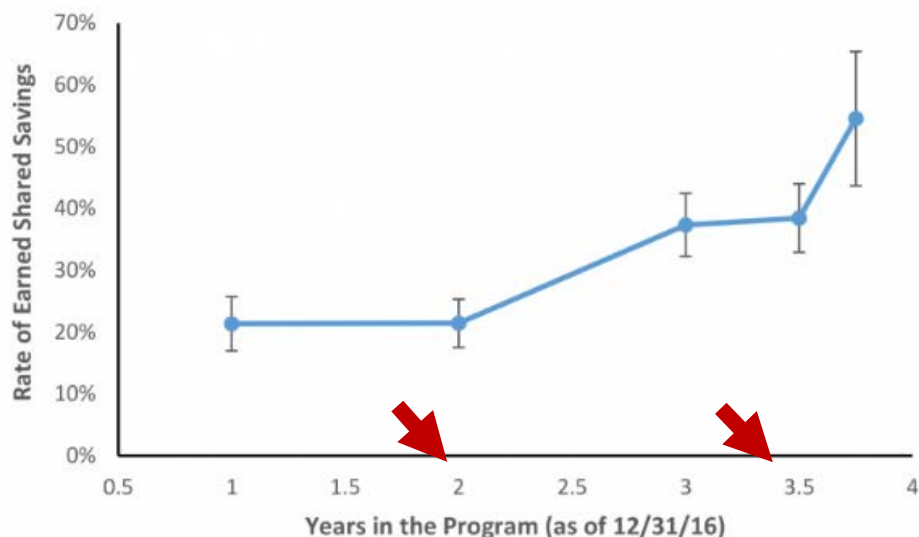# How is MIPS working?

At what cost?

Is this the best we can do?

Aaron Lyss

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Adaptation to new payment models

Exhibit 6. The Percentage Of ACOs Earning Shared Savings Bonuses As A Function Of Years In The Program

ACOs that remain in the program longer have a significantly higher probability of achieving shared savings.

"Challenges, Perceptions, and Readiness of Oncology Clinicians for the MACRA Quality Payment Program"

- 4% "in-depth knowledge
- 9% never heard of it
- 44% recognized the name but not familiar w/ requirements
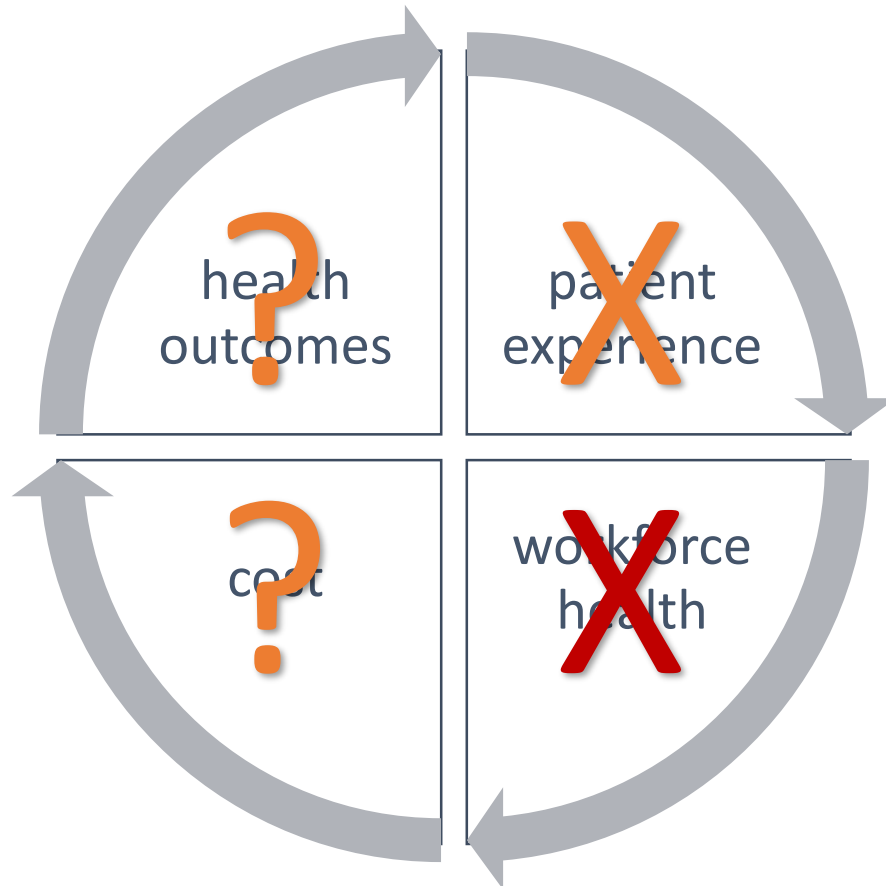- 43% somewhat familiar

