Embrace the MIPS Additional Payment Adjustment for Exceptional Performance

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Many healthcare practices are assessing their return on investment for engaging resources designed to improve performance under the Centers for Medicare and Medicaid Services' (CMS) Merit-based Incentive Payment System (MIPS) program. One area of MIPS, the additional positive payment adjustment, should be on the radar of providers for the financial benefits it grants for providing quality care. This article will review how MIPS payment adjustments are determined, with an emphasis on the additional positive payment adjustment for exceptional performance. It will also briefly touch upon strategies that may help practices achieve relatively high MIPS performance.

'Standard' MIPS Payment Adjustment

For clarity, this article will refer to the MIPS payment adjustment that may be negative, neutral, or positive as the "standard" MIPS payment adjustment. These payment adjustments are determined by comparing a practice's total MIPS score to a performance threshold that is established by CMS each year.[1] The applicable payment adjustments gradually increase in the first four years of MIPS from +/- four percent in the 2019 payment year to +/- nine percent in the 2022 payment year.

The payment adjustments for each practice are based upon performance during the corresponding performance year. For example, practices that achieve a perfect MIPS performance score of 100 points in 2017 could see positive payment adjustments of four percent for each Part B Medicare paid claim in 2019. See the table below charting the payment adjustments under MIPS for the performance and payment years.

Table 1: Payment Adjustments Under MIPS

Payment Adjustment Range	Performance Year	Payment Year
+/- 4 percent	2017	2019
+/- 5 percent	2018	2020
+/- 7 percent	2019	2021
+/- 9 percent	2020 (and beyond)	2022

Overall, the standard MIPS payment adjustments must remain budget neutral. For this reason, a reduction in the number of practices subject to negative payment adjustments will result in fewer funds being available to support positive payment adjustments.

Conversely, if a high percentage of practices are subject to negative payment adjustments and additional funds are available for positive payment adjustments, CMS can apply a scaling factor that cannot exceed three times the established applicable payment adjustment for a given year. For example, if a practice were to achieve a perfect score of 100 in the 2020 performance year and adequate funds were available from the negative payment adjustments, the practice could in theory receive a positive payment adjustment of up to 27 percent (three times nine percent) for all payments in 2022. However, this scenario is not likely to occur—particularly in 2017, the first year of the MIPS program.

Using a special rule in the Medicare and CHIP Reauthorization Act of 2015 (MACRA), during the first two years of MIPS CMS may establish the MIPS performance thresholds. In future years, and no later than the 2019 performance year, CMS is required to establish the MIPS performance threshold based on the mean or median scores for all MIPS participants in a prior performance period.

In order to assist with the transition process into MACRA, CMS has established the performance threshold for 2017 at three points. This will limit the number of practices that fall below the performance threshold and, consequently, the amount of available funds for positive payment adjustments.

This means that very high-performing practices with MIPS scores of 100 points will see payment adjustments significantly lower than the applicable payment of four percent established by MACRA for performance year 2017. Practices may feel that the level of effort and resource expenditure required to reach this performance level may not be offset sufficiently by the "standard" positive payment adjustments, as it may not even reach two percent for very high performers. However, the additional payment adjustment for exceptional performance, which is discussed below, may be a source of significant revenue for practices.

The MIPS performance threshold for the 2018 performance year has not been established, but CMS did state in the MACRA Final Rule that it intends to increase the standard MIPS performance threshold in the 2018 performance year. In future years, and no later than the 2019 performance year, the MIPS performance threshold will be based on the mean or median of the final scores for all MIPS clinicians for a prior period. The performance thresholds will be published prior to the performance year either in a final rule or on the CMS website.

Additional MIPS Positive Payment Adjustment

MACRA provides for an additional positive MIPS payment adjustment factor for exceptional performance, which is in addition to the "standard" positive payment adjustment for performance above the MIPS threshold. These additional funds are derived from a pool of $500 million per year for the first six years of the MACRA program. They represent allocated funds (i.e., they do not require budget neutrality) and are not funded by negative payment adjustments assigned to MIPS practices that do not achieve the MIPS performance threshold.

MIPS-eligible clinicians and groups will receive an additional positive payment adjustment if they achieve or exceed an established additional payment threshold based on their overall MIPS composite performance score. Starting in the 2019 performance year CMS is required by MACRA to establish the performance threshold at 25 percent above the MIPS performance threshold. For example, if the MIPS performance threshold for a given year is 60 points, the additional payment threshold will be set at 25 percent of the possible remaining points (i.e., from 60-100 points), meaning the performance threshold would be set at 70 points.

The additional positive payment adjustment starts at 0.5 percent and then rises on a linear scale to reach as high as 10 percent for practices that achieve a MIPS score of 100 points. If a large number of practices achieve or exceed the additional payment threshold, however, then the distribution may be diluted to some degree due to a cap of $500 million per year for exceptional performers. Under these circumstances a perfect score of 100 may not yield the full 10 percent additional payment adjustment.

