MERIT-BASED INCENTIVE PAYMENT SYSTEM

2022 ISSUE BRIEF

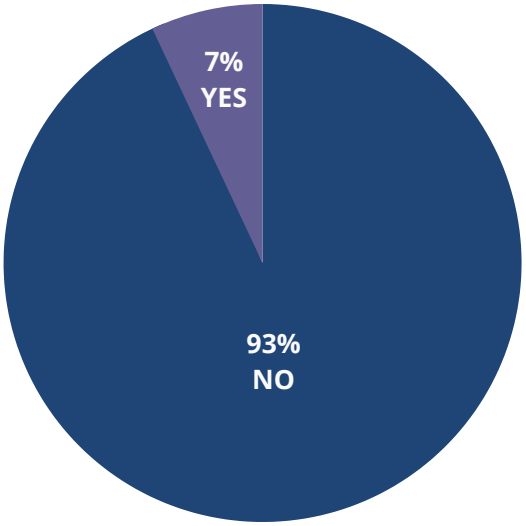
MGMA advocates for improvements to the Merit-based Incentive Payment System (MIPS) to reduce overall group practice burden, simplify scoring complexities, and refine it from the current one-size-fits-all reporting program to a system based on clinically relevant and efficient metrics. MIPS should support groups in their transition to APMs by creating an on-ramp to voluntary participation.

CURRENT LANDSCAPE

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was passed to support the transition to value-based care. MACRA codified the concept of alternative payment models (APMs), which encourage the delivery of high-quality, cost-effective care. Medicare-enrolled providers that do not participate in APMs are required to report under MIPS, a quality reporting program that retains a fee-for-service payment mechanism but adjusts reimbursement rates based on performance across four categories. The original intent of MIPS was to drive improvement in care processes and serve as an on-ramp to APM participation.

Rather than improve clinical care, medical groups participating in MIPS report that the program detracts from patient care efforts and that complying with the program entails significant costs that could be better spent on achieving clinical goals and priorities.

DO POSITIVE PAYMENT ADJUSTMENTS COVER THE COSTS OF TIME AND RESOURCES SPENT PREPARING FOR AND REPORTING UNDER THE MIPS PROGRAM?



Source: 2021 MGMA Regulatory Burden Survey, Qualifying Payment Program: MIPS. October 26, 2021.

MIPS SCORING POLICIES

Policy changes are necessary to extend flexibilities and reduce regulatory burden. MACRA requires the Centers for Medicare & Medicaid Services (CMS) to set the MIPS performance threshold using a previous year's mean or median score beginning in the sixth performance year (2022) of the program. It also requires CMS to weight the cost category at 30% of the final score.

Based on available 2021 performance data, CMS set the 2022 performance threshold at 75 points. This threshold is too high and risks penalizing many practices, particularly small practices, who do not have access to the same resources as large systems. Based on the most recent Quality Payment Program (QPP) report, in 2020 the mean MIPS score for small groups was 69.50 points.

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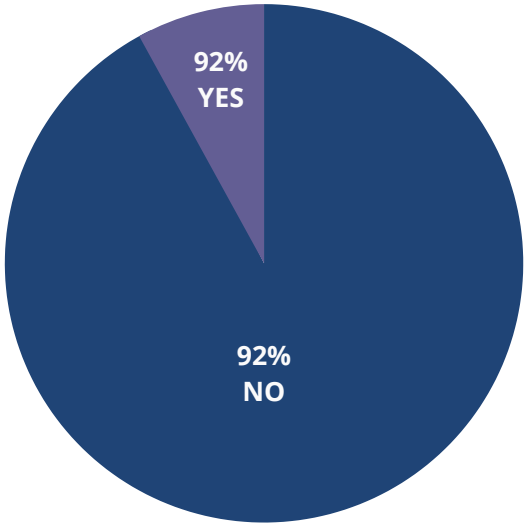
COST CATEGORY

The cost category is problematic for many reasons, including that it holds clinicians accountable for costs they cannot control. Further, CMS does not provide adequate or timely feedback on measure performance. Critically, this means providers do not understand how they are measured on cost metrics and therefore are unable to meaningfully improve performance. Until this category can be improved, and clinicians can be provided with actionable feedback on a regular basis, the cost category weight should not be increased.

MIPS VALUE PATHWAYS (MVPS)

As outlined in the 2022 QPP final rule, CMS intends to begin voluntary reporting under the MIPS Value Pathway (MVP) beginning in the 2023 performance year. The agency intends eventually to fully replace traditional MIPS as a reporting option under the QPP. Since 2019, CMS has offered critical flexibilities under MIPS, including permitting practices to apply for MIPS exceptions from the program. While additional flexibilities under the MIPS program were critically necessary, the pandemic has disrupted many practices' quality reporting mechanisms and prevented practices from gaining additional experience under the program. Practices need the flexibilities to continue reporting under traditional MIPS while uncertainties about the MVP program remain.

IS CMS' FEEDBACK IN ASSISTING YOUR PRACTICE IN IMPROVING CLINICAL OUTCOMES OR REDUCING HEALTHCARE COSTS RELATED TO THE COST PERFORMANCE CATEGORY?



Source: 2021 MGMA Regulatory Burden Survey, Qualifying Payment Program: MIPS. October 26, 2021.

ADVOCACY PRIORITIES

- **Reduce the weight of the cost category or provide CMS with flexibilities to weight it at less than 30%** while CMS engages in efforts to more accurately measure providers in order to hold clinicians accountable only for resource use within their control
- **Grant CMS the flexibility to set the MIPS performance threshold** to ensure a more gradual transition so CMS does not have to use the mean or median of the previous year's scores to set the performance threshold
- **Ensure there is flexibility for CMS to provide multi-category credit** for MIPS activities and measures that overlap performance categories
- **Reduce requirements for reporting quality measures** and create reporting options based on clinical continuums of care
- **Maintain traditional MIPS as a reporting option** alongside voluntary MVP reporting under the QPP

With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 medical groups in which more than 350,000 physicians practice. These groups range from small private practices in rural areas to large regional and national health systems and cover the full spectrum of physician specialties and organizational forms.

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