The Merit-based Incentive Payment System (MIPS): Ripe for Repeal

Kristin S. Held, M.D.

At its January 2018 meeting, the Medicare Payment Advisory Commission (MedPAC) voted 14 to 2 to repeal the Merit-based Incentive Payment System (MIPS),[1] which was created in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).[2]

MedPAC is an independent congressional agency established by the Balanced Budget Act of 1997, whose members are appointed by the Comptroller General, which is required by law to review Medicare payment policies and to make recommendations to Congress.[3]

MACRA repealed the Medicare Sustainable Growth Rate (SGR), which was also enacted in the Balanced Budget Act of 1997 in an effort to control spending on physicians' fees. If expenditures in a given year exceeded the targeted growth rate, Congress was supposed to change the conversion factor in the Resource-based Relative Value Scale that determines Medicare physician fees so as to reduce spending in the following year. Because of fears that fee cuts would reduce the availability of services to Medicare beneficiaries, Congress postponed implementation year after year. The American Medical Association (AMA) lobbied hard for the repeal of this constant threat of draconian fee cuts, which accumulated over the years of delay.

MACRA also established statutory payment update rates, created an incentive for advanced alternative payment model (A-APM) participation, and created MIPS.[4]

MIPS is a government program for grading individual physicians with a composite performance score between 0 and 100, and then either penalizing or rewarding that physician with a negative or positive payment adjustment based on this score. The composite performance score (CPS) is determined by the sum of each individual provider's weighted grades in four performance categories as set forth by a complex, untested, and flawed federal government rubric. The CPS is then posted on the Centers for Medicare and Medicaid Services (CMS) Physician Compare public website (www.medicare.gov/physiciancompare).

MACRA also expanded the definition of physician by creating the term MIPS Eligible Clinicians and using the term Eligible Professional; thus, MIPS applies not only to physicians, but to physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, clinical psychologists, nurse midwifes, physical therapists, occupational therapists, audiologists, speech pathologists, clinical social workers, dieticians and nutritional specialists, and so on. In the MACRA rule-making process, CMS granted itself immense power and expanded its authority, including the potential "to expand the definition of MIPS eligible clinician to include additional eligible clinicians through rulemaking in the future."[5] In other words, the federal government could subject anyone and everyone to its social engineering scheme.

Social engineering report cards of this sort have been seen in recent years in China, for example, as a way to harness big data and score its people on their behavior. China's personal social credit score was recently tested on 89 million Communist Party members on their performance in 136 performance categories. Those with good behavior according to the collected data will be rewarded while those who fall short of the Party's expectations will be denied basic freedoms like loans or travel.[6]

MACRA, in its ensuing rule, re-branded key terminology[7] to make it appear more palatable and vastly expanded the federal government's control over patient care and the patient-physician relationship. The stated goal is to drive physician behavior. Government seeks to move physicians away from a fee-for-service payment model and into alternative payment models (APMs) that are claimed to reward what government perceives as value-based care and that require "providers" to assume significant financial risk.

The federal government's social engineering plan in medical care is called the Quality Payment Program (QPP). Lawmakers believe they can drive physician behavior by incentivizing or penalizing physicians monetarily and psychologically through the threat of public shaming on the CMS Physician Compare website, where each "eligible professional's" government compliance score is posted for all to see.

Fortunately, MedPAC concluded that MIPS cannot succeed. In a presentation at MedPAC, a slide about MIPS states that it "replicates the flaws of prior value-based purchasing programs" and is "burdensome and complex." Also, "much of the reported information is not meaningful," and scores are "not comparable across clinicians." Payment adjustments will be "minimal in [the] first two years [and] large and arbitrary in later years." Finally, it "will not succeed in helping beneficiaries choose clinicians, helping clinicians change practice patterns to improve value, or helping the Medicare program to reward clinicians based on value."[4]

MIPS does not promote, create, or reward value. In fact, it may do quite the opposite. A 2017 article in the *Annals of Internal Medicine* reports that pay-for-performance programs such as the Value-Based Payment Modifier, a predecessor to MIPS, implemented by CMS, may actually contribute to "healthcare disparities" without improving performance.[8] Physicians were incentivized to care for lower-risk patients and penalized for serving higher-risk patients. In other words, money was inadvertently shifted away from physicians who treat poorer and sicker patient populations to fund bonuses for physicians treating more affluent, healthier populations.

That MedPAC recommends repealing MIPS is encouraging, but then, MedPAC arbitrarily concocts something to replace MIPS, called the Voluntary Value Program (VVP). The MedPAC commissioners propose to withhold a percentage of all fee schedule payments unless the physician abandons fee for

service and joins an A-APM or "voluntary group" to be assessed at a group level. Much of the discussion in the transcript of the recent MedPAC meeting revolved around how big the withhold penalty needs to be to force physicians to join A-APMs, which include an array of Accountable Care Organizations (ACOs). ACOs are essentially reincarnations of the reviled HMOs of the 1980s and 1990s. If MIPS is repealed, MedPAC recommends a 2% across-the-board withholding from payments to providers, but MedPAC Commissioners discussed withholding amounts ranging from 0.5% to 10%.[1]

Beyond the Financial Implications

Beyond the economic consequences of the government's price controls, the issues are on the front lines of the battle for the soul of American medicine—and American society. Who determines and what constitutes value-based medicine? What physician behaviors deserve a high score and high pay, and what behaviors warrant a low score, low pay, and public humiliation? As C.L. Gray, M.D., astutely reminds us, this struggle began with Plato, the ancient Greek philosopher who urged that doctors refrain from curing the weak and infirm in order to improve society, vs. his contemporary, Hippocrates, who taught that physicians worked on behalf of the patient, not for the good of the state.[9] Today, we face the same question: whom do we serve, the patient or the state?

