



Advising the Congress on Medicare issues

Medicare physician payment and quality

Amol S. Navathe, M.D., Ph.D.

Chair, Medicare Payment Advisory Commission

October 21, 2026

MedPAC's mission and structure

- Provide independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program
- Seven public meetings during the year
- Transparency is integral to MedPAC's work: Public comments, meeting transcripts, presentations, annual analytic agendas, and other products are all available on MedPAC's website
- MedPAC's principles of Medicare payment
 - Payments should be sufficient to support beneficiary access to high-quality health care in an appropriate clinical setting
 - Providers should have incentives to supply appropriate and equitable care in an efficient manner
 - Medicare payments should reflect efficient care delivery, thereby ensuring that the program's fiscal burden on beneficiaries and taxpayers is not greater than necessary

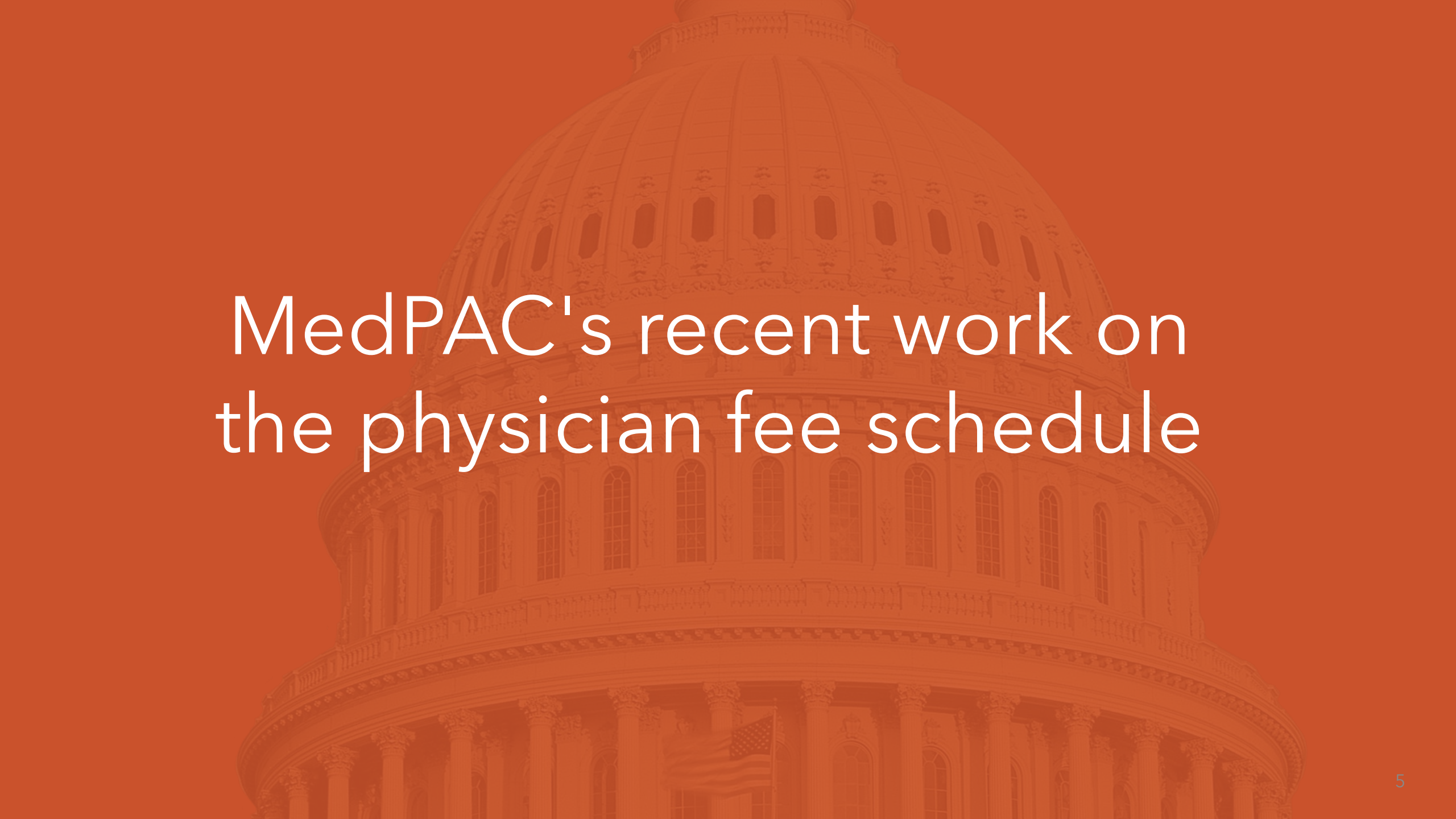


Priorities for future work

MedPAC's upcoming analytic agenda includes a broad range of topics

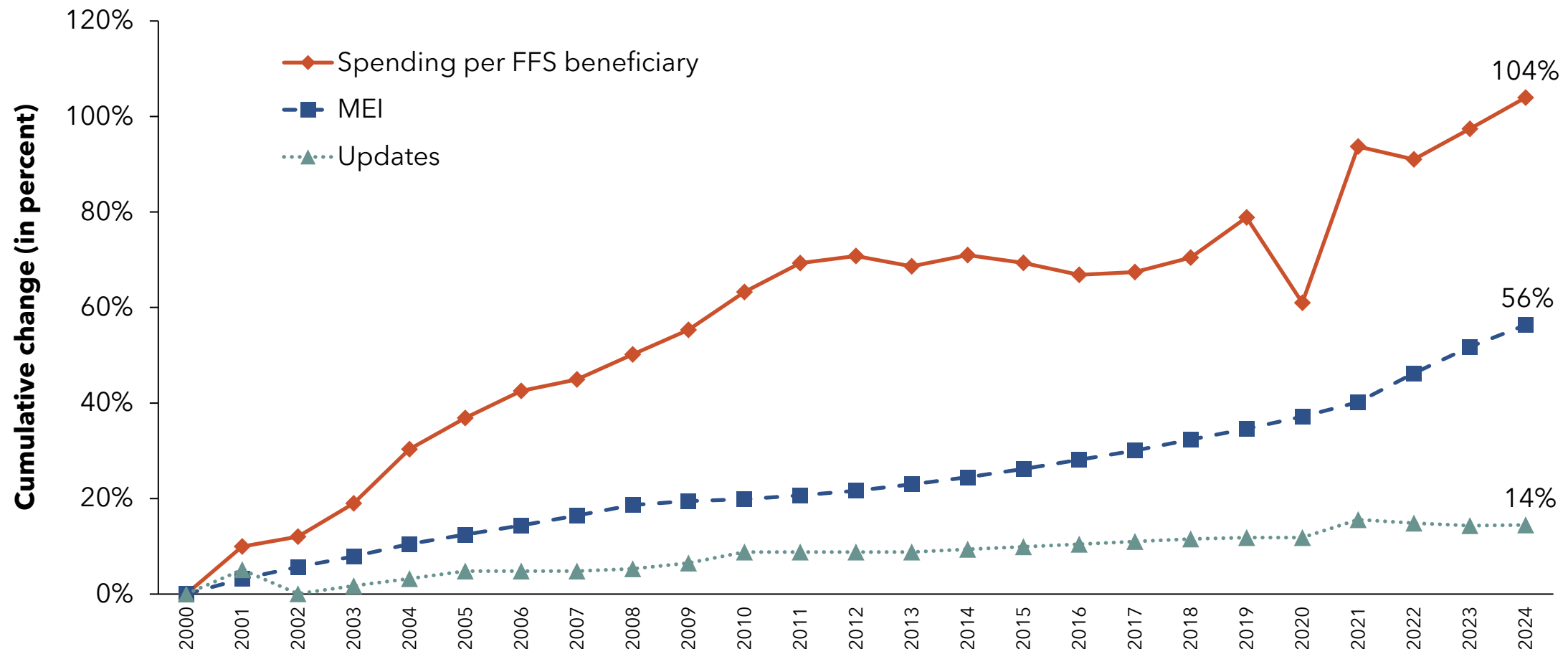
- Planned and ongoing analysis
 - Trends in utilization and spending for Part B drugs and hospice
 - Payments for software as a medical service and prescription digital therapeutics
 - Access to care for rural beneficiaries
 - The average generosity of medical benefits in MA relative to FFS
 - Recent trends in cost sharing and spending under Part D
 - Opportunities to simplify beneficiary enrollment process
- Selected policy areas for 2026 - 2027
 - Accuracy in the physician fee schedule
 - Medicare's approach to clinician quality measurement and value

