Who Wins and Loses If CMS Kills MIPS?

written by Theresa Hush | March 8, 2018

Last month, the new Health and Human Services (HHS) Administrator, Alex Azar, tolled the death knell on MACRA MIPS quality reporting. Even as the MIPS program just began its second year, Azar reinforced what MedPAC (Medicare Payment Advisory Commission) has been suggesting since June 2017: trash MIPS quality reporting and speed up provider transition to APMs (Alternative Payment Models). MedPAC is so eager to engineer this that it recently suggested even more incentives to help physicians make the switch.

If you believe the hype, both providers and patients will win if MIPS is eliminated or vastly rewritten. Certainly, the notion that reduced MIPS paperwork will enable providers to spend more time with patients sounds appealing. But providers are not naïve. They know that generating more APM participation is a major undertaking with significant risk. CMS is quite clear that "Regular" participation in Medicare—with or without MIPS quality reporting—will essentially disappear. As a result, Medicare's Value-Based Health Care program will focus on capping costs; that will only happen through provider participation in Medicare Advantage and

APM financial risk arrangements.

We'll save that part of the Kill MIPS message for another post, as it deserves its own quality time.

MIPS Is an Easy Target for Regulatory Reform

By now it's quite evident that the MIPS regulatory approach is inconsistent with the anti-regulatory philosophy of the current administration. There is no question that the measures are overly complex, do not incorporate enough patient outcomes, and fail to provide a foundation for good comparisons between providers. There are valid questions about what benefit such measures provide to the Medicare program or to its beneficiaries.

Indeed, we predicted the program's demise more than a year ago. MIPS was always intended as a transitional stop on the way to providers' participation in Alternative Payment Programs. In addition, the complex infrastructure needed by both providers and Medicare to calculate results across hundreds of measures is, arguably, unsustainable.

But those arguments have always been about improving how we measure Value and Quality—not eliminating measurement altogether—to more closely align with medical effectiveness and patient outcomes. By killing MIPS, CMS risks minimizing "Value" to equate only with "Savings" as the primary criteria for APM success. By using claims alone and eliminating the reporting of clinical data, CMS suggests that it is no longer concerned with patient outcomes, nor with improvement.

Whether and when CMS will kill MIPS has not yet been determined, but there's good reason to believe that a massive overhaul or elimination is in the works. Would the death of MIPS quality reporting be a boon for providers? What will it mean for Medicare patients, if anything? Let's take a closer look at who might benefit and lose from a derailment of MIPS. The answers may surprise you.

Does MIPS Actually Burden Providers?

CMS accuses MIPS of increasing the burden on providers and asserts that eliminating MIPS in lieu of claims-based reporting will help physicians by "leaving more time for clinicians to focus on patient care." Indeed, the "provider burden" associated with quality reporting has become a flashpoint for the new CMS administration, which casts its top priority as "patients over paperwork."

It is doubtful, however, that physicians will truly have more time for patient care because of changes in MIPS or elimination of the program altogether. Most data for quality reporting is harvested from Electronic Medical Records (EMRs) or billing data, not provided by physicians. In fact, the vast majority of physicians are not at all involved in collecting data for reporting or in the reporting itself, unless this functionality is built into patient EMR templates. Most EMRs are now designed to facilitate a standard of care and include many prompts for providers.

Office staff can be heavily involved in the quality process, completing data for patients and organizing workflows that ensure collection of data to meet quality reporting. But clinician time with patients is not significantly affected by the quality reporting process because doing so would negatively affect their productivity and patients—plus, most physicians would not tolerate it.

It's important to remember that Medicare is not the only program requiring quality reporting. Many Blue Cross plans provide incentives based on quality, and some organizations have sought certification of quality or medical home status, requiring adherence and reporting of quality data.

Quality Measures Are Deeply Embedded in Physician Compensation

Consolidated health systems were quick to incorporate quality and performance measures into physician compensation schemes. In fact, on average, around 10 percent of physician pay is based on quality incentives; in more mature, value-focused markets, that figure is around 20-30 percent.

But less than half of physicians subject to such compensation plans are earning most of their incentive dollars. As a result, these incentives can't be undone without vastly increasing the organization's physician compensation budget. While incentives are not always tied one-to-one to MIPS measures, sometimes they are. Incentives are also often connected to equivalent indicators or other CMS-provided cost measures, such as readmissions.

