The Merit-based Incentive Payment System (MIPS): A Primer for Otolaryngologists

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Abstract
Following passage of the 2015 Medicare Access and CHIP Reauthorization Act, most clinicians caring for Medicare Part B patients were required to participate in a new value-based reimbursement system known as the Merit-based Incentive Payment System (MIPS) beginning in 2017. The MIPS adjusts payment rates to providers based on a composite score of performance across 4 categories: quality, advancing care information, clinical practice improvement activities, and resource use. However, factors such as practice size, setting, informational capabilities, and patient population may pose challenges as otolaryngologists endeavor to adapt to this broad-reaching payment reform. Given potential barriers to adoption, otolaryngologists should be aware of several important initiatives to help optimize their performance, including advocacy efforts by the American Academy of Otolaryngology—Head and Neck Surgery, the development of otolaryngology-specific MIPS quality measures, and the launch of a Centers for Medicare & Medicaid Services—qualified otolaryngology clinical data registry to facilitate reporting.

Keywords
otolaryngology, MIPS, MACRA, accountable care organization, alternative payment model

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In 2015, US Congress passed the bipartisan Medicare Access and CHIP Reauthorization Act (MACRA; Table 1), which ended the controversial sustainable growth rate formula for updating physician fees and mandated the Centers for Medicare & Medicaid Services (CMS) to implement a new value-based reimbursement system known as the Quality Payment Program. Beginning in 2017, more than 600,000 clinicians (including physicians, physician assistants, and nurse practitioners) caring for the 55 million patients enrolled in Medicare Part B were required to participate in 1 of 2 tracks under the Quality Payment Program (QPP)—the Merit-based Incentive Payment System (MIPS) or an advanced alternative payment model (APM), such as an Accountable Care Organization (Figure 1).1 Most clinicians (nearly 90% of QPP providers) participated in MIPS—the default track—and will receive payment adjustments (–4% to 4%, with additional positive adjustments for exceptional performers) from CMS in 2019. These adjustments are based on a composite score of performance in 2017 across 3 categories: quality, advancing care information, and clinical practice improvement activities (CPIAs); CMS began evaluating resource use as an additional performance category in January 2018.2 Providers may elect to report on performance measures as individuals or within a group.

The year 2017 served as a transition year for MIPS, during which CMS permitted providers to pick their own pace for participation.2 MIPS performance in 2017 predominantly depended on the quality category, which accounted for 60% of the composite score and accounts for 50% in 2018 (Figure 2).3 Providers are required to select at least 6 of nearly 300 quality measures, which focus on aspects of care such as appropriate use, patient experience, and clinical outcomes.4 Performance on each measure is largely determined relative to historical benchmarks.2

The remainder of composite scoring in 2017 was based on advancing care information (25%) and CPIAs (15%). To advance care information under MIPS, providers are...
Table 1. Key Terminology Describing Medicare Access and CHIP Reauthorization Act.

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<th>Term</th>
<th>Definition</th>
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<td><strong>Legislation</strong></td>
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<td>Medicare Access and CHIP Reauthorization Act (MACRA)</td>
<td>Bipartisan legislation enacted by the US Congress in 2015 that repealed the sustainable growth rate formula for updating physician fees and mandated the Centers for Medicare &amp; Medicaid Services (CMS) to replace fee-for-service reimbursement with value-based payment models.</td>
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<td>Sustainable growth rate (SGR)</td>
<td>Formula used by CMS to annually update the physician fee schedule between 1997 and 2017. Under this system, physicians were subject to across-the-board payment reductions when Medicare expenditures exceeded target costs predicted by the sustainable growth rate formula. However, due to the political unpopularity of such cuts, Congress regularly implemented fee increases known as “doc fixes” instead.</td>
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<td>Quality Payment Program (QPP)</td>
<td>Pay-for-performance quality incentive program for Medicare Part B clinicians established under MACRA. Clinicians may choose from 1 of 2 tracks in the QPP: the Merit-based Incentive Payment System or advanced Alternative Payment Models.</td>
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<td><strong>Value-based payment models</strong></td>
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<td>Merit-based Incentive Payment System (MIPS)</td>
<td>The default track for clinician participation in the Quality Payment Program. MIPS adjusts future payment rates for Medicare Part B services based on composite performance across 4 domains: quality, advancing care information, clinical practice improvement activities, and resource use.</td>
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<td>Advanced Alternative Payment Model (APM)</td>
<td>The alternative track for clinician participation in the Quality Payment Program. To participate in advanced Alternative Payment Models, organizations are required to use certified electronic health technology, report quality measures comparable to MIPS, and bear more than “nominal” financial risk for performance. Few CMS reimbursement models (eg, the Next Generation Accountable Care Organization) are considered advanced Alternative Payment Models. Providers participating in advanced Alternative Payment Models are eligible for additional financial incentives.</td>
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<td>Accountable Care Organization (ACO)</td>
<td>Groups of hospitals and health care providers who voluntarily provide coordinated care to patients in an effort to improve quality and reduce costs. These organizations typically share achieved savings with payors and may bear financial risk if pay-for-performance targets for quality and cost are not met.</td>
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Figure 1. Centers for Medicare & Medicaid Services Quality Payment Program. ACO, Accountable Care Organization; APM, Alternative Payment Model; MIPS, Merit-based Incentive Payment System. *2018 exemption criteria.
required to attest to 5 mandatory activities (protecting health information, e-prescribing, providing patient access to electronic records, and sending/accepting summaries of care) and may earn additional points for completing other activities, such as secure electronic messaging with patients and clinical data registry reporting; this MIPS category supersedes the Meaningful Use program. For the CPIA category, providers may attest to completing up to 4 of over 90 prespecified activities focused on care coordination, beneficiary engagement, and patient safety. Resource use is determined on a per beneficiary basis relative to spending by other providers. These costs will account for 10% of composite scoring in 2018 and 30% in 2019.