Note: MA (Medicare Advantage), FFS (fee-for-service).



MedPAC's recent work on the physician fee schedule

Physician fee schedule spending per FFS beneficiary grew substantially faster than the MEI or fee schedule payment updates, 2000-2024



Note: FFS (fee-for-service), MEI (Medicare Economic Index). MEI data are from the new version of the MEI (based on data from 2017) and include updated total-factor productivity data. Spending per FFS beneficiary is based on incurred spending under the physician fee schedule. The graph shows updates to payment rates in nominal terms. Fee schedule updates do not include Merit-based Incentive Payment System adjustments or bonuses for participating in advanced alternative payment models. One-time payment increases of 3.75% in 2021, 3.0% in 2022, 2.5% in 2023, and a weighted average of 1.25% and 2.93% for 2024 are included.

Source: MedPAC analysis of Medicare regulations, CMS market basket data, and reports from the Boards of Trustees of the Medicare trust funds.

However, MEI growth is projected to exceed fee schedule updates by more than it did in the past

- MEI growth outpaced fee schedule updates by just over 1 percentage point per year for the two decades ending in 2020
- MEI growth likely substantially exceeded updates from 2020 to 2025
- From 2025 to 2034, the average annual difference between projected MEI growth and current-law fee schedule updates is larger than the two decades ending in 2020:
 - 1.5% per year for clinicians in A-APMs
 - 2.0% per year for clinicians not in A-APMs
- This larger gap between MEI growth and PFS updates could negatively affect access to clinician care in the future

Note: MEI (Medicare Economic Index), A-APM (advanced alternative payment model), PFS (physician fee schedule).

June 2025 recommendation to update PFS rates annually by a portion of MEI growth

- Replace the dual PFS updates based on A-APM participation with an update based on a portion of MEI growth
 - Key concept: Historical evidence suggests that a full MEI update has not been needed to maintain access to care
- Policymakers could consider a range of specific designs (e.g., update floors and ceilings)
- Updates based on a portion of MEI growth have multiple benefits:
 - Automatically adjust to changes in inflation
 - Improve predictability
 - Simple to administer
 - Balance beneficiary access with beneficiary and taxpayer financial burden

Note: PFS (physician fee schedule), MEI (Medicare Economic Index), A-APM (advanced alternative payment model).

Payment accuracy is an important aspect of the Commission's work

- Commission contends that payment rates should:
 - Be set high enough to ensure beneficiary access to high-quality care
 - Minimize financial burdens on beneficiaries and taxpayers
- Payment accuracy is also important to reduce inappropriate incentives
- CMS has recently taken multiple steps to improve payment accuracy, but opportunities for improvement remain

MedPAC work on accuracy of the physician fee schedule

- Accuracy of RVUs is important because misvaluation has multiple effects
 - Can incentivize oversupply or undersupply of services
 - Can influence decisions about vertical consolidation
 - Non-Medicare payers base payments on misvalued codes
- Approaches to improve accuracy of relative payment rates (2025)
 - Update allocation of work, practice expense, and malpractice insurance RVUs
 - Improve the accuracy of global surgical payment codes
 - Improve the accuracy of relative payments for indirect practice expense*
- Recommendations to improve fee schedule accuracy (2006 and 2011)
 - Establish expert panel to assist CMS's review of RUC recommendations and regularly collect data from cohort of efficient practices

Note: RVU (relative value unit), Relative Value Scale Update Committee (RUC).

