Medicare Payment Reform

Merit-based Incentive Payment System (MIPS): Problems and Solutions

Since the enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the American Medical Association (AMA) has worked closely with Congress and the Centers for Medicare & Medicaid Services (CMS) to promote a smooth implementation of MIPS. We supported MACRA's goals to harmonize the separate, burdensome, and punitive Meaningful Use, Physician Quality Payment System (PQRS), and Value-Based Payment Modifier programs. Throughout the years, the AMA has offered a steady series of constructive recommendations to improve MIPS. However, for a variety of reasons, CMS has not adopted many of them. Consequently, the implementation of a new Medicare quality and payment program for CMS and physicians has been a significant undertaking, which was drastically disrupted by the COVID-19 pandemic.

The AMA had anticipated when MACRA passed that, by the time physicians would be subject to significant penalties from MIPS, the challenges with the program would be minimal and there would be many Alternative Payment Models (APMs) for all specialties to participate in. Unfortunately, that is not the case. In its current form, MIPS is a repackaging of several legacy programs, including PQRS. Further refinements are urgently needed to achieve the goals of MACRA and reduce the administrative burden for physicians. Worse, there is a growing body of evidence that the program is disproportionately harmful to small, rural, safety net, and independent practices, as well as devoid of any relationship to the quality of care provided to patients. The AMA is strongly recommending that Congress make three key changes to MIPS to remedy these problems.

Background

CMS applied automatic MIPS hardship exceptions due to the COVID-19 pandemic in 2019, 2020, and 2021, and accepted applications for COVID-19 hardship exceptions in 2022 and 2023. While the AMA supported these much-needed flexibilities, the program was severely disrupted for five years due to unforeseeable circumstances and, as a result, the gradual implementation of MIPS as originally envisioned by Congress in 2015 under MACRA was not realized. Meanwhile, CMS continues to rachet up the requirements and the potential penalties have become much more severe.

As MIPS requirements have continued to increase each year and the penalties (now at nine percent) apply in full, CMS expects a substantial rise in the number of physicians who will receive MIPS financial penalties. In the 2024 Medicare Physician Payment Schedule proposed rule, CMS estimates that over half (54 percent) of eligible clinicians (ECs) will receive a MIPS penalty averaging -2.4 percent in 2026. This is in large part due to the proposed increase to the number of points needed to avoid a MIPS penalty in 2024 (the number of points needed now stands at 82 points compared to just 15 points in 2018, the last year that MIPS was fully in effect before the COVID-19 automatic hardship exceptions took effect). Even more alarming, CMS estimates that nearly 65 percent of ECs in solo practices and 60 percent of ECs in small practices would receive a penalty, confirming that this program is penalizing small practices and redistributing those funds to large, well-resourced health systems. To be clear, there is no reason to believe that the disproportionately negative impact on small, rural, safety net, and independent practices is due to differences in the quality or cost of care provided to Medicare beneficiaries. Rather, this discrepancy can be traced to the administrative burden of participating in MIPS, which has a disproportionate impact on these types of practices with fewer resources.

Additionally, we are hearing alarming reports that physicians are receiving penalties in 2024 for the first time in the program, which will compound the -3.36 percent reduction to the conversion factor proposed for 2024. We have serious concerns that a lack of awareness of the expiration of the automatic COVID-19 flexibilities unfairly penalizes

physician practices and disproportionately impacts small, independent, and rural practices. Even practices that were historically successful in the program are now expected to receive a penalty in 2024 due to the Cost Category being weighted at 30 percent of MIPS final scores for the first time as the cost measures were not even calculated in the two prior performance years due to COVID-19. Furthermore, there were errors in CMS' code and measure specifications in the Cost Category that we anticipate will contribute to the number of physicians who will receive penalties. Also, physicians had no way to anticipate, monitor, or improve their 2022 cost performance category score because CMS did not share any data about attributed measures, patients, or observed costs until August 2023—more than eight months after the conclusion of the performance period.

The AMA strongly urged CMS to extend the deadline to appeal a MIPS payment penalty and to permit physicians to apply for a COVID-19 hardship exception as part of the appeal. **We believe this is a wakeup call for all policymakers regarding the serious negative unintended consequences of MIPS,** particularly on the heels of the COVID-19 pandemic. For more details about the MIPS program in general and its well-documented problems, review the AMA's Medicare Basics: Merit-based Incentive Payment Systems (MIPS) paper.

Recommendations

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 believes it does not have statutory authority to remedy these problems directly. Congress must step in and act to prevent unsustainable penalties, particularly on small, rural, safety net, and independent practices, help practices transition to value-based care, and increase transparency and oversight in the program. Below we offer three legislative changes that would help to streamline and improve the MIPS program, drive quality improvements, and reduce negative impacts on the most vulnerable while reducing unnecessary burdens.

