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ACROinsights – MIPS – The Dollars of Quality Care

The goal of this series of articles is to ensure that radiation oncologists are aware of and provided with the knowledge to ensure day-to-day processes are being addressed in a compliant manner. This installment will discuss results of the Medicare Merit-based Incentive Payment System and analyses of its "success" so far. The information contained within this ACROinsights article is meant as general guidance and is not intended to replace appropriate legal or authoritative guidance.

Focus on Quality vs. Quantity

The Merit-based Incentive Payment System (MIPS) was initiated on January 1, 2017, having been required as an element of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), signed into law on April 16, 2015. MACRA was designed to strengthen access to Medicare by improving how physicians and other clinicians were paid for services, by incorporating quality measurements into the payments and incentivizing participation in Alternative Payment Models (APMs). At its core, MACRA, established a transition from the traditional Fee-for-Service (FFS) reimbursement model under the Medicare Physician Fee Schedule (MPFS) to the Quality Payment Program (QPP).

MIPS was established with four categories through which eligible clinicians could be measured on the quality of care, Quality, Improvement Activities, Advancing Care Information, and Cost. Initially the program was designed with a 2-year testing period. The payment period, including penalties, began in 2019. Financially, MIPS was established as a budget neutral program. Any monies paid to eligible clinicians who met or exceeded the performance thresholds were generated by penalties assessed against those providers who did not meet the performance thresholds.

Return on Investment

As part of MACRA, the Government Accountability Office (GAO) was tasked with examining the MIPS program. Their report, *Medicare Provider Performance and Experiences under the Merit-based Incentive Payment System,* GAO-22-104667[1], was released to Congress in October 2021 and focused on performance years 2017-2019, which was the only available data at the time. The findings of the report highlighted several unsurprising conclusions: 1) positive payment adjustments were significantly under what had been anticipated and did not match the administrative burden for many to participate, and 2) lack of proof that any actual improvement in clinical quality had been attained.

The final score data from CMS reflects that at least 93% of providers earned a small positive payment adjustment for performance years 2017-2019. Of those that received a positive adjustment, 72 to 84% also qualified for an exceptional performance bonus, which varied over the three years. For 2019 alone, 950,000 Medicare Part B providers, which is nearly half of the total number of providers, were eligible to participate in MIPS. Any budget neutral program in which there is a disproportionate number of providers who are funding the program, opposed to those benefiting from the program, is going to create a scenario where any positive benefit is severely limited by any negative.

An article in the *Oncologist*, February 2023, "Oncologist Participation and Performance in the Merit-Based Incentive Payment System"[2] analyzed MIPS data of oncologists. Compared to other specialties, the authors

[1] United States Government Accountability Office (GAO), MEDICARE Provider Performance and Experiences under the Merit-based Incentive Payment System, GAO-22-104667, https://www.gao.gov/assets/gao-22-104667.pdf.

[2] Patel VR, Cwalina TB, Gupta A, Nortjé N, Mullangi S, Parikh RB, Shih YT, Hussaini SMQ. Oncologist Participation and Performance in the Merit-Based Incentive Payment System. Oncologist. 2023 Apr 6;28(4):e228-e232. doi: 10.1093/oncolo/oyad033. PMID: 36847139; PMCID: PMC10078897.

found oncology had a lower participation in MIPS than other specialties, 86% (14,211 out of 16,511 oncologists) compared to all-specialties at 97%. Radiation oncologists were estimated to account for approximately 24.2% of the eligible oncologists, second to hematology oncology with 46.1% participation. Oncologists participating in alternative payment models (APMs) had higher final scores than oncologists who did not, point totals of 91 to 77.6 respectively.

The following table combines data from the GAO report, which reflects the potential payment adjustments, established thresholds, achieved scores, the actual negative adjustments assessed and the resulting positive payment adjustments with and without exceptional performance bonus. Based on the data of the first three years of the MIPS program, the ability to achieve thresholds was easy and/or the expectation of payment adjustments was such that providers participated in greater numbers than properly planned.

Year	Thresholds and Potential Adjustments			Actual Amounts of Penalties and Payments			
	Performance threshold	Exceptional performance threshold	Range of potential payment adjustment (percent)	Median MIPS Final Score 2017-2019	Negative	Positive without an exceptional performance bonus	Positive with an exceptional performance bonus
2017	3	70	-4.00 to 4.00	89.7	-4.00 to -2.11	0.00 to 0.20*	0.28 to 1.88
2018	15	70	-5.00 to 5.00	99.6	-5.00 to -0.01	0.00 to 0.20*	0.20 to 1.68
2019	30	75	-7.00 to 7.00	92.3	-7.00 to 0.00*	0.00 to 0.00*	0.00 to 1.79*
2020	45	85	-9.00 to 9.00				
2021	60	85	-9.00 to 9.00				

*According to CMS officials, in some cases, payment adjustments may be so small that they round to 0.00 percent.

