AMA AMERICAN MEDICAL ASSOCIATION

MEDICARE BASICS

Merit-based Incentive Payment System (MIPS)

Under the Medicare Access and CHIP Reauthorization Act (MACRA), the Merit-based Incentive Payment System (MIPS) ties physicians' Medicare payments to their individual, group practice, or alternative payment model (APM) score on reported and applicable: (1) quality measures, (2) cost measures, (3) health IT use and (4) practice improvement activities. All physicians in the United States must participate in MIPS unless they qualify for **one** of the following exceptions:

1. They are a qualifying participant in an advanced APM.
2. They see fewer than 200 Medicare Part B patients or bill less than $90,000 in Part B covered professional services per year.
3. They are in their first year of participating in the Medicare program.

Using data from the four MIPS categories, CMS calculates a score of 0-100 for each physician, group, and APM and compares the score to a performance threshold to determine the applicable bonus or penalty amount, which applies to their Medicare payment two years after the performance period. The performance threshold is set prospectively each year by CMS through the annual regulatory process. MIPS uses a tournament model, so that performance penalties fund the bonuses with no additional funding provided.

To ease the financial impact of the COVID-19 public health emergency (PHE), CMS allowed physicians to apply for a hardship exemption from MIPS penalties in 2020, 2021 and 2022, and recently announced that it would extend the exemption through 2023. For illustrative purposes, the following is an explanation of what physicians, groups, and APMS were facing if CMS had continued using 2023 as a performance year without a hardship exception.

In 2023, physicians, groups and APMs who scored higher than 75 points would receive a bonus. CMS estimated that the average bonus would have been 3.71%. Physicians, groups and APMs who scored below 75 points would have received a penalty of up to -9%. Using the most up-to-date information, which is the 2020 QPP Experience Report and CMS' estimates in the 2023 final rule, **there would have been 308,000 eligible clinicians who faced a MIPS penalty in 2025 based on their 2023 score, and 75,000 eligible clinicians who faced a MIPS penalty between -3 and -9% in 2025.** Under current law, there is a zero percent payment update for physicians in 2025, so any MIPS penalties would have represented true payment cuts

Evidence of the shortcomings of MIPS continues to pile up:

- MIPS may be divorced from achieving meaningful clinical outcomes. A 2022 study in *JAMA* found that MIPS scores are inconsistently related to performance, and physicians caring for more medically and socially vulnerable patients were more likely to receive low scores despite providing high-quality care.
- MIPS is administratively burdensome. Compliance with MIPS costs $12,800 per physician per year and physicians spend 53 hours per year on MIPS-related tasks. These 53 hours are equivalent to a full week of patient visits. This study is based on 2019, prior to full MIPS implementation, and is likely an underestimate of today's costs. For smaller practices, the cost of MIPS compliance may be far greater than any bonuses they may receive, turning the effort into a penalty avoidance rather than quality improvement exercise.

- MIPS exacerbates health inequities. According to a study in *JAMA* that looked at the first year of MIPS, physicians with the highest proportion of patients dually eligible for Medicare and Medicaid had significantly lower MIPS scores compared with other physicians. MIPS may penalize physicians for social factors outside of their control and transfer resources from those caring for poorer patients to those caring for more affluent patients. This is called the reverse *Robin Hood effect*.
- Rural and medically underserved practices face challenges participating in MIPS, including lack of technology vendor support and high costs of ongoing investments needed for participation, staffing shortages, and challenges staying abreast of program requirements. According to another GAO report, similar challenges limit rural practices' ability to transition to alternative payment models (APMs), meaning they are largely stuck in MIPS.
- MIPS hurts independent practices. According to a study in *JAMA*, MIPS eligible clinicians affiliated with better resourced health systems were associated with significantly better 2019 MIPS performance scores.

While CMS has tried to improve the program, such as by introducing the MIPS Value Pathways (MVPs) option, these changes are superficial as the agency is hamstrung by its lack of statutory authority to remedy these problems directly. Congress must step in and act to: prevent unsustainable penalties, particularly on small, rural, and underserved practices; invest in and enable the move to value-based care; and increase transparency and oversight in the program.

Following is a more detailed description of the MIPS process that illustrates the program's complexity.