* CMS implemented a policy consistent with this in its CY 2026 final rule.

Source: Medicare Payment Advisory Commission, 2025, *Report to the Congress*. Medicare Payment Advisory Commission, 2006, *Report to the Congress*. Medicare Payment Advisory Commission, 2011, *Moving forward from the sustainable growth rate system*.

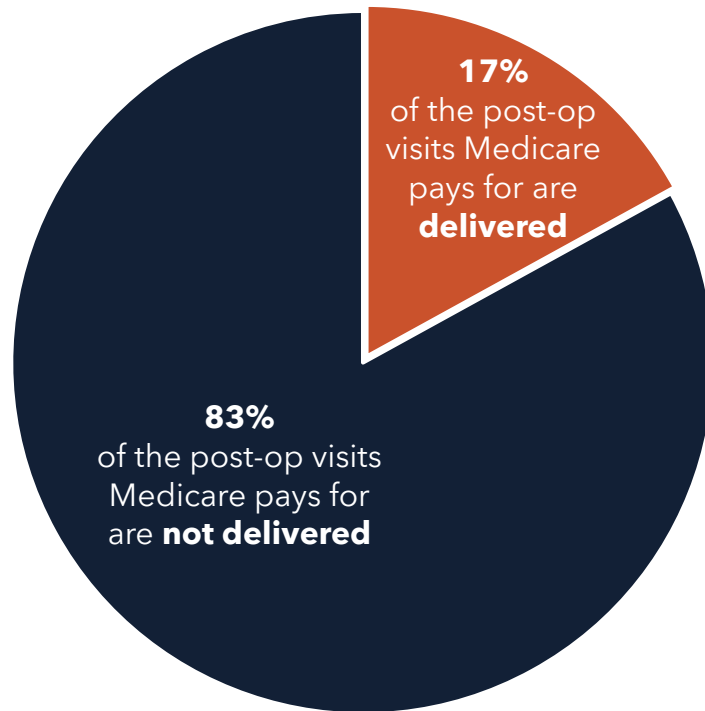
Updating aggregate allocation of RVUs

- On an aggregate basis, allocation of work, PE, and MP RVUs should reflect the distribution of the costs of running a clinician practice
- MEI cost share data from 2006 are used as basis for allocation of work, PE, and MP RVUs, though more recent data are available.
- Using more recent data that appropriately reflects the cost of running a practice would:
 - help ensure that RVUs accurately reflect how costs are distributed
 - reduce chances that RVUs will experience large changes each time the MEI is updated

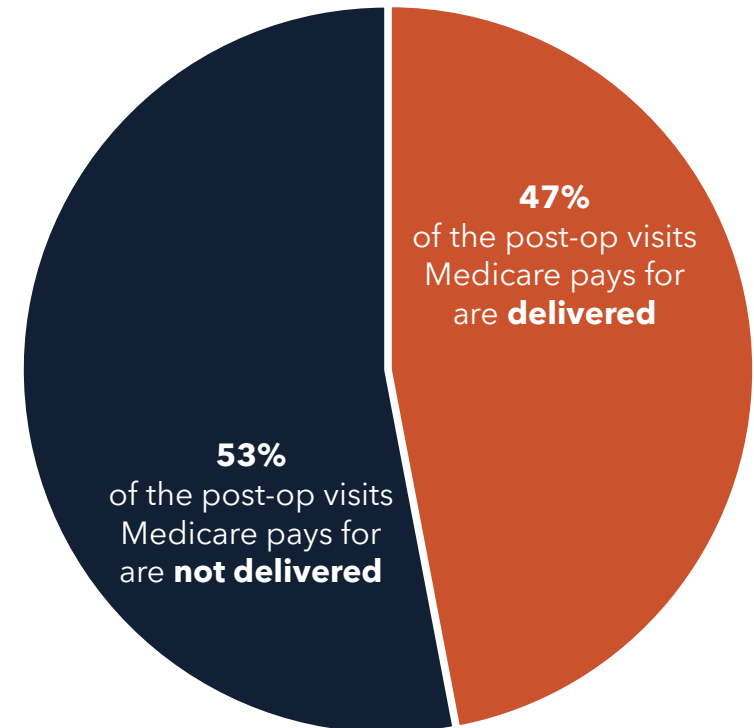
Note: RVU (relative value unit), PE (practice expense), MP (malpractice insurance), MEI (Medicare Economic Index).