A physician who received $105,000 in MPFS payments for performance year 2017, would only receive a $1,974 increase for the maximum payment adjustment for exceptional performance paid in 2019. For performance years 2018 and 2019 with same scenario, the additional payments would be $1,764 and $1,879 respectively. Likely not the anticipated positive payment adjustment radiation oncologists were expecting.

The Good and the Not so Good

The thresholds established as part of the MIPS program allowed many independent practice physicians or smaller group practices to participate and in a more equitable way. While the data support solo providers and small practices (2-15 providers) tended to score lower than medium (16 to 99 providers) and large (100 or more providers) practices, the gap in median scores closed significantly following performance year 2017. This allowed many of these providers to participate, instead of being overshadowed by larger counterparts.

Exemptions for participation were provided for providers who do not see patients face-to-face. Measures requiring reporting of these types of interactions would put many specialists, such as radiologists, at risk of not meeting thresholds and being negatively impacted. By allowing for reweighting of final scores, these providers could also participate in a manner relative to the services they provide.

For a program designed to promote “quality of care” provided to Medicare beneficiaries, the administrative burden, lack of timely or meaningful feedback, and heavy focus on generality created a scenario of work for the sake of work. Perhaps more significant is that as more program data becomes available, there is increasing evidence that measurable “quality” related to the required interventions failed to improve.

The administrative and financial costs for many single practitioners and small practices to be eligible to participate far exceeded any positive payment adjustment received thus far. This also includes ensuring staff are familiar with and reviewing yearly updates, ensuring accurate and appropriate capture, and reporting of measures, and identifying when any adjustments did not match expected amounts and filing appeals.

Lack of any timely or meaningful feedback from CMS has also been an issue. There is a lag in the time CMS calculates the final score to the time any feedback or information is provided, typically this lag occurs well into the next performance cycle and the opportunity to make changes or adjustments is lost. Additionally, many providers have no idea how they measure against their colleagues within the same specialty or geographic area. Without any idea how a provider's performance is measured, there is little or no incentive to make any significant or meaningful changes.

For many specialties there is also a lack of specific measures. Many measures remain generalized, and specialties like radiation oncology have over the course of MIPS had only 3-4 specialty-specific measures. While there are other measures in the oncology or general medicine space, this lack of specificity continues to highlight concerns regarding the program to certain disciplines. The lack of opportunity to gather meaningful data at a specialty-specific level is lost.

Following the release of the GAO's report and feedback from stakeholders, CMS has changed the MIPS program. Performance thresholds have been increased, 75 points to qualify for exceptional performance bonus in 2023 and proposed to be 82 points for performance year 2024. Final scores of 0-20.5 points would see a -9% payment adjustment; scores 20.51-81.99 points, a negative MIPS payment adjustment greater than negative 9% and less than 0% on a linear sliding scale; scores of 82 points would see no adjustment, and scores 82.01-100 points would see payment adjustment >0% on a linear sliding scale ranging from 0-9% for scores of 86-100 points. The positive payment adjustment would be determined by a scaling factor not to exceed 3.0 to preserve budget neutrality.

If the thresholds are higher, the expectation is fewer providers will qualify for positive payment adjustments, thereby creating a larger pool of monies available because more providers would be assessed negative adjustments. There is money to be had, but determining whether the positives outweigh the negatives is the bigger decision.

Setting Yourself Up for Success

Physicians should be aware of the tools available and utilize them to promote their success within the program. The four measures specific to radiation oncology have been the same for the past few years, it is anticipated they will remain for performance year 2024 but will know when the final rule is published in November 2023. The four measures are:

- 143- Oncology: Medical and Radiation - Pain Intensity Quantified
- 144 - Oncology: Medical and Radiation - Plan of Care for Pain
- 226 - Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- 102 - Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients

Eligible clinicians have three options for reporting in performance year 2023, Traditional MIPS, Alternative Payment Model (APM) Performance Pathway (APP) or MIPS Value Pathways (MVPs). The *2023 MIPS Quick Start Guide*[3] provided by CMS reviews the methods for reporting measures.

The Take Home Message

Radiation oncologists have seen the initiation of the MIPS program and the attempt at an alternative payment model to advance quality care for Medicare beneficiaries, and ultimately all oncology patients. The requirements for radiation oncologists to get appropriately paid for the work and care they provide continues to increase, leaving many to question the stability of future reimbursement. As a specialty we may now have an opportunity

[3] Center for Medicare and Medicaid Services, Quality Payment Program, 2023 MIPS Quick Start Guide, https://qpp-cm-prod-content.s3.amazonaws.com/uploads/2219/2023%20MIPS%20Quick%20Start%20Guide.pdf

to participate in setting metrics and defining quality care. It is critical that working as a collective specialty, we do not waste this opportunity.