The poor implementation of quality measures by health care systems and organizations has been one of the downsides of Value-Based Health Care. With problematic data and programs that all-too-often focus on finding the bad apples among providers, physicians have become sensitized and demoralized by scores and rankings. But eliminating MIPS won't provide them any relief. The real solution requires a shift to a more participatory and investigative approach to both quality and cost data. It also requires a reorientation to measuring improvements in patient health status and outcomes over time—the real test of value.

Indeed, the use of incentive-based physician compensation is likely to increase, not decrease, as physicians participate in APMs. Risk of excessive costs will be passed on to providers generating the services for patients and will likely further reduce physician compensation in organizations that are unable to generate savings.

Does MIPS Quality Data Have Any Value for Medicare or Consumers?

To claim that consumers have directly benefited from quality measurement efforts such as MIPS would be difficult to prove. Nor have consumers gained more accessible information about patient outcomes or quality that they could use in making medical decisions. Consumers, including Medicare beneficiaries, are still totally reliant on word-of-mouth and Yelp reviews to choose providers.

But it would also be foolish to claim that PQRS and MIPS had no beneficial effect, even if the statement cannot be proven. Prior to quality reporting requirements, most physician organizations did not even track patients in populations and calculate gaps in care. There were no templates to integrate quality measures; in fact, quality measures didn't exist. Whatever services a patient received were solely up to the provider.

PQRS changed the culture for examining patient care and helped instigate a transition to population health. This didn't move health care far enough to the goal, but it was an important step in the right direction. It happened because organizations needed to measure and report quality to meet Medicare and commercial payer requirements. That's a lot of change in ten years.

To make informed decisions about who delivers their care, consumers will need real data that provides a window on provider quality and how their patients fare. If consumers must bear the costs and choices that Medicare, health plans and their employers intend, they must have the tools to manage.

MIPS is too fragmented, too complicated and too measurement-period-fixed to serve consumers effectively. But whatever results from the next iteration of MIPS, consumers will still need information that the MIPS support infrastructure currently provides. This includes:

- Use of clinical data to support quality measurement;
- All-provider and all-patient data, not only for providers who don't participate in APMs, but also for making APM choices
- Simplified quality measure sets for patients that reflect outcomes over time for chronic

conditions, as well as cost per condition;
Specific episodic procedure sets for patients that show functional outcomes and cost.

MedPAC has correctly targeted MIPS as overly complex and not delivering on its goals. Consumers and Medicare beneficiaries, however, should be able to use quality assessments of providers just as we use financial audits, to verify both that providers have the internal quality controls required to deliver good care, and that they are measuring their results. Indeed, the measurement is the point.

So, Who Wins and Who Loses if CMS Kills MIPS?

1. Physicians are unlikely to win under any MIPS death scenario.

Physicians won't see a sudden increase in time available for their patients. Some non-patient care staff resources could be eased. Small-to-midsized practices could, in the short term, spend fewer resources on data collection and reporting for Medicare.
Physicians won't see quality-related incentives disappear from compensation plans. It is unlikely that health systems will unwind the incentives that have become embedded, because that would require additional resources.

2. Provider Organizations may actually lose if the infrastructure to capture quality information unravels.

If CMS uses claims data to evaluate quality, as opposed to the current capture of clinical data, physicians go back to the method of relying on CMS for their scoring and lose the ability to improve their performance before the measurement period ends. That would be a real loss for large groups that have been successful.
Killing MIPS will not eliminate similar efforts required by physician contracting networks, by large institutional or health system efforts, or by compensation plans.

3. Consumers and Medicare beneficiaries lose if Value is solely defined by cost versus quality of patient care or improvement in health status.

Replacing quality reporting entirely with claims is a step backwards for both providers and consumers.

Ironically, by streamlining the predecessor programs and making MIPS more comprehensive as well as detailed, CMS highlighted the complexity and flaws of the individual programs. The paradox is that MIPS is a step forward in beginning to focus on improvement, properly assess the cost of care, and take advantage of the wealth of clinical data now available. But it is a step back in its complicated design, the sheer volume of quality measures across all providers, and its continued reliance on procedural measures and limited clinical values.

Both providers and consumers would benefit from a major redo of quality measurement, analogous to a framework used by the financial industry. We need validation of an organization's efforts to measure provider and patient performance, regardless of APM or other participation, and assurance of ongoing efforts to investigate quality gaps.

Most of all, we need to take the time to appropriately evaluate MIPS, provider burdens and potential harms to beneficiaries before rushing to solutions that could affect patients. Who among us does not remember the flight from HMOs caused by denials of care and selective enrollment? Provider-owned entities that must assume financial risk for patient care are not without danger. Like everything in health care, even the best solution has both potential benefits and harms.

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