Most of the postoperative visits included in the valuation of global surgical services are not actually furnished

10-day global surgical services



90-day global surgical services



Note: These are results of a sensitivity analysis restricted to the subset of clinicians who billed for any postoperative visits during 90-day global periods. RAND's main results (using a larger pool of clinicians) suggested an even higher share of post-operative visits were not provided. RAND studied commonly used 10- and 90-day global codes.

Source: Crespín, D. J., A. M. Kranz, T. Ruder, et al. 2021. *Claims-based reporting of post-operative visits for procedures with 10- or 90 day global periods: Updated results using calendar year 2019 data*. Santa Monica, CA: RAND. <https://www.cms.gov/files/document/rand-cy-2019-claims-report-2021.pdf>.

Improving the accuracy of global surgical services

- Two broad policy approaches:
 - Convert 10- and 90-day global surgical services to 0-day services and let clinicians separately bill for postoperative visits
 - Keep the current payment structure but adjust valuations for 10- and 90-day global surgical services to reflect postoperative visits actually performed
- Phase-in of reforms could be considered

Source: MedPAC June 2025 Report to the Congress.



Medicare's approach to clinician quality measurement and value

MedPAC's prior work on quality measurement in Medicare

- Support of Medicare's measurement of the quality of care furnished by providers to:
 - Monitor performance
 - Inform patients and payers
 - Encourage the provision of high-quality care
- Published principles in June 2018 to:
 - Address the proliferation of measures (many burdensome and not tied to clinical outcomes) in Medicare quality programs
 - Create incentives for accountable entities to offer high-quality care to beneficiaries

Source: MedPAC's June 2018 report to the Congress.

MedPAC recommended eliminating MIPS because it is fundamentally flawed (March 2018)

- Flaws in the design
 - Burdensome and complex
 - Quality and payment adjustments determined at individual clinician level
 - Many clinicians not evaluated due to insufficient number of cases
 - Clinicians evaluated and compared on dissimilar measures
 - Due to self-chosen measures and low-performance thresholds, most clinicians receive a small, positive payment adjustment
- Recommended creating a new value component to take MIPS's place (conceptual direction, not a detailed design)