Impact so far?

Is this the best we can do?

Intentions:
1. create performance-based variation in reimbursement
2. reimbursement commensurate with provider influence over the outcome
3. increase provider consideration of cost

Intentions:
- correlate w/ program requirements & measures
- include patient experience measures & required patient-centric activities

Reality:
- relative impact on program performance overwhelmed by extent of other requirements & measures
- Computer-centric **>** patient-centric

HEALTH OUTCOMES

PATIENT EXPERIENCE

COST

WORKFORCE HEALTH
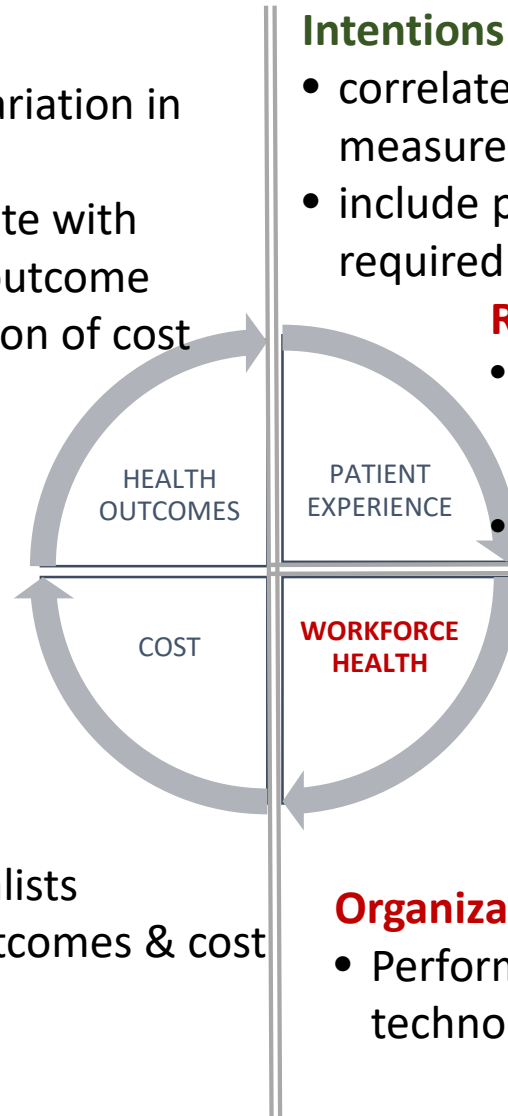
Individual frustration:
- Care teams prefer patients to computers, time is zero sum
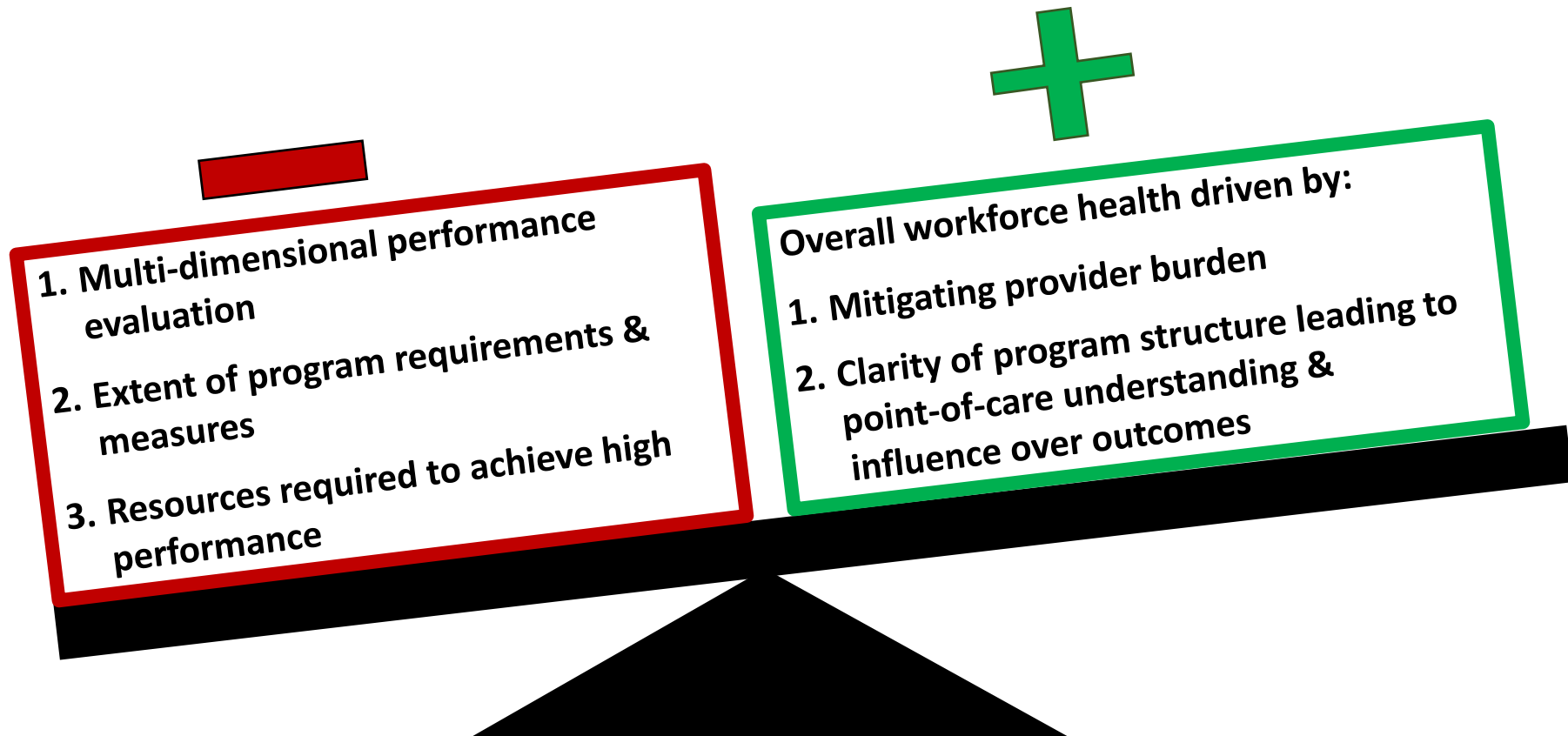
Organizational economics:
- Performance driven by increase in technology and FTE resources

Reality:
- Insufficiently nuanced for specialists
- Questionable counterfactual outcomes & cost

Could there be a better alternative?

"If everything is important, then nothing is" -- Patrick Lencioni

−

1. Multi-dimensional performance evaluation

2. Extent of program requirements & measures

3. Resources required to achieve high performance

+

Overall workforce health driven by:

1. Mitigating provider burden

2. Clarity of program structure leading to point-of-care understanding & influence over outcomes

Why not A-APM?

15x

Uncertainty that payers can evaluate performance while accounting for:
1. Cost of all care
   Incl. on-pathway drugs
2. Case mix severity

X

+5% "bonus"
(based on Part B prof. service fees)