1. **Congress should mitigate steep MIPS penalties following the COVID-19 pandemic that disproportionately harm small, rural, safety net, and independent practices, including practices that care for the underserved and allow practices to revitalize quality improvement infrastructures.**

To accomplish this aim, the MACRA statute should be amended to:

- Freeze the MIPS performance threshold for three years to prevent steep penalties and allow practices to continue to recover from the effects of the pandemic and transition back to MIPS following a five-year interruption due to COVID-19. Importantly, this would also allow CMS time to implement and educate practices on these legislative improvements to the program. Congress should use the 2021 performance threshold of 60 points (out of 100), which CMS established as a transitionary policy to encourage participation on all MIPS measures.
- Eliminate MIPS win-lose style payment adjustments and instead link physicians' MIPS performance to an annual inflation-based payment update (e.g., tied to the Medicare Economic Index (MEI)). Specifically, physicians could be subject to up to a one-quarter reduction in their update based on their MIPS performance, which would be consistent with the Hospital Inpatient Quality Reporting Program.
- Reinvest money from penalties in bonuses for high performers, as well as investments aimed at assisting under-resourced practices with their value-based care transformation, with an emphasis on small practices, rural practices, and practices that care for underserved patients.

2. **Congress should hold CMS accountable for timely and actionable MIPS and claims data.**

Congress recognized the importance of timely data to drive performance improvement, which is why it originally mandated under MACRA that CMS must provide timely (i.e., quarterly) MIPS quality and resource use feedback, as well as claims data to physician practices, similar to the types of data provided to Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs).[1] Despite this requirement, physicians did not receive

[1] §42 USC 1395w-4(q)(12).

their most recent MIPS Feedback Report based on 2022 performance from CMS until August 2023. These reports are also high-level summary reports. No physician in MIPS has ever received Medicare claims data similar to what MSSP ACOs receive, which includes Medicare Parts A, B, and D claims data for their assigned beneficiaries. This means that physicians do not know in real time or even on a quarterly basis which cost 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 until well after the performance year is already over, making it impossible for them to leverage this data to implement changes that would improve patient care, outcomes, and use resources more efficiently, saving costs.

Furthermore, our in-depth analysis of 2021 MIPS performance data revealed concerning data inconsistencies in CMS' publicly available files, including missing physician information. Without valid, reliable data from CMS at the aggregate level, the AMA and others cannot drill down to better understand what measures and requirements are driving the different scores among physician practice sizes, for example.

Accordingly, the AMA urges Congress to exempt from penalties any ECs who do not receive at least three quarterly MIPS feedback and claims data reports during the performance period.

3. Congress should make MIPS more clinically relevant while reducing burden.

As discussed above, MIPS is unduly burdensome and has not been shown to improve clinical outcomes or reduce unnecessary costs. Moreover, the program does not prepare physicians to move to APMs. Therefore, we recommend that Congress amend the statute to solve these problems by:

- Removing siloes between the four MIPS performance categories to allow for multi-category credit, therefore reducing burden.
- Bringing MIPS into alignment with other CMS value-based programs to better align with and support care provided in hospitals and other care settings.
- Recognizing the value of clinical data registries and other promising new technologies by allowing physicians to meet the Promoting Interoperability requirements via attestation of using certified electronic health record technology (CEHRT) or technology that interacts with CEHRT, participation in a clinical data registry, or other less burdensome means. The attestation of using CEHRT is consistent with the hospitals' requirements in Promoting Interoperability, as well as current APM requirements.
- Enhancing measurement accuracy and clinical relevance, particularly within the cost performance category, to target variability that is within the physician's ability to influence.
- Aligning cost and quality goals. MIPS rarely evaluates quality and cost on the same patients and for the same conditions, which has been a key factor inhibiting its ability to drive clinical improvement. Quality and cost measures are developed in isolation of one another and use different patient populations, attribution methodologies, and risk adjustment methodologies. Harmonizing these measures would ensure MIPS is driving high-value care as intended while reducing burden on physician practices.
- Improving quality measurement accuracy by awarding credit for testing new or significantly revised measures, including Qualified Clinical Data Registry measures, for up to three years.

The AMA strongly believes that each of these policy changes is essential to improve the clinical relevance of MIPS, provide a bridge to transition to APMs, and promote the intended goals of MACRA to leverage health information technology, improve quality, and reduce Medicare costs while reducing burden on physician practices more effectively. **Notably, none of these recommendations are expected to score.**