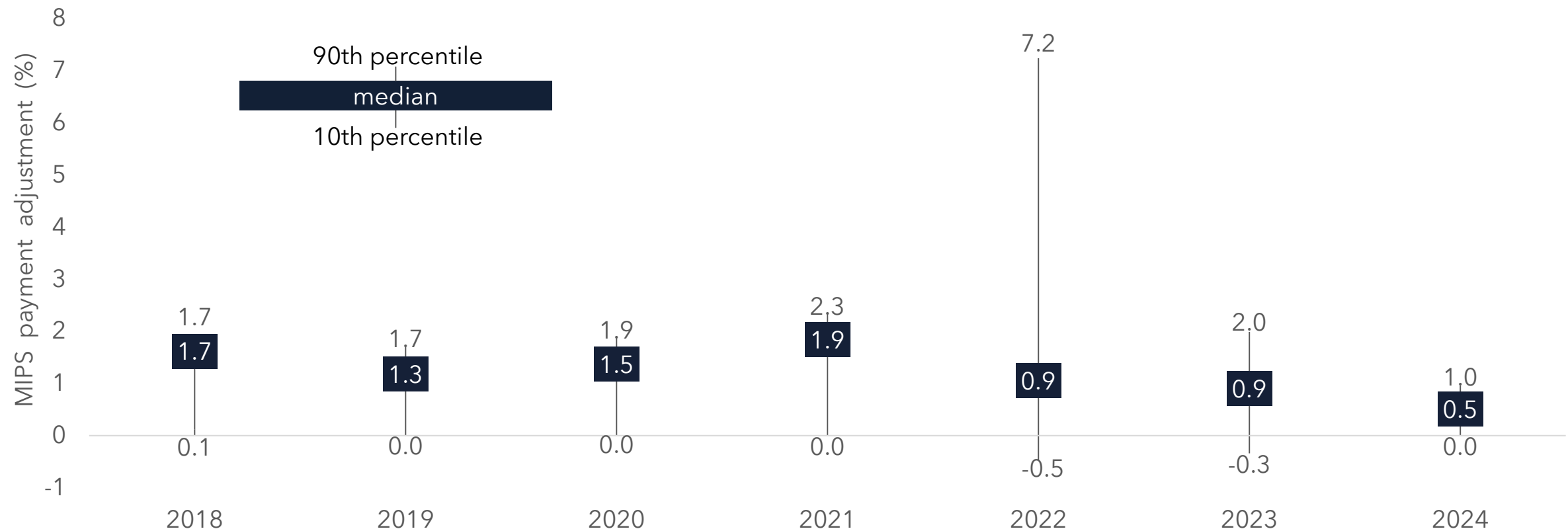
Note: MIPS (Merit-Based Incentive Payment System).
Source: MedPAC's March 2018 Report to Congress.

Clinicians report that MIPS reporting requirements are burdensome

- In multiple studies, clinicians and practice leaders reported substantial administrative burdens and costs to participate in MIPS
- Practice costs to participate in MIPS include:
 - Clinician and staff time to check MIPS eligibility, select a reporting track, collect performance data, and submit it to CMS
 - Working with technology vendors and consultants to collect data and determine which measures and options will optimize payments

Note: MIPS (Merit-based Incentive Payment System).
Source: Berdahl et al. 2019. Khullar, et al. 2021.