Additional Payment Adjustment in 2017, 2018 Performance Years

Under the same special rule mentioned above for the "standard" applicable payment adjustments, during the initial two years of MIPS the Department of Health and Human Services may establish performance thresholds for the additional positive payment adjustment. The MIPS additional performance threshold for exceptional performance has been established at 70 points for the 2017 performance year. CMS stated that this figure was chosen based on a review of available performance Physician Quality Reporting System (PQRS), Value Modifier Program (VM), and "meaningful use" Electronic Health Record (EHR) Incentive Program data from 2015.

The additional positive payment adjustment associated with exceptional performance may represent the most significant opportunity for substantial financial rewards for highly performing practices. In theory, if a practice were to achieve a MIPS score of 85 points in 2017 they would be eligible for as much as an additional five percent positive payment adjustment in addition to their "standard" payment adjustment. However, as noted previously, this would depend on the number of practices and clinicians that achieved this level of performance. If a relatively small number of clinicians meet or exceed a score of 70 points in 2017, practices that have achieved exceptional performance may see significant positive payment adjustments during the 2019 payment year.

The additional positive payment adjustment is added to the "standard" payment adjustment. Using the above example, where a practice achieves a MIPS score of 85 in 2017, the practice would be eligible for a small "standard" positive payment adjustment, potentially in the realm of one percent or lower. However, this score may allow the practice to qualify for up to an additional five percent payment adjustment for exceptional performance. In this hypothetical example, the practice would receive a one percent positive payment adjustment for MIPS performance and an additional five percent for "exceptional" performance. For this reason, practices that achieve a score of 85 MIPS points in 2017 may expect to receive a positive payment adjustment of approximately six percent for each Part B Medicare claim submitted in 2019.

Payment Adjustments in 2019-2022 Performance Years

As noted above, starting in the 2019 performance year the "standard" MIPS performance threshold will be based upon performance across the entire spectrum of MIPS-eligible clinicians and groups. A larger number of practices will be subject to a negative payment adjustment, increasing the pool of funds available for positive payment adjustments. Practices with high performance should then see more significant "standard" positive payment adjustments. For example, a practice that achieves 100 points in the 2019 performance year may be eligible for a seven percent "standard" positive payment adjustment during the 2021 payment year and an additional 10 percent positive adjustment for exceptional performance.

Also, as noted, CMS is required to establish the additional payment adjustment threshold for exceptional performance at 25 percent above the MIPS performance threshold, starting with the 2019 performance year. For example, if the aggregated MIPS performance threshold is 70 points for a given year, the threshold for additional positive payment adjustments for exceptional performance will be established at 77.5 points.

CMS will continue to pay practices from this fund through the 2024 payment year. Following this, the "standard" payment adjustment that will have reached +/- nine percent by this time will continue indefinitely. However, the 3x multiplier that would allow the "standard" positive payment adjustment to be tripled, as described earlier, continues indefinitely.

Strategies to Achieve Exceptional MIPS Performance

As reviewed elsewhere, MIPS scores depend on performance in four categories: quality, advancing care information, improvement activities, and cost.[2] In 2017 the quality category has a weight of 60 percent, the advancing care information category has a weight of 25 percent, improvement activities have a weight of 15 percent, and cost has a weight at zero percent. In the 2018 performance year quality is weighted at 50 percent, advancing care information has a weight of up to 25 percent, improvement activities remain at 15 percent, and cost is weighted at 10 percent. These numbers shift in the 2019 performance period, with quality and cost both being weighted at 30 percent, advancing care information weighted at up to 25 percent, and improvement activities remaining at 15 percent.

Quality Performance Category

Based on these weightings, quality performance, which is very similar to PQRS, is the most heavily weighted performance category in the first two years of MIPS, but it also remains at a minimum equivalent to all other performance categories for the duration of the program. Quality reporting requires practices to choose six quality measures (including at least one outcome or high priority measure) and to report performance on each measure. Performance is determined based on the raw performance score for each measure and then compared to benchmarks that vary based on reporting mechanism. Practices will need to carefully select measures that they feel they can achieve high performance. If a measure's benchmark is significantly elevated it will be difficult to obtain high performance scores for that measure.

CMS has published a spreadsheet of benchmarks for quality measures. Some quality measures that have been approved for use in the MIPS program in 2017 do not have benchmarks. CMS has stated that these benchmarks will be determined based on data submitted during the performance year. If inadequate data is reported, however, then the measure will be scored at three out of a possible 10 points. For this reason, it may be in the practice's best interest to select measures that have established benchmarks—in particular benchmark performance values that the practice feels it can surpass.

