MedPAC perspective: The changing payment environment for physician practice

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MEDPAC

MedPAC Payment Principles

- Assure beneficiary access to high quality care
- Pay providers fairly
- Provide for taxpayers and beneficiaries to receive value for their dollars

MedPAC Policy Interests

- Rebalance the PFS toward primary care
  - Improve payment fairness among physician specialties
  - Ensure a physician/other professional workforce to support beneficiary choice of provider and delivery reform success
- Improve information used in determining fee schedule values
  - The large number of codes makes it difficult to maintain the accuracy of the fee schedule in a timely manner
  - There is evidence that the time component of many procedural codes are out of date
- Further improve physician payment, including MACRA elements: A-APMs and MIPS

MedPAC Formal Recommendations

- CMS should broaden the sources of and more regularly update input on PFS relative valuations, including the time component of physician work (2006, 2011)
- Congress should improve payments for primary care, on a budget-neutral basis-
  - Differential updates (2011-letter to CMS)
  - Annual targets for adjusting mispriced services (ibid)
  - Per-beneficiary payment for primary care (2015)

MedPAC Formal Recommendations

- Congress should reduce or eliminate differences in payment rates between HOPDs and physician offices for selected ambulatory payment classifications (2012,2014,2017)
- Congress should change the way physicians are paid for Part B drugs, including by creating incentives for appropriate drug selection and utilization (June, 2017)

Ongoing MedPAC Areas of Focus

- Can we identify patterns of “low-value” physician services and make recommendations accordingly?
- What recommendations should we make regarding the implementation of A-APMs and MIPS?-
  - Make A-APMs more attractive; MIPS -> A-APM
  - But…A-APM physician accountability for results
  - Much simpler, more accurate, more relevant quality measurement in MIPS

Issues with Current MIPS Framework

- Uses hundreds of quality measures, many of which are topped out and narrowly targeted to specific specialties and cases
- Data elements for meaningful use and practice improvement activities are attestation-only
- Relatively small number of patients for an individual clinician contribute to noisy performance scores
- Individual measures chosen by the clinician used to assess clinicians' performance, thus results not comparable across clinicians
- Overall, MIPS will likely fail to identify high- or low-value clinicians and will not be useful for
  - Beneficiaries (in selecting high-value clinicians)
  - Clinicians (in understanding their performance and what to do to improve)
  - The Medicare program (in adjusting payments based on value)

Discussion Idea: MIPS

- All clinicians contribute to quality pool through a percentage withhold
- Clinicians could be eligible for a quality adjustment if they elect a clinician-defined “virtual group”
- “Virtual group” must be sufficiently large to detect performance on population measures
- Clinicians who don’t elect virtual group or join A-APM lose withhold

Discussion Idea: Rebalancing MIPS Towards A-APMs

- MIPS quality withhold automatically returned to clinicians in A-APMs, incentive for clinicians to join A-APMs
- Move MIPS “exceptional performance” fund to A-APMs to fund asymmetric risk corridors; $500 million each year (2019-2024)