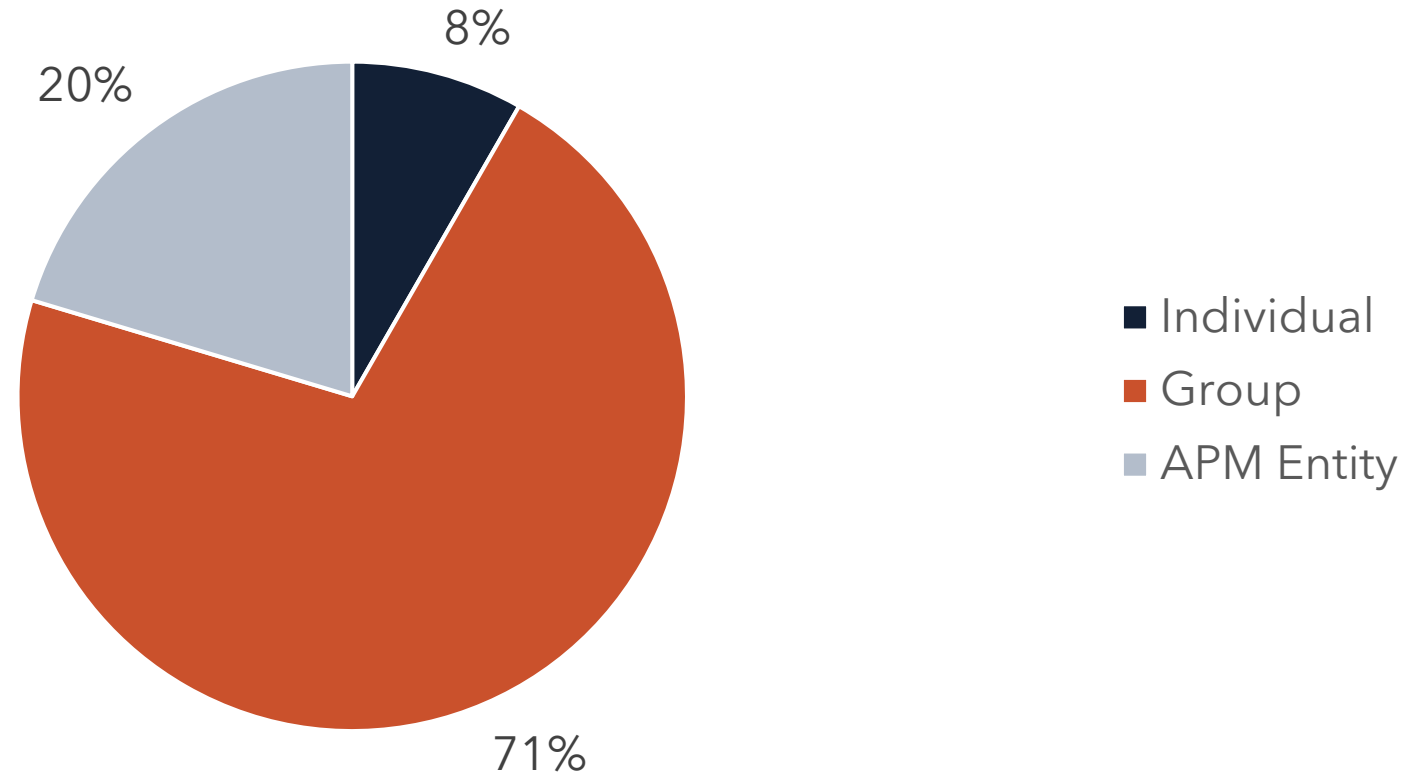
Most clinicians receive relatively small positive MIPS payment adjustments, 2019-2024 performance years



Note: From 2017 to 2022, CMS distributed an additional \$500 million amongst exceptional performers. In 2022, the performance threshold to receive an exceptional bonus increased, resulting in less exceptional performers and therefore higher exceptional adjustments than in previous years. Also, that year more clinicians earned a final score below the positive adjustment threshold, resulting in higher base adjustments than in past years; 2022 was also the end of some COVID-19-related “extreme and uncontrollable circumstance” policies. CMS updated the Cost category scoring policies from 2023 to 2024, which resulted in higher median performance so less of a range of payment adjustments.

Source: MedPAC analysis of CMS’s 2019-2024 QPP public use file.

The vast majority of MIPS-eligible clinicians are now scored as a group or APM entity



