Findings And Implications From MIPS Year 1 Performance Data

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The Centers for Medicare and Medicaid Services (CMS) recently published 2017 MIPS performance data from the first year of the Quality Payment Program (QPP). Implemented through the Medicare Access and CHIP Reauthorization Act of 2015, QPP is a value-based payment program with two participation options: the MIPS track and the Alternative Payment Model (APM) track.

MIPS is a nationwide pay-for-performance program that aims to reward clinicians who provide high-value care with upward professional services payment adjustments, while penalizing clinicians who do not with downward adjustments. As discussed in a previous post, multiple factors are used in MIPS payment adjustments, some of which are determined only after the end of the performance year. As a result, clinicians may find it challenging to estimate their expected payment adjustments and make informed choices regarding the appropriate QPP participation track. Examples of these complexities include dynamic composite performance score (CPS) thresholds that differentiate between high and low performers, scaling factors that ensure payment adjustments remain budget neutral, and funding earmarked for "exceptional performance."

Given Medicare's decision to roll out MIPS with low CPS thresholds, one concern is that the program could generate a relatively large number of high performers across whom payment adjustments could be spread (i.e., each high performer would receive relatively small bonuses that were smaller than generally publicized values), thereby undercutting participation incentives. Because clinicians' QPP participation decisions are partially driven by beliefs and expectations about performance, complexities in MIPS payment adjustments can pose significant implications for clinicians' QPP participation decisions. For example, clinicians who do not expect significant positive payment adjustments may opt out of MIPS, enrolling instead in one or more advanced APMs, each of which is governed by its own rules and requires participants to assume more financial risk.

The 2017 MIPS performance data included information about maximum and minimum payment adjustments and average CPS scores by practice setting and size (Exhibit 1). In this post, we highlight three findings from the 2017 MIPS performance year data and

discuss related policy implications, particularly in light of the recently released QPP Year 3 rule.

Findings From MIPS Year 1 Performance Data

Magnitude Of Payment Adjustments

In 2017, the maximum positive MIPS payment adjustment for any participants was +1.88%, an amount lower than the widely publicized value of +4%, and far lower than the theoretical maximum value of +22%. This validates concerns that the latter amounts may be unrealistic and unhelpful for informing clinicians' QPP participation decisions, at least in the transitional years of QPP. Moreover, the maximum positive adjustment for MIPS clinicians who were not exceptional performers (i.e., those who received a positive adjustment but did not exceed the exceptional performance CPS threshold of 70) was 0.20% -- further evidence of the limited financial gains early in MIPS.

Based on planned QPP program changes, CMS expects the maximum positive adjustment to increase over time (e.g., the agency estimates a +4.7% maximum adjustment in Year 3, inclusive of the exceptional performer bonus). These changes would produce financial incentives more consistent in magnitude with those available to clinicians in the APM track (i.e., +5% of professional services payments).

Certainty Of Payment Adjustments

Beyond information about magnitude, the MIPS Year 1 data also demonstrate the sizeable uncertainty associated with payment adjustments. In particular, beyond adjustment methodology issues (e.g., scaling factors, CPS thresholds), a clinician or group's individual MIPS performance is highly dependent on others clinicians' performance. For example, initially reported positive payment adjustments ranged up above +2% but were corrected downward to +1.88% after Medicare incorporated corrections of some clinicians' scores (e.g., as a result of additional score and eligibility verification and an appeals process).

This issue will only become more pronounced as MIPS evolves in coming years. Beginning in 2019, additional provider types such as physical therapists and nutritionists newly qualify for the program, and their performance will be incorporated into participants' scores and payment adjustments. This will increase the clinician pool and uncertainty in individual performance scores, especially as adjustments will be calculated across specialties. Moreover, other clinicians may enter MIPS from the APM track as its policies change. For example, the recent overhaul of the Medicare Shared Savings Program is expected to prompt significant program dropout, with clinicians defaulting back into MIPS. Finally, clinicians may face additional uncertainty about

payment adjustments as a result of future policy revisions (prior revisions delayed increases in the *Cost* domain weighting and the CPS threshold to avoid penalties).

Performance By Practice Size And Setting

One major take-away from the 2017 MIPS performance data is that larger and non-rural practices performed considerably better than their smaller and rural counterparts (Exhibit 2). In particular, many large practices qualified as exceptional performers (mean and median CPS of 74.37 and 90.29, respectively), while most small practices did not (mean and median CPS of 43.46 and 37.67, respectively). On average, rural practices performed worse than large practices (median CPS of 75.29 versus 90.29, respectively).

Nearly 1 in every 5 small practices in MIPS (19%) received negative payments adjustments compared to 5% of program participants overall (Exhibit 2). This could have occurred for a number of reasons, including limited ability to shoulder program reporting burden or a combined effect of inadequate risk adjustment in MIPS and high clinical or social complexity at smaller practices. Further research should examine why smaller practices appear to be at a systematic disadvantage, and policymakers consider measures to avoid unfairly penalizing these practices in MIPS.

Final Thoughts

The 2017 MIPS performance data suggest that many clinicians in the program will face uncertainty about reimbursement adjustments. Though the magnitude of positive adjustments is expected to increase with planned program changes, performance varied considerably by practice size. This fact underscores the urgency facing policymakers to both support additional research and consider policy measures that support clinicians in smaller practices as they move towards value-based payment and care. In an upcoming post, we will discuss several ways Medicare can achieve this in the MIPS program.