From that hallowed resource Wikipedia: "*The Medicare Payment Advisory Commission is an independent US federal body. MedPAC was established by the Balanced Budget Act of 1997. The Commission's 17 members bring diverse expertise in the financing and delivery of health care services. Commissioners are appointed to three-year terms by the Comptroller General of the United States and serve part-time. Its primary role is to advise the US Congress on issues affecting the administration of the Medicare program. Specifically, the commission's mandate is to advise the US Congress on payments to private health plans participating in Medicare and health providers serving Medicare beneficiaries. MedPAC is also relied on by Medicare administrators and policy makers to evaluate beneficiary's access to care and the quality of care received. MedPAC's mandate is broad enough that it can also evaluate other issues affecting Medicare."* The members include physicians, healthcare executives, and other policy experts. Alice Coombs, MD (Anesthesia and Critical Care), of South Shore Hospital in Weymouth, Massachusetts, and David Nerenz, PhD, of Henry Ford Health System in Detroit, Michigan, were the two no votes. Francis "Jay" Crosson is the chair and recently headed up the AMA's Physician Satisfaction and Sustainability (PS2) efforts after being the lead physician for Kaiser. Drs. Coombs, Crosson, and Rita Redberg, MD, MSc, are the only physicians who have a history of direct patient care. The remainder are mainly associated with health plans and think tanks. A link to the member composition: http://medpac.gov/-about-medpac-/commission-members.

Why would they make such a recommendation? MedPac's analysts believe the fatal flaw with MIPS is that it is not structured to achieve the policy goals that it's designed to achieve. Since the American healthcare system is at times more different than alike, MIPS required a great deal of flexibility (e.g., reporting options and reasonable exemptions) that introduces both variability (more difficult to manage) and complexity (barriers to comprehension, statistical validity, and participation). David Glass, a principal policy analyst for MedPAC, opined that "Everyone will seem to have high performance when in fact many of the measures are topped out or appear to be topped out…and that will limit Medicare's ability to detect meaningful differences in clinician performance," and it is "extremely unlikely that physicians will understand their score or what they need to do to improve it." In a really enlightened moment, he came to the same realization that we have felt for some time: "Our most basic concern is that the measurers in MIPS have not been proven to be associated with high-value care." Glass and Kate Bloniarz are the staff policy analysts with MedPAC who appear to be the principle architects of the plan.

What are they proposing? The foundation for their alternative policy approach is based upon leveraging population-based measures. It would replace MIPS with elimination of the reporting requirements in the quality, Advancing Care Information (ACI or the old *meaningless* use), and the Clinical Practice Improvement domains. Instead the program would assess clinical quality that these are based on large populations of patients-not patients with a specific condition (e.g., infection rates, avoidable readmissions), patient experience (better be a 5 star), and value. So, the only leg of MIPS to survive as a component in VVP is cost (AKA Resource Use, value-based payment modifier, etc.). While the amount has not been determined, the figure of 2% has been mentioned in the pat. In the final iteration of the proposal, they left the "withhold" up in the air. The specific recommendation does not require a withhold though the text is going to mention that one way to move forward would be with a withhold. Unfortunately, MedPAC then presented an "illustrative" example that does include a 2% withhold.

Under the plan, clinicians would have one of the three options:

- Option 1: Join a “sufficiently large entity” (e.g., physicians affiliated with a single hospital or one geographic area) of clinicians and be eligible for value payments, which would then be collectively measured using a set of population-based measurers. The entities must be “sufficiently large” in order to have “statistically detectable performance on the population-based measurers.”
- Option 2: Choose to participate in an advance APM model.
- Option 3: Lose the withheld fee schedule dollars. Since this option would almost certainly generate a groundswell of opposition, especially among vulnerable practices that don’t feel either of the other two options are realistic in their community, it is possible that this end goal could be achieved without a frontal assault. Perhaps this bucket would just not be eligible for any financial bonuses. Another variant in the beginning would be to use the $500 million MIPS has authorized for exceptional bonuses to draw physicians into the VVP. Bottom line, there is no inkling of how this might evolve and what other factors might be in pay at the time.

Bloniarz observed that all of the proposed measures could be pulled from Medicare claims data or “centrally conducted patient surveys” which avoids the current main complaint by physicians of the reporting burden with MIPS. The devil is always in the detail and claims-based versus clinical-based in already a know impediment in other areas. While popular in some areas of the country, many in this caucus do not find the phrase “centrally conducted” a reassuring term. Part of the concern by both positive and negative votes would be a negative effect on existing healthcare disparities and dual-eligible who already have significant barriers.

What could possibly go wrong? There is a lot of debate on repeal ad replace or just repeal; sound familiar? The issues of claims-based data, universal survey validity, and

yet another learning curve begin the list. The other risk is that legislators will identify some risk amount, such as the previous 2% value, and adjust it upwards or take the withhold and not establish a way to distribute it. In fact, various members at the monthly meetings since November have advocated in one form or another to repeal the MIPS program, withhold the funds from the clinicians who aren't participating in an advanced APMs, and then reallocate the withhold to reward APM performance. The underlying goal would be to actually increase the penalty and make it less attractive to stay in MIPS. Transparency, timing, attribution, and supporting infrastructure are also material hurdles; black boxes yield results based on their programming!

What is the impact of their recommendations? It is important to understand that they only make recommendations: they do not mandate acceptance or implementation. Acceptance is often dependent upon whether CMS or Congress have any interest in moving in a suggested direction. However, they often provide a frame of reference and starting point for legislative and regulatory members and staff. Their withhold concept could rapidly become an object of interest and potential source of funding for any number of possibilities. So, the impact of their recommendations may be indirect and unintended as part of other initiatives.

When is MIPS gone? Thus far, their recommendations have not created any momentum. Thus far, Congress has shown no interest in changing the program before it has even gotten off the ground; and right now, Congress has trouble passing anything, which for us is a key prerequisite! So, while it may initially seem enticing, consider the impediments discussed above and I suspect your smile may be fading a bit. Short answer, probably no time soon. *So, neither delete your MIPS files nor cease your efforts to comply with MIPS.* I think that you are going to need to report if after all! Next steps for MedPAC are for staff to develop a revised voluntary replacement program similar to the one discussed above and suggestions on how to make the advanced Alternative Payment Models more accessible for physicians, which actually could be a silver lining in the discussion. We need options that are realistic, manageable, and sustainable. I would like to thank our AMA staff for sharing their

superb edits and insight for this article. We are so blessed to have such a deep bench of subject matter expertise working to support us and protect our patients.

Some links for more information:

http://www.healthleadersmedia.com/finance/medpac-sinks-mips-recommends-alternative-program?spMailingID=12734830&spUserID=MjA5MjkyNTAzMjgzS0&spJobID=1321121229&spReportId=MTMyMTEyMTIyOQS2&page=0%2C2