Assessing payment adequacy and updating payments: physician and other health professional services; and Alternative to the Merit-based Incentive Payment System (MIPS)

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MEDPAC

Measures of payment adequacy

- Access to care
  - Measures of reported access
    - Telephone survey
    - Focus groups of beneficiaries and site visits
    - Other surveys
  - Supply of providers
  - Volume of services
- Quality
- Medicare payments and provider costs

Background: Physician and other health professional services in Medicare

- $69.9 billion in 2016, 15 percent of FFS spending
- 952,000 clinicians billed Medicare: 589,000 physicians, 203,000 advanced practice nurses and physician assistants, 160,000 therapists and other providers
- Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established new payment updates in law
  - Update: 0.5% in 2016-2019, 0% in 2020-2025
  - 5% incentive payment each year from 2019-2024 for certain participants in Advanced Alternative Payment Models (A-APMs)
  - Merit-based Incentive Payment System (MIPS) for non-A-APM clinicians, starting 2019

Data preliminary and subject to change.

MedPAC survey: Beneficiaries have comparable access to privately-insured

- Most beneficiaries are able to obtain care when needed
  - Small share of beneficiaries report trouble finding a new provider
  - Beneficiaries more likely to report trouble finding a new primary care doctor than specialist
  - 2017 results show modest improvement from last year (e.g., return to trend)
- Minority beneficiaries report more trouble obtaining care when needed
- Minimal differences in reported access between rural and urban beneficiaries
- Medicare beneficiaries report higher satisfaction with care than privately-insured

Data preliminary and subject to change.

Other payment adequacy indicators

- Medicare provider participation and assigned claims remain high
  - 95% of providers are in Medicare's participating provider program
  - 99% of claims are paid on assignment
- Number of providers billing Medicare per beneficiary in 2016 similar to 2015
  - Number of primary care physicians fell slightly, specialists fell slightly, advanced-practice nurses and physician assistants increased
- Medicare's payment rates to clinicians were 75% of commercial PPO rates in 2016, a decline from 2015 (78%)

Data preliminary and subject to change.

Quality

- Two population-based measures of ambulatory care quality
  - Low-value care is common in Medicare: 23-37% of beneficiaries had at least one low-value service in 2014
  - National avoidable hospitalization rates continued to decline for most conditions in 2015
- Medicare's value-based payment modifier (began in 2015) resulted in some groups receiving very high payment adjustments
- Will discuss MIPS at the end of this presentation

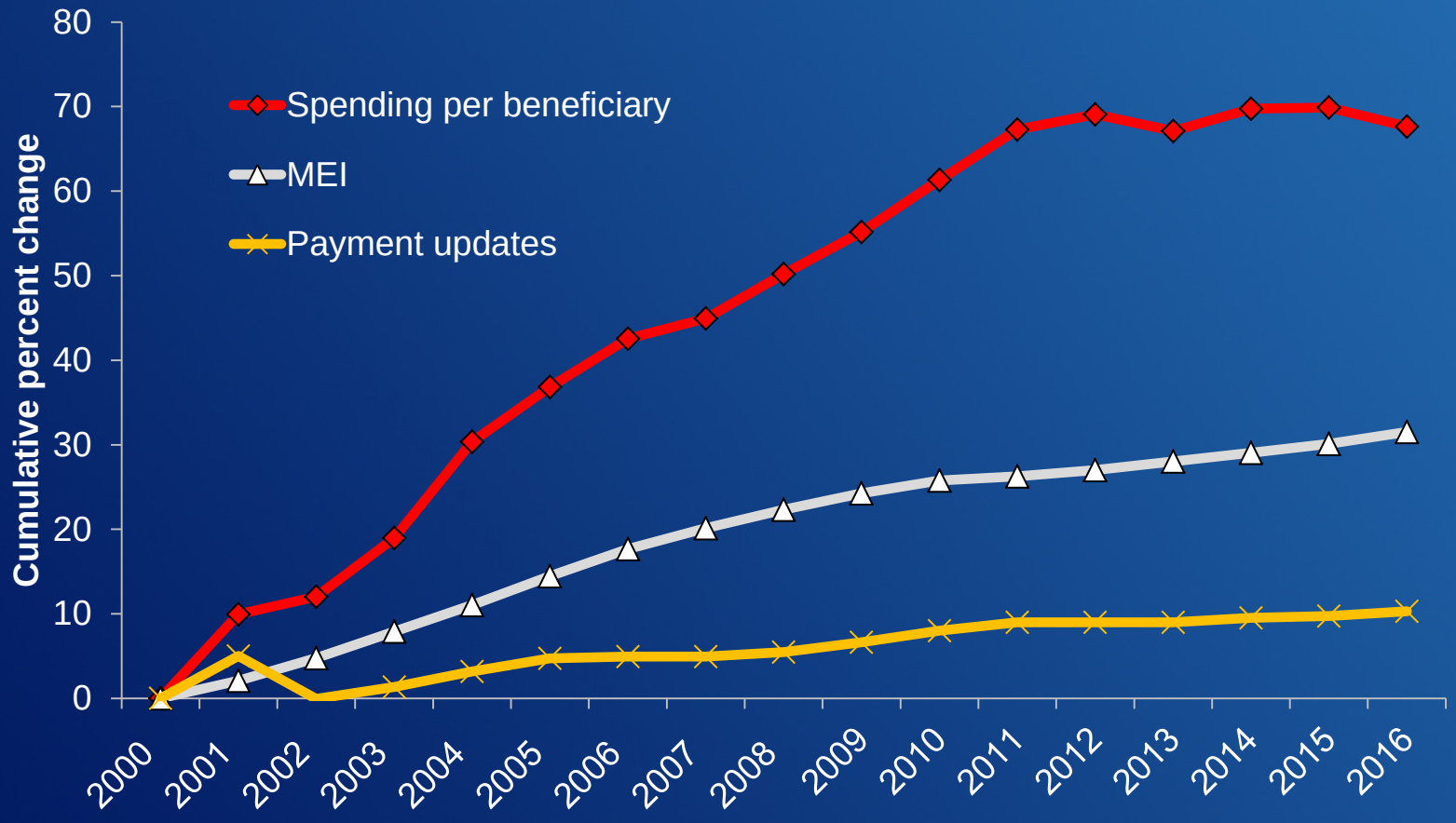
Data preliminary and subject to change.