In 2017 the reporting period will be a minimum of 90 days if practices wish to achieve high performance scores. CMS requires that performance measure data be submitted on 50 percent of all applicable patients regardless of payer. In 2018 a longer reporting period will likely be established and data pertaining to 60 percent of all patients, again regardless of payer, seen during the performance period that meet the measure's requirements will need to be reported.

In summary, since the quality performance category has such a high weighting for the first two years of the MIPS program, practices may need to focus efforts on optimizing their quality performance through informed selection of measures, establishing workflows that encourage high measure performance, modifying clinical content within electronic health records to facilitate the capture of measure-related information, and maintaining ongoing due diligence with providers to ensure that measures are being addressed.

Advancing Care Information Performance

The Advancing Care Information (ACI) performance category of MIPS replaces the "meaningful use" program for Part B Medicare. In 2017 practices are allowed to use health IT technology certified by CMS for either the 2014 or 2015 edition. All practices will need to move to the 2015 edition, which meets the stage 3 "meaningful use" requirements, in 2018. The majority of practices are familiar with the 2014 edition as it was used for "meaningful use" reporting in 2016.

ACI performance is divided into two components; a base score and a performance score (with bonus measures) that are both equally weighted at 50 percent of the total ACI score. Achieving a 100 percent score in the ACI performance category would award the practice 25 total MIPS performance points.

Achieving the base score requires relatively minimal activities, and most practices are anticipated to achieve at least 50 percent of the ACI performance points. The performance and bonus component of ACI will be significantly more challenging. It requires high performance on measures such as sending summary of care records during patient transitions, having patients review, download, and/or transmit the data electronically, and other measures. There are additional bonus points available for using certified EHR technology for certain improvement activities and for interfacing with a public health registry.

High performance in the ACI category will require workflows and training related to transitioning from a pass/fail system for meeting the "meaningful use" objectives in 2016 to a performance process in 2017 and beyond. It may also benefit from best EHR practices and the customization of relevant clinical content. Practices are encouraged to look at their "meaningful use" performance metrics in 2016 to identify areas that require additional focus. The minimum ACI reporting period is 90 days in the 2017 and 2018 performance years, but this will likely increase in 2019 and later years.

Improvement Activities Performance Category

The requirements for achieving high performance in this category depend on practice size. Smaller practices of less than 16 clinicians need to attest they were engaged in two medium weighted or one highly weighted improvement activity for a minimum 90-day period in 2017. This will qualify them to receive the full 15 MIPS points allocated to this performance category. Practices that attest for only one medium weighted improvement activity will receive a 50 percent score in this category, which translates to 7.5 total MIPS points. Larger practices (16 or more clinicians) need to, at a minimum, report on four medium weighted improvement activities or two highly weighted activities to achieve the maximum score.

In 2017, reporting performance in the improvement activities category is limited to attestation. In the future, this may change to data reporting, which has the potential to make scoring in this performance category more difficult.

Cost Performance Category

Scoring in this category depends on Part A and Part B expenditures for certain types of specified "Episode-based Cost Measures" that can be attributed to an individual clinician or group. Expenditures are also risk-adjusted, meaning that patients who are identified as having higher risk-adjusted scores will have anticipated higher levels of cost. CMS will take this into consideration when determining cost performance scores for practices.

Practices can influence performance in this category by ensuring that the patient's overall health is accurately represented through the submission of the most complete, accurate, and specific ICD-10-CM codes. This will allow CMS to determine the appropriate risk-adjusted score. In addition, practices may wish to consider engaging in coordination of care efforts that reduce the number of preventable admissions to hospitals and other cost saving approaches.

Patience May Reward Higher Payment Adjustments

This article discusses factors that may influence positive payment adjustments under the MIPS, and how they will evolve over time. It may help practices make budgetary decisions that include investment in MIPS performance optimization activities, goals, and potential earnings.

Given that this is the first year of MIPS, a significant amount of uncertainty remains as to the potential financial rewards that may accompany high performance. Many practices are aligning their efforts to achieve high MIPS scores and optimal positive payment adjustments. However, in the first two years of MIPS the most significant source of these adjustments may be related to exceeding the exceptional payment thresholds. Following these additional payment adjustments will remain important and supplement potentially larger "standard" MIPS payment adjustments.

Notes

1. Centers for Medicare and Medicaid Services. "Executive Summary: Medicare Program; Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Model." October 14, 2016.
2. Marron-Stearns, Michael. "How MACRA Changes HIM." *Journal of AHIMA* 88, no. 3 (March 2017): 18-20.

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Article citation:
Marron-Stearns, Michael. "Embrace the MIPS Additional Payment Adjustment for Exceptional Performance" *Journal of AHIMA* 88, no.6 (June 2017): 30-33.