MIPS bonus threshold sticks at 75, as lower APM bonuses signal hurdles to come

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Quality Payment Program

The Quality Payment Program (QPP) changes in the final 2024 Medicare physician fee schedule deliver a reprieve to the Merit-based Incentive Payment System (MIPS) performance threshold but bring cuts to other value-based programs, with worse possibly to come.

One of the big takeaways from the final rule is that CMS is retaining the MIPS performance threshold for 2024 at 75 points. A new floor of 82 points, based on mean clinician scores in 2017-2019, had been proposed in July. That was, in itself, a concession, as CMS had originally planned to make it 86. But the agency noted that the basis years were a bad metric for provider performance during the COVID-19 pandemic.

“During the pandemic, only those who felt they could earn an incentive would submit data for MIPS — the rest would apply, and receive, Extreme and Uncontrollable Circumstance (EUC) Exemptions,” explains Dave Halpert, chief, client team of Roji Health Intelligence in Chicago. “That artificially inflated average MIPS scores. This is the first post-PHE rule, meaning that EUCs will be harder to come by than in the last three years. Practices and providers coming back to MIPS after that sort of extended absence will already be challenged to meet existing standards, and ratcheting that standard an additional notch would have been too much, given the 30% weight for both cost and quality, and finicky year-to-year quality measure updates.”

But don’t count on CMS extending the 75-point floor another year. “We continue to believe that once MIPS eligible clinicians have been given at least one complete year of performance after expiration of the COVID-19 PHE, as clinicians gain more experience with MIPS, and as more recent data are available, we should incorporate more recent data in determining the performance threshold,” the final rule states.

Mara McDermott, CEO of Accountable for Health, a Washington D.C.-based advocacy organization committed to accelerating the adoption of effective accountable care, cites reports that “for the first time this year, there are organizations receiving bonuses north of 8% — which is a pretty dramatic departure from what we’ve seen [in MIPS bonuses] historically, which has hovered around 2%.”

At the same time, the maximum MIPS penalty has ballooned to 9%. “For so long MIPS was mostly something you could kind of ignore as a competing incentive with APMs because the bonuses were so small,” McDermott says. “But if it’s that kind of money at stake, that’s no longer true.”

APMs take cut, but how much?

In 2022, QPP Advanced APM QPs, which had been rewarded with annual 5% bonus payments for meeting program requirements, were rescued from a bonus-free 2025 by last-minute legislation (*PBN 11/14/22*). That was necessary because MACRA, the law that created the QPP and mandated a transition from straight bonuses to a payment adjustment based on the fee schedule, had a gap in it.

But now the rubber meets the road: Next year the bonus drops from 5% to 3.5%, and starting in 2025 — the year that had the payment gap — QPs will instead get a 0.75% increase in their Medicare Part B payments. That will probably mean a haircut for many APMs in the program.

But all is not lost. McDermott points to some draft legislation that just came out of the Senate Finance Committee, which includes an APM bonus extension of 1.75% to go on top of the first conversion-factor year — 1.75% plus 0.75%, in other words (*see resource, below*).

But for 2024, Advanced APM participants will just have to bite the bullet.

While 3.5% is “not what they’d hoped,” Halpert expects ACOs in the model “will press on, as the cap on regional benchmarks and health equity adjustments can generate shared savings in excess of that missing 1.5%.” The alternative of jumping to MIPS “is even more risky, given the higher data completion threshold for quality measures, and the uncertainty that still surrounds MIPS Cost Measures,” Halpert says.

Individual QPs: Not yet

Contrary to an earlier proposal, Advanced APM QP status will still be made at the APM Entity exclusively, with no option to be a QP at the individual clinician level. Halpert says this is meaningful especially to specialist clinicians in multispecialty practices.

"CMS is trying to balance the 'free rider' scenario," he says — that is, those who receive QP status based on their fellow clinicians' practice and thus avoid accountability. It also avoids the "dilution" scenario, "where a provider is critical for the APM's success, but may not meet APM payment thresholds as an individual. Maintaining the status quo shows that CMS is more concerned about dilution, and the effect that it would have on APM participation."

McDermott thinks that, this being "such a time of change with regard to Advanced APM policy, with the bonus expiring and the shift to the conversion factor update in 2026," CMS may not have thought the time was right to fiddle with the QP calculus.

MVPs on the move

CMS added measures to its MIPS Value Pathways (MVP) alternative reporting path, but has not said when they might make it mandatory.

MVP reporters pick one of 16 pathways and report its requirements. For example, one of the five new MVPs, Women's Health, includes 17 quality measures, such as Cervical Cancer Screening, Appropriate Workup Prior to Endometrial Ablation, and Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture. All data for the measures are collected via MIPS CQMs specifications, putting participants in sync with the new CMS guidelines proposed to be mandatory for Shared Savings ACOs in 2025 *(see related story, p. 9)*.

Participants must fulfill four Quality measures and one high-weighted or two medium-weighted Improvement Activities (IA). The Women's Health IAs include Implementation of a Trauma-Informed Care (TIC) Approach to Clinical Practice, Use of Toolsets or Other Resources to Close Healthcare Disparities Across Communities (both medium), and Behavioral/Mental Health and Substance Use Screening and Referral for Pregnant and Postpartum Women (high). **Note**: Some of these IAs also apply to other MVPs. The Toolsets IA, for example, is among the choices for the Mental Health and Substance Use Disorders MVP.

Participants will get to choose MVPs, but all must also fulfill a "foundational" layer population health measure, which CMS will judge via administrative claims, and the same Promoting Interoperability requirements that are currently in MIPS.

McDermott hasn't seen very strong uptake of MVPs, and reckons CMS "will have to more strongly encourage — or force — participation in MVPs" in the near future.

Most other significant proposed changes are finalized, including a longer 180-day minimum performance period for the Promoting Interoperability reporting category. The new "streamlined" CEHRT standards that QPP participants will share with MSSP participants, however, are delayed one year.

Resource

- U.S. Senate Finance Committee discussion draft filed Nov, 2, 2023: *https://bit.ly/discussiondraft110223*

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