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.

In 2025, physicians, groups and APMs who scored higher than 75 points will receive a bonus. Physicians, groups and APMs who score below 75 points will receive a penalty of up to -9% for the 2025 performance period/2027 payment year. Under current law, physicians in MIPS will receive 0.25% annual payment update beginning in 2026, which is far below the growth in medical practice inflation and inadequate according to the Medicare Payment Advisory Commission (MedPAC). The AMA is aggressively advocating that Congress replace current law updates with annual, baseline increases that are linked to the rate of inflation in practice expense.

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.

To fix these problems, the AMA, all 50 state medical associations, the District of Columbia, and 76 national medical specialty societies are calling on Congress to replace key elements of MIPS with a new Data-Driven Performance Payment System (DPPS) that:

- Freezes performance thresholds for three years to allow recovery from the COVID-19 Public Health Emergency (PHE) and Change Healthcare cyberattack.
- Eliminates the current tournament model and replaces corresponding payment penalties of up to 9% with payment adjustments assessed as a percentage of statutorily mandated payment updates (i.e., 0.25% of MEI).
- Ensures CMS provides quarterly feedback reports by holding physicians harmless from penalties should the Agency fail to provide this data.

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

How physicians participate in MIPS

For the 2025 reporting period (Jan. 1–Dec. 31, 2025), which determines a physician's 2027 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 or APM.

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 the performance category weight = Earned points

A physician's four performance category scores will then be added to determine a physician's score. 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), a specialty measure set or MVP.
- A physician/subgroup/group/APM must have a data completion rate of 75% 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.

- Hospital-Wide, 30-Day, All Cause Unplanned Readmission (HWR) Rate (This measure is only applicable to groups and virtual groups).
- 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.
- Standardized Acute Unplanned Cardiovascular-Related Admission Rates for Patients with Heart Failure for the Merit-based Incentive Payment System.

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.

Promoting interoperability (25% of final score): CMS requires physicians to report on six or seven measures across four objectives, depending on the reporting option chosen under the Health Information Exchange objective. 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 or submit an affirmative "yes" attestation for other measures. 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): Clinicians, groups, and virtual groups with the small practice, rural, non-patient facing, or health professional shortage area special status must attest (submit a "yes") to one activity. All other clinicians, groups, and virtual groups must attest (submit a "yes") to two activities.

Beginning in the 2025 performance period, improvement activities won't be weighted. Improvement activities have a minimum of a continuous 90-day performance period unless otherwise stated in the activity description.