Challenges for Otolaryngologists

Otolaryngologists serving Medicare patients are now, with few exceptions, required to fully participate in MIPS. However, many practices may struggle when selecting among quality measures, as few of the available metrics are of relevance to otolaryngology, and applicable measures (eg, avoidance of imaging in acute sinusitis) may be more appropriate for initial care by primary care providers rather than complex cases referred to otolaryngologists. Moreover, factors such as practice size, setting, informational capabilities, and patient population may pose challenges as otolaryngologists endeavor to adapt to payment reform. Given that approximately half of otolaryngologists are employed in solo or group practice, individuals or small groups may lack the financial stability to incur negative payment adjustments or fixed (eg, administrative) costs necessary for compliance. Moreover, these practices may not possess the infrastructure to perform activities relating to advancing care information (eg, sharing of medical records or e-prescribing) or analytic expertise to optimally select and measure quality metrics; an estimated one-seventh of otolaryngologists practices without electronic health records. Even large, sophisticated (eg, hospital-based or academic) practices may encounter difficulties securing adequate return on investment for MIPS-related quality improvement activities, particularly as measures and benchmarks are annually updated and initial positive payment adjustments are anticipated to be modest. The performance of such practices may further be affected by an influx of socially or medically complicated patients from providers less able to assume financial risk.

The Way Forward

Given these potential barriers to MIPS adoption, otolaryngologists should be aware of several important initiatives to help optimize their performance. First, advocacy groups of several medical specialties, including the American Academy of Otolaryngology—Head and Neck Surgery (AAO-HNS), have already successfully advocated CMS to reduce the burden of reporting requirements, exempt additional low-volume providers from participation, and provide bonuses for practices that are small or treat complex patients. Moving forward, the AAO-HNS is encouraging CMS to further develop methods of patient attribution and risk adjustment in anticipation of increased scoring emphasis on cost.

Second, otolaryngologists may select performance metrics applicable to their practice from a specialty-specific quality measure set developed by the AAO-HNS and CMS. There are currently 18 quality measures within the otolaryngology-specific set (see Supplemental Table S1 in the online version of the article), such as rates of appropriate antibiotic therapy prescription in acute otitis externa and overimaging in chronic sinusitis. The validation of
additional quality measures, including metrics related to conditions such as dysphonia, posttonsillectomy bleeding, and cerumen impaction, is under way.10

Third, otolaryngologists may report MIPS performance through a CMS-qualified clinical data registry sponsored by the AAO-HNSF. In addition to measures within the otolaryngology-specific quality measure set, the registry allows otolaryngologists to report on 26 other metrics, such as rates of biopsy follow-up, antibiotic prescription in children with otitis media with effusion, and sleep symptom documentation in patients with obstructive sleep apnea.10 Otolaryngologists may additionally leverage the registry to earn a 5% bonus in their advancing care information score and complete CPIAs, including high-weighted activities such as utilization of patient-reported outcome measures (PROMs).5,9

Conclusion

MIPS is the largest pay-for-performance program in the history of health care.1 The quality of otolaryngology care is now being measured and reported with direct financial ramifications. As unintended consequences of the legislation come to light and CMS continues to refine reimbursement policies, otolaryngologists will need to embrace change rapidly in order to thrive in the era of value-based care.

Author Contributions

Vinay K. Rathi, study conception and design, drafting the article, revising manuscript critically for important intellectual content, final approval; Matthew R. Naunheim, study conception and design, drafting the article, revising manuscript critically for important intellectual content, final approval; Mark A. Varvares, study conception and design, drafting the article, revising manuscript critically for important intellectual content, final approval; Kenneth Holmes, study conception and design, drafting the article, revising manuscript critically for important intellectual content, final approval; Nancy Gagliano, study conception and design, drafting the article, revising manuscript critically for important intellectual content, final approval; Christopher J. Hartnick, study conception and design, drafting the article, revising manuscript critically for important intellectual content, final approval.

Disclosures

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Supplemental Material

Additional supporting information is available in the online version of the article.

References