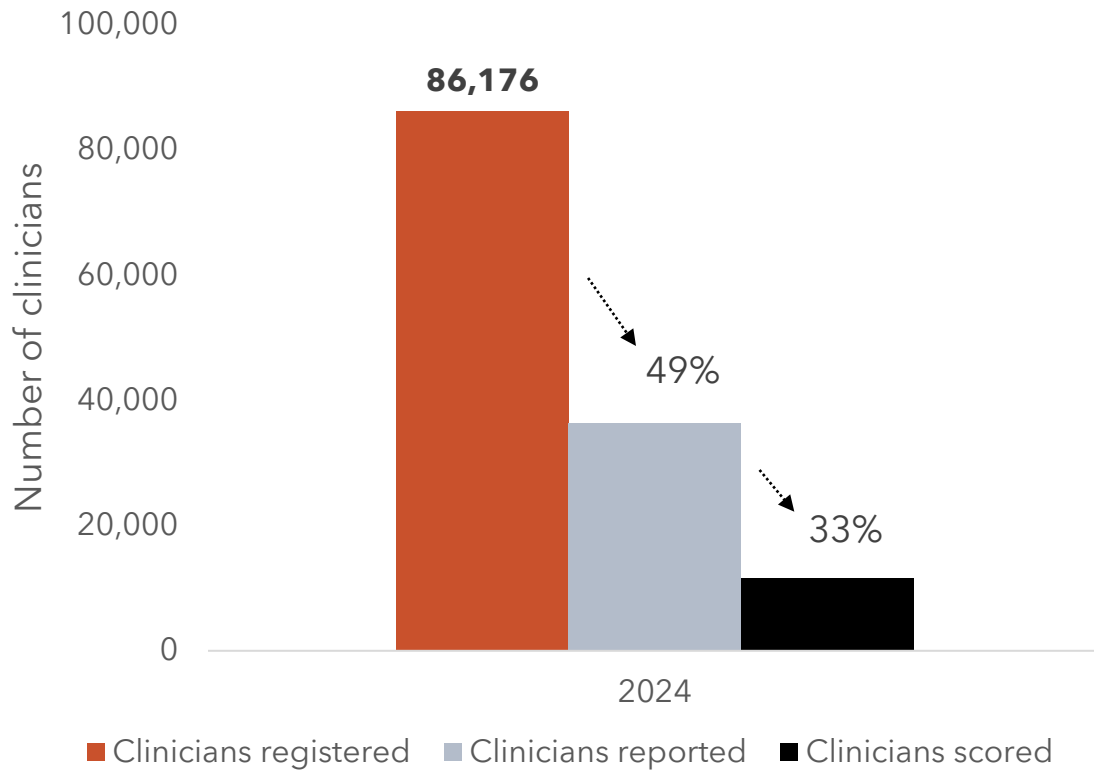
Note: APM (alternative payment model). The group category includes group, subgroup, and virtual groups participation options. Subgroup and virtual groups make up less than 1 percent of participants. Components may not sum to 100 percent due to rounding.

Source: CMS's 2024 QPP Experience report.

Inherent challenges to measuring clinician quality

- Some aspects of clinical care are difficult to measure, e.g.:
 - Teamwork
 - Bedside manner
 - Diagnostic accuracy
 - Clinical judgement
- Quality is hard to measure accurately
 - Small providers with a limited number of cases can produce unreliable results with high statistical noise
 - Risk-adjustment is imperfect, which makes comparisons challenging
 - Many providers perform similarly on some metrics, so performance differences are hard to detect

New optional MIPS Value Pathways are rarely being used for scoring



Note: 16 MVPs available in 2024.
Source: CMS QPP Experience report.

- CMS established optional MIPS Value Pathways (MVPs) in 2023
- Each MVP includes a subset of measures and activities related to a given specialty or medical condition
- 27 MVPs available in 2028
- CMS proposed making MVPs mandatory in 2029, but final timing will be made in future rulemaking

Note: MIPS (Merit-Based Incentive Payment System).

Challenges with paying for clinician performance

- Difficult to align incentives for performance-based payment
 - Outcomes are the product of multiple individuals and external factors
 - Time lags may reduce the salience of incentives
- Opportunity costs to choosing to focus on aspects of care tied to performance incentives over other aspects of care
- Payment incentives may introduce unintended consequences
- Complexity of reporting and scoring requires providers to invest in additional resources

Administrative burden and costs of P4P

- Survey data has indicated that physicians and their staff spend substantial time on activities related to quality reporting
- Case studies of health systems have concluded that participation in P4P generates millions in administrative costs, a substantial portion of which goes to third-party vendors
- CMS has spent over \$1B in measure development costs over a decade
- The tradeoff between small improvements to quality compared to substantial administrative burden raises questions about value of P4P

Note: P4P (pay-for-performance).
Source: Casalino et al. 2016, Saraswathula et al. 2023, Zhou et al. 2026, Scott et al. 2018, Wadhera et al. 2020, Emmert et al. 2012

Questions?

✉ Stephanie Cameron, Assistant Director, scameron@medpac.gov

🌐 www.medpac.gov

✕ @medicarepayment



Advising the Congress on Medicare issues

Medicare Payment Advisory Commission



www.medpac.gov



@medicarepayment