MERIT-BASED INCENTIVE PAYMENT SYSTEM

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 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 for MIPS, a quality reporting program that retains fee-for-service payments but adjusts reimbursement rates based on performance in four categories. The 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.

MIPS SCORING POLICIES

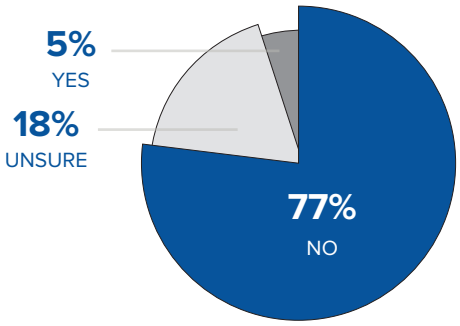
Policy changes are necessary to extend flexibilities and reduce regulatory burden. MACRA requires the Centers for Medicare & Medicaid Services (CMS) to set the MIPS performance threshold using a previous year's mean or median score in the sixth performance year (2022). It also requires CMS to weight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

Based on available data, CMS estimates the 2022 performance threshold to be 74.01 points. This threshold is too high and risks penalizing 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 2018 the mean MIPS score for small groups was 65 points.

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.

IS CMS' FEEDBACK ON COST PERFORMANCE ACTIONABLE IN ASSISTING YOUR PRACTICE IN REDUCING COSTS?



Source: MGMA 2019 regulatory burden survey

MGMA
Medical Group Management Association®

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ADVOCACY PRIORITIES

- **Reduce the weight of the cost category, or provide CMS with flexibility 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

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