



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 alternative payment models (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 APMs, which encourage the delivery of high-quality, cost-effective care. Medicare-enrolled providers who do not participate in APMs must report under MIPS. This quality reporting program 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.

### MIPS SCORING POLICIES

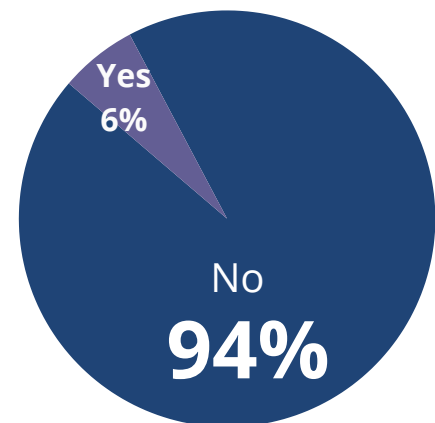
Policy changes are necessary to extend flexibilities and reduce regulatory burden. MACRA requires the Centers for Medicare & Medicaid Services (CMS) to set the MIPS performance threshold using a previous year's mean or median score beginning in the program's sixth performance year (2022). It also requires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

CMS finalized maintaining the performance threshold at 75 points for the 2025 performance year. 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 2022 the mean MIPS score for small groups was 71.52 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, cannot 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 be reduced.

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

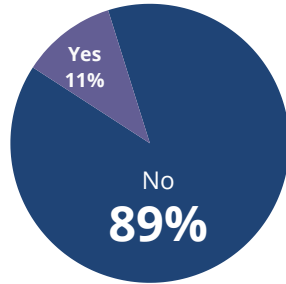


Source: MGMA's [Annual Regulatory Burden Report](#)

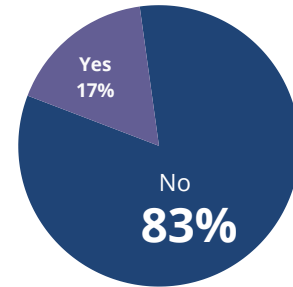


**IS CMS' FEEDBACK ACTIONABLE IN ASSISTING YOUR PRACTICE IN IMPROVING CLINICAL OUTCOMES OR REDUCING HEALTHCARE COSTS RELATED TO THE...**

**...COST  
PERFORMANCE  
CATEGORY?**



**...QUALITY  
PERFORMANCE  
CATEGORY?**



Source: MGMA's [Annual Regulatory Burden Report](#)

**MIPS VALUE PATHWAYS (MVPs)**

CMS began voluntary reporting under MIPS Value Pathways (MVPs) for the 2023 performance year. There are currently 21 finalized MVPs for 2025. The agency intends to eventually 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. Practices need the flexibilities to continue reporting under traditional MIPS while uncertainties about the MVP program remain.

**ADVOCACY PRIORITIES**

- ➔ **Reform the MIPS program** to improve its clinical relevance and reduce the cost and administrative burden of reporting
- ➔ **Reduce the weight of the cost category** or provide CMS with the ability to reduce the category's weight while the agency engages in efforts to more accurately measure providers so to only hold them accountable for resources within their control
- ➔ **Grant CMS the flexibility to set the MIPS performance threshold** to ensure a more gradual transition so the agency does not have to use the mean or median of the previous year's scores to set the performance threshold
- ➔ **Ensure CMS can 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
- ➔ **Eliminate punitive penalties** that disproportionately impact medical practices unable to participate in APMs
- ➔ **While working to implement significant reforms to the MIPS program, maintain traditional MIPS as a reporting option alongside voluntary MVP reporting under the QPP**, while simultaneously ensuring that MVPs do not simply repackage existing problems within the MIPS program