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EDITORIAL COMMENT



The Centers for Medicare and Medicaid Services (CMS), the nation's largest single payer system, strives to provide quality care to vulnerable populations in a cost-effective manner.¹ Historically, care provision has been a numbers game where providers and health systems were incentivized based on the quantity of care. Value based care programs are evidence of a paradigm shift in evaluating care.

The authors importantly evaluate one such program – the Merit-Based Incentive program relative to physician spending. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established the quality payment program.¹ Under this program physicians are incentivized to provide high quality care to patients. It is estimated that starting in 2019 payments will be linked to quality and value under a Merit-based Incentive Payment System (MIPS), however, the complex manner in which the program is set up allows for payments to be affected nearly 4 years.

The authors reviewed average procedure-based payments utilizing Surveillance Epidemiology End Results (SEER) -Medicare data from urologists for 14,585 patients undergoing prostatectomy, nephrectomy, or cystectomy by 1,895 urologists between 2008 and 2012. They identified wide variation in physician-specific payments for the procedures, and unstable physician spending patterns over time. They conclude that cost-based measures in MIPS will be challenged to change behavior and to reliably distinguish between less efficient versus lower quality care.

The authors' raise valid concerns that variations across physician spending will impact efficiency of care delivery and quality metrics. Considering the challenges surrounding cost evaluations especially involving complicated programs such as the MIPS, it is difficult to accurately evaluate such a program in its infancy. CMS

has yet to finalize risk-adjustment of performance measures, an important measure as it relates to the MIPS program. The eight episode-based measures are currently being field-tested and are not included in 2017 or 2018 MIPS performance years.¹ They will then be shared with stakeholders for review and refinement, for use in later years, further complicating assessment of value-based care.

Identifying challenges and limitations of SEER-Medicare databases is important. Williams et al reported that inherent selection-bias because of unmeasured confounding variables limits interpretation of survival data for prostate cancer patients who undergo radical prostatectomy or radiotherapy.² It will be important to hone in on appropriate risk-adjustment measures. As the Institute of Medicine noted, more comprehensive patient-level data, including improved measures of comorbid conditions, will be needed to ensure high-quality cancer care.^{3,4}

Value based care is important for patients as it can translate to higher quality care, by rewarding providers for coordinated care and positive health outcomes. It may be a while before the system can truly be evaluated, however, findings from this study provide important insight into baseline concerns with the MIPS program. As the authors correctly note, this study provides more questions than answers—are the MIPS measures really valid? Are there better measures out there? Does the MIPS evaluation work for other programs? The study team has done an excellent job. However, more is needed before widespread clinical implementation.

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