How physicians participate In MIPS

For the 2023 reporting period (Jan. 1–Dec. 31, 2023), which determines a physician's 2025 payment, CMS set the performance threshold at 75 points. If physicians are interested in earning an incentive they must score above the performance threshold. Physicians may participate as an individual, group, subgroup[1] or APM.[2]

The general formula used to determine a physicians' score within a performance category is as follows:

Points earned by physician, subgroup, group or APM divided by the total possible points within the performance category x multiplied by theperformance category weight = Earned points

A physician's four performance category scores will then be added to determine a physician's score.[3] Performance is measured across four areas—quality, improvement activities, health IT use and cost.

Quality category (30% of final score): Physicians must collect measure data for the 12-month performance period. General reporting requirements:

- A physician/subgroup/group/APM will need to submit collected data for six quality measures (including one outcome measure or high-priority measures in the absence of an applicable outcome measure), or a specialty measure set.[4]
- A physician/subgroup/group/APM must have a data completion rate of 70% of all denominator eligible patients, regardless of payer.
- CMS will also score the physician, subgroup, group, or APM on four administrative claims quality measures, if they meet the attribution methodology.

1. Multispecialty groups that wish to participate in MVPs have the option to form subgroups around specialty or care teams within the larger group.
2. Physicians in APMs are included in MIPS unless they meet the definition of a qualifying APM participant (QP) in an Advanced APM. MIPS ECs who do not meet the QP definition or who participate in a MIPS APM may participate in MIPS through their APM Entity. In 2020, 43% of MIPS eligible clinicians participated via an APM Entity. APMs are exempt from the cost performance category and typically receive automatic full credit in the IA performance category. As a result, APMs generally do exceptionally well in MIPS.
3. Requirements may change each Performance Year due to policy changes.
4. If reporting through MIPS Value Pathways (MVP), you only report four quality measures within the MVP.

- Hospital-Wide, 30-Day, All Cause Unplanned Readmission (HWR) Rate.
- Risk-standardized Complication Rate (RSCR) following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) for MIPS.
- Clinician and Clinician Group Risk-standardized Admission Rates for Patients with Multiple Chronic Conditions.
- Risk-Standardized Acute Unplanned Cardiovascular-Related Admission Rates for Patients with Heart Failure for the Merit-based Incentive Payment System

- CMS will then benchmark each measure through a decile-based approach and calculate an individual score on each measure.[5]
- Physicians/subgroups/groups/APMs may earn up to 10 additional percentage points based on their improvement in the quality performance category from the previous year.
- All quality measures are subject to public reporting on Care Compare, which is based on a separate methodology for scoring and ranking measures.

Cost category (30% of final score):[6] CMS uses Medicare claims data to calculate cost measure performance on up to 25 cost measures, including total Medicare Part A and B spending per beneficiary, Medicare spending around a hospitalization, and 23 episode-based cost measures.

- Each measure is attributed to physicians or groups according to the measure's unique specifications, including its attribution methodology, case minimum, and other measure parameters.
- CMS calculates a single, national benchmark using 10 deciles for each cost measure.
- Physicians do not know in real time which measures are being attributed to them, which patients are being assigned to them, and what costs outside of their practice they are being held accountable for.
- The "Cost Performance" category was zeroed out in 2020 and 2021 due to the COVID-19 pandemic, so the most recent feedback that physicians have about their performance in this category is from 2019.

Promoting interoperability (25% of final score): CMS requires physicians to report on seven measures across five objectives. Physicians must adopt, implement, and use certified electronic health record technology (CEHRT) and meet "Meaningful Use" era requirements. CEHRT vendors charge physicians each time their products are upgraded to meet CMS' Promoting Interoperability measures and objectives. Several of CMS' reporting measures dictate how EHRs are designed and used. Physicians must check boxes to calculate numerator and denominator measure reports for CMS. In addition to submitting measure and objective reports, physicians must also report on:

- Actions to limit or restrict the compatibility or interoperability of CEHRT
- Direct review attestations from the Office of the National Coordinator for Health Information (ONC)
- A security risk analysis
- High-priority practices guides and safety assurance factors for EHR resilience

Failing to report on any required attestation or measure (or claim an exclusion for a required measure if available and applicable) will result in a score of 0 for the entire Promoting Interoperability performance category.

Improvement activities (15% of final score): To earn full credit, physicians must generally submit one of the following combinations of activities: two high-weighted activities, one high-weighted activity and two medium-weighted activities, or four medium-weighted activities.

- High-weighted activities receive 20 points and medium-weighted activities receive 10 points.
- Improvement activities have a minimum of a continuous 90-day performance period unless otherwise stated in the activity description.

5. Additional scoring rules may apply if CMS determines a measure has been topped out.
6. For more information, visit CMS' 59-page 2023 MIPS Cost User Guide.

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