MIPS relief, reform and research in play to make program relevant

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Andis Robeznieks
Senior News Writer

Physician advocacy efforts to refine the Medicare Merit-based Incentive Payment System (MIPS) seek to make the program more clinically relevant, less burdensome and more transparent have continued through the pandemic. So have efforts to promote regulatory and financial relief for physician practices facing economic hardships because of COVID-19.

Most notably, these efforts resulted in the Centers for Medicare & Medicaid Services (CMS) recent decision to reweight the MIPS cost performance category to 0% of the final score for practices and physicians who report quality, promoting interoperability, or improvement activity data for the 2020 performance year.

As a result of the reweighting, physicians will be held harmless from unfair evaluations in the MIPS cost performance category.

MIPS uses a scoring system designed to reward physicians and other clinicians for improving the quality of the health care they deliver. Last fall, in recognition of the difficulties practicing during the COVID-19 pandemic, CMS invoked a policy allowing MIPS participants to request reweighting of one or more of the program’s performance categories, which are: quality, cost, promoting interoperability, and improvement activities. In addition, physician advocacy resulted in CMS’ decision to automatically apply an extreme and uncontrollable hardship exception to all MIPS eligible clinicians, holding them harmless from a penalty if they were unable to submit any data.

In its more recent decision to reweigh the cost category to 0%, CMS acknowledged the negative financial impact COVID-19 has had on practices, which included severe drops in the volume of patient visits. It also prevented physicians from being unfairly penalized for services associated with caring for patients diagnosed with COVID-19 during the pandemic.

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More transparency, relevancy needed

While financial relief measures offer short-term mitigation, advocacy efforts are also in progress that are part of an effort to make improvements to the system that will have long-term benefits.

This includes advocating for increased transparency in how cost measures are developed. Earlier this spring, the AMA and nearly 50 other physician organizations called on CMS to release the cost-measure benchmarks it used in 2018–2020.

“Because the benchmarks have not been published, physicians cannot compare their spending to the target in the current performance period or prior periods, nor can they determine whether the benchmarks are fair and valid, accounting for variations in resource use that are within a physician’s control,” the organizations said in a letter to acting CMS Administrator Elizabeth Richter.

CMS has agreed to release those files. The AMA will closely review the files to identify the target spending for those years, how the benchmarks capture any variations in spending, and whether the benchmarks are leading to fair and valid comparisons among physicians.

The AMA is also urging CMS to alter its approach to the MIPS Value Pathway (MVP) program, moving it away from siloed categories and pivoting toward a holistic, condition-focused approach with a clear goal of improving patient outcomes. The AMA joined 41 national specialty societies in recommending reforms the agency could make.

MIPS’ $12,811 tab

The need to reform MIPS was made clear in a pair of recent studies funded by the AMA and the Physicians Foundation Center for the Study of Physician Practice and Leadership at Weill Cornell Medicine.

Practices spent an average of $12,811 per physician to participate in MIPS in 2019, according to “Time and Financial Costs for Physician Practices to Participate in the Medicare Merit-based Incentive Payment System,” a qualitative study published in JAMA Health Forum.

Physicians, clinical staff and administrative staff together spent more than 200 hours annually per physician on MIPS-related activities. Physician time accounted for 54% of overall MIPS-related costs and averaged $6,909.

On average, physicians spent more than 53 hours a year on MIPS-related tasks. Those hours could
provide care for an extra 212 patients a year, researchers estimated.

In the other study, researchers reported on the views held by the 30 practice leaders who were interviewed. Those finding were listed in a recent Journal of General Internal Medicine study. Practice leaders were conflicted on whether MIPS improves care, said it creates a big administrative burden made worse by annual changes, and that incentives are small compared with the effort need to take part.