Annual volume growth was higher in 2016 than 2011-2015

- Volume growth accounts for change in number of services and change in intensity (e.g., substitution of CT for X-rays)
- Average annual volume growth per FFS beneficiary, 2011-2015 = 0.5% (across all services)
- Volume growth in 2016 = 1.6%
- Growth by type of service in 2016 ranged from 1.1-2.8%

Data preliminary and subject to change.

Volume growth caused fee schedule spending to increase faster than input prices and updates, 2000-2016



Note: MEI (Medicare Economic Index). The MEI measures the change in clinician input prices.
Source: 2017 Medicare Trustees' report and CMS.

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Data preliminary and subject to change.

Payments for physician and other health professional services appear to be adequate

- Access indicators are stable
  - Provider participation and assigned claims
  - Number of clinicians billing Medicare per beneficiary
- Ratio of Medicare payment rates to private PPO rates declined, probably due to price increases for private payers
- Quality indeterminate
- Increase in volume of services

Merit-based Incentive Payment System (MIPS) recap

- Four components in MACRA
  - Repealed sustainable growth rate
  - Established permanent statutory payment updates
  - Created incentive for participants in Advanced Alternative Payment Models (A-APMs)
  - Established a value-based purchasing program for FFS Medicare (MIPS)
- Discussion only addresses MIPS, not the other parts of MACRA
- MIPS is an individual level payment adjustment based on quality, cost, advancing care information (ACI), and clinical practice improvement activities (CPIA)
  - Repurposes prior value-based purchasing programs
  - Three out of four MIPS categories rely on clinician-chosen and reported measures

MIPS process is burdensome and inequitable

- Reporting burden
  - Over $1 billion in reporting burden for clinicians in 2017 alone
  - CMS supports six reporting methods for the MIPS quality category plus two new systems
- Much of the reported information is not meaningful
  - Only a few MIPS quality measures assess meaningful outcomes
  - Other categories (ACI, CPIA) not shown to be associated with high-value care
  - Small sample sizes
- Each clinician is scored on different measures representing different levels of effort
- Results in non-comparable scores across clinicians, but nonetheless is used to allocate payment

Many exceptions, modifications and adjustments

- CMS has exempted more clinicians in 2018 than are required to participate
- Special rules and reweighting
- Arbitrary payment adjustments
  - Near-term: Lots of effort, minimal adjustments because of low standard (3/100 points then 15/100 points)
  - Longer-term: Small differences in apparent performance will result in big payment differences (penalties increase over time and compressed distribution—most will score high)
- Overall, system is inequitable, burdensome, and will not improve care for beneficiaries nor move the Medicare program and clinicians towards high-value care

Action on MIPS is urgent

- First reporting year is 2017 for payment year 2019
- CMS has delayed full implementation for first two years, provider groups requested continued flexibility for an additional three years, but payments will continue to be made
- Time for action is now before there is an established constituency of clinicians getting very high positive adjustments
- Our approach is to eliminate MIPS and create a new program

New voluntary value program (VVP)

- Goals
  - Maintain a value component in Medicare FFS clinician payment
  - Encourage movement to A-APMs
    - Limit potential bonuses in unconstrained FFS to be less than in A-APMS
    - Encourage clinicians to form/join groups and increase familiarity with population–based measures
  - Eliminate clinician measure reporting to CMS
- Design
  - Uniform, population-based, claims-calculated, and patient-surveyed set of measures important to beneficiaries and the program
  - Clinicians assessed in voluntary groups of sufficient size to support population measures
  - Voluntary group performance determines value payment (funded by withhold)

Scope of recommendation on new program

- Language around recommendation would provide Commission position on design issues and raise policy decisions for the Congress such as:
  - Size of withhold and total value payment
  - Weighting
- Notice and comment rulemaking would address additional design elements
  - Leverage CMS expertise on case sizes for measures, minimum voluntary group size, virtual groups
  - Provide stakeholder input

Discussion

- Payment adequacy and updating payments: Physician and other health professional services
- Alternative to MIPS