One of the four MIPS performance categories, Advancing Care Information (ACI), is really a re-branding of the Meaningful Use of Electronic Health Record Technology (MUEHRT). This category is especially disconcerting, as it requires physicians to fully disclose all of our patients' medical information to government data auditing agencies for surveillance or direct review, including the patients' "protected" health information (PHI). PHI comprises individually identifiable information, including all demographics, all medical history, all medications ever taken, and even genetic information. The physician who does not comply will receive a score of zero (0) in the ACI performance category.

MACRA makes data blocking illegal and demands bidirectional, unfettered access by outside government-created or approved entities to clinicians' electronic health records—for all patients, not just Medicare patients, for all data, not just MIPS data, and for all insurers, including commercial insurers, not just Medicare. The federal government wants to collect, audit, assess, and sell the patient data and wants to be able to input government treatment guidelines, templates, restrictions, and controls. In effect, the federal government wants to dictate the medical care of the American people. The federal government, through the Office of Civil Rights (OCR) of the Department of Health and Human Services (HHS), via the Office of the National Coordinator of Health Information Technology (ONC-HIT), specifically granted itself access to our once sacred, private medical records.

Direct unrestricted access to all individually identifiable protected health information without patients' authorization under any circumstance by the ONC-HIT and its ONC-Authorized Certification Bodies (ONC-ACBs)[5] is the most dangerous part of the MACRA Rule. MACRA instructs the Secretary of HHS to create third-party intermediaries to collect the data and fourth-party entities to audit it, potentially including unblocked surveillance on demand and even on-site auditing.[7] Further, MACRA requires the data collectors to keep all the data for a minimum of 10 years, if not eternity if government so says.[5] In this light, engaging with certified electronic health record technology (CEHRT) may be a violation of our professional code of ethics. Our ethical duty as Hippocratic physicians is to keep our patients' data from government, not to transmit it to government. We must ask ourselves again: Whom do we serve, the patient or the state?

In 2016, after reading MACRA and the proposed MACRA Rule and submitting comments, I personally met with CMS acting administrator, Andy Slavitt, and a group of high-ranking CMS officials at CMS headquarters in Washington, D.C., to convey concerns about such intrusive, self-granted government data collecting practices. A distinction was ultimately made in the final rule allowing voluntary continuing data surveillance, but ONC direct review of CEHRT data remains mandatory. This highlights the critical importance of U.S citizens reading verbatim not only bills before and after they become laws, but also reading and commenting on proposed rules, and then reading the final rules once they are published. If we do not do this, we will fail to secure our blessings of liberty as instructed in the Preamble to the U.S. Constitution.

Our concerns are not theoretical. In recent months and years, we have become aware of abuses of data collection and surveillance of American citizens by federal agencies, such as the Federal Bureau of Investigation, the Central Intelligence Agency, the National Security Agency, and the Internal Revenue Service, as well as the Department of Justice and Department of Defense. Why are we to presume federal agencies within the Department of HHS, such as the ONC, CMS, and the Centers for Disease Control and Prevention, will behave any better? And, might our most intimate medical, physical, psychological, and even genetic information be even more vulnerable to EHR-related injury and death, foul play, and public control than our phone conversations, e-mails, texts, and finances? If agencies can lose five months of texts and thousands of e-mails, can they not also lose our vital medical information? There is no limit to the potential consequences of government malfeasance, should our supposedly confidential medical information remain subject to unblocked, bidirectional manipulation by government agents. The risk to our medical data comes not only from national forces, but international as well. Politicized and weaponized data can affect our very lives.

The Need for Repeal

Will Congress heed MedPAC's advice and repeal MIPS? For that matter, will our elected officials honor their word and repeal the Affordable Care Act, root and branch? Or, is the allure of $1.3 trillion per year spent on "healthcare" and the power over each individual American's life just too hard to resist?

Tragically, as if penned by Shakespeare himself, MACRA, replete with its MIPS and Advancing Care Information performance category, was sponsored by a physician colleague and fellow Texan, Rep. Michael Burgess (R-26-Tex.), and passed with broad bipartisan support. Will egos, money from special interests, political pressures, and irrational excuses such as "we've invested so much on this, we have

to go forward," rule the day, or will Congress, led by MACRA sponsor Burgess, step up, admit it was a mistake, and repeal MIPS, and all of MACRA for that matter? In other words, will Congress use some common sense, cut our losses, and do the right thing?

Americans might never dream that the scoring of individual citizens through massive government data collection, in order to drive behavior through threat of public humiliation, is part of federal law. But this social engineering scheme is precisely what is contained in MACRA and MIPS. The confiscation, surveillance, and potential manipulation of our medical data as codified by MIPS violates the Constitutional rights of U.S. citizens and places us in harm's way. We are heading toward a totalitarian state unless we stand up and fight for our rights and liberties.

I call on my physician colleagues, with Rep. Burgess, M.D., leading the charge, to follow MedPAC's advice, and make MIPS repeal a reality. The MACRA rule-making process revealed how this law could be too easily and too vastly contorted beyond the sponsors' intent. Rep. Burgess must ask himself as a physician: Whom does MACRA serve, the patient or the state? If he answers honestly, he must next courageously draft the repeal legislation for not just MIPS, but MACRA itself, and not simply replace MIPS with something worse.

Kristin S. Held, M.D., is an ophthalmologist, who is opted out of Medicare and practices in San Antonio, Tex. She serves as a Director of AAPS. Contact: kksheld@aol.com.

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