

Clinician quality initiatives in fee-for-service Medicare

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Presentation roadmap

- ① **Background on quality measurement**
- ② **Concerns with Merit-based Incentive Payment System (MIPS)**
- ③ **Incentivizing clinician quality: Evidence from the literature**
- ④ **Discussion**

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.

Clinicians have two quality incentive pathways in FFS Medicare

- Quality Payment Program launched in 2017
 - **A-APMs**: Participating entities assume financial risk for their patients with payment based on meeting quality standards; can receive payment incentives for participation
 - **MIPS**: Pay-for-performance program with additional reporting and payment requirements; intended to increase payments for high-value clinicians and reduce payment for low-value clinicians

Note: FFS (fee-for-service), A-APMS (advanced-alternative payment model), MIPS (Merit-based Incentive Payment System).

A-APMs are held accountable to quality performance standards

- CMS estimates that about half of clinicians now participate in A-APMs, vast majority are in MSSP ACOs
- CMS measures quality for all MSSP ACOs using 8 quality measures
- ACOs that meet or exceed CMS's quality performance standards receive their maximum shared savings rate and reduce their shared losses if they are in the arrangement with the highest risk
- ACO's clinician participants change annually, so it is difficult to discern the extent to which MSSP ACOs improve quality outcomes, although studies suggest that APMs do not harm care quality, and in some cases, can improve care quality

Note: A-APM (advanced-alterative payment model), MSSP (Medicare Shared Savings Program), ACO (accountable care organization).



Concerns with MIPS

Merit-based Incentive Payment System (MIPS)

- Calculates individual clinician-level or group-level payment adjustments based on four areas: Quality, improvement activities, promoting interoperability, and cost
- Assesses performance for the first three MIPS categories mainly using measures that clinicians themselves choose and report; cost measures are calculated by CMS
- Performance scores are then used to adjust Medicare Part B payments two years later

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)

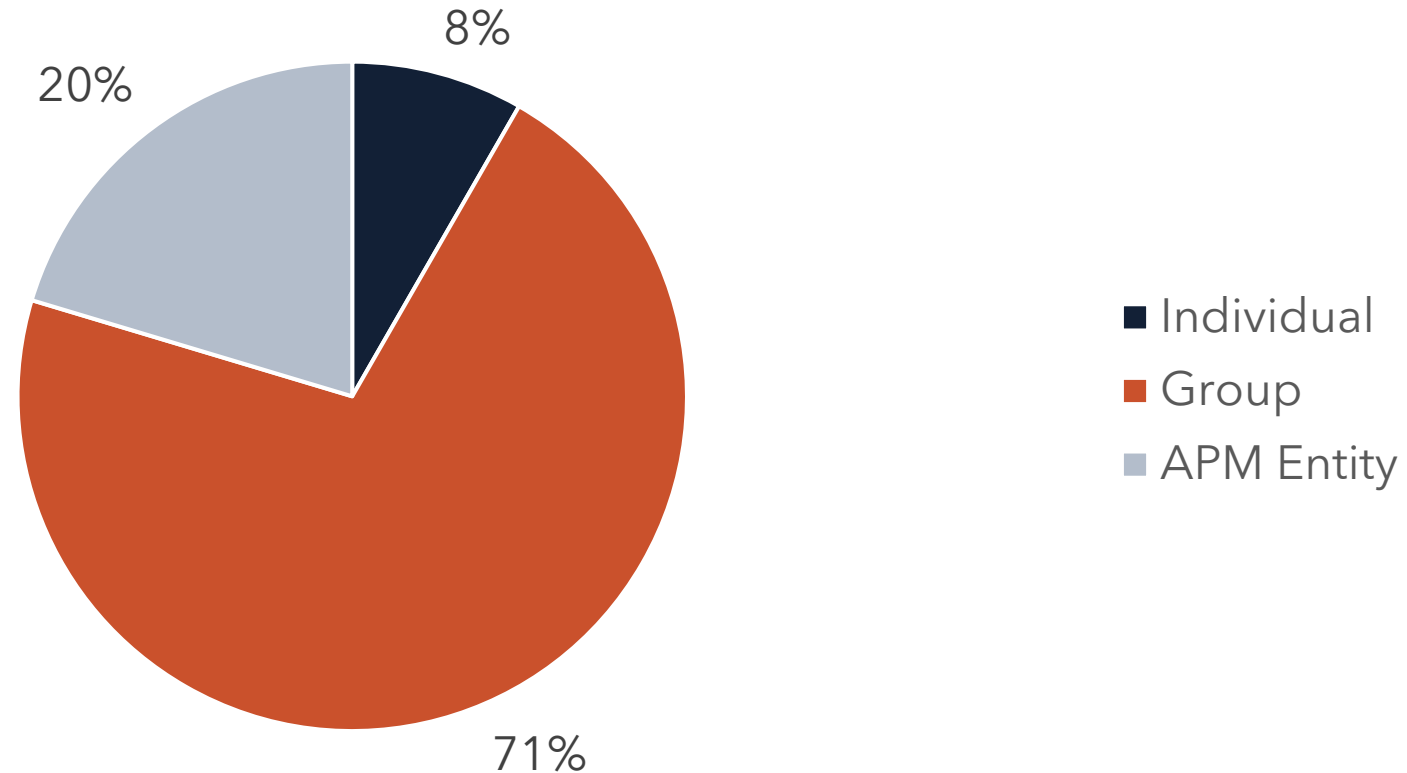
Note: MIPS (Merit-Based Incentive Payment System).
Source: MedPAC's March 2018 Report to Congress.

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.

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.

Some clinicians are ineligible for MIPS or chose not to report

- Estimate of Part B-billing clinicians who are exempt from MIPS has declined
 - CMS estimates that 11% of Medicare billing clinicians will be exempt from MIPS payment year 2029
- Decrease mainly due to increased A-APM participation and larger group reporting
- MIPS-eligible clinicians who do not submit data still receive a MIPS payment adjustment
 - CMS reported that 6% of MIPS-eligible clinicians did not report in 2024
 - 63% of these clinicians received a neutral payment adjustment

Note: MIPS (Merit-based Incentive System), A-APM (advanced-alternative payment model).
Source: CMS PFS 2026 proposed rule; CMS's 2024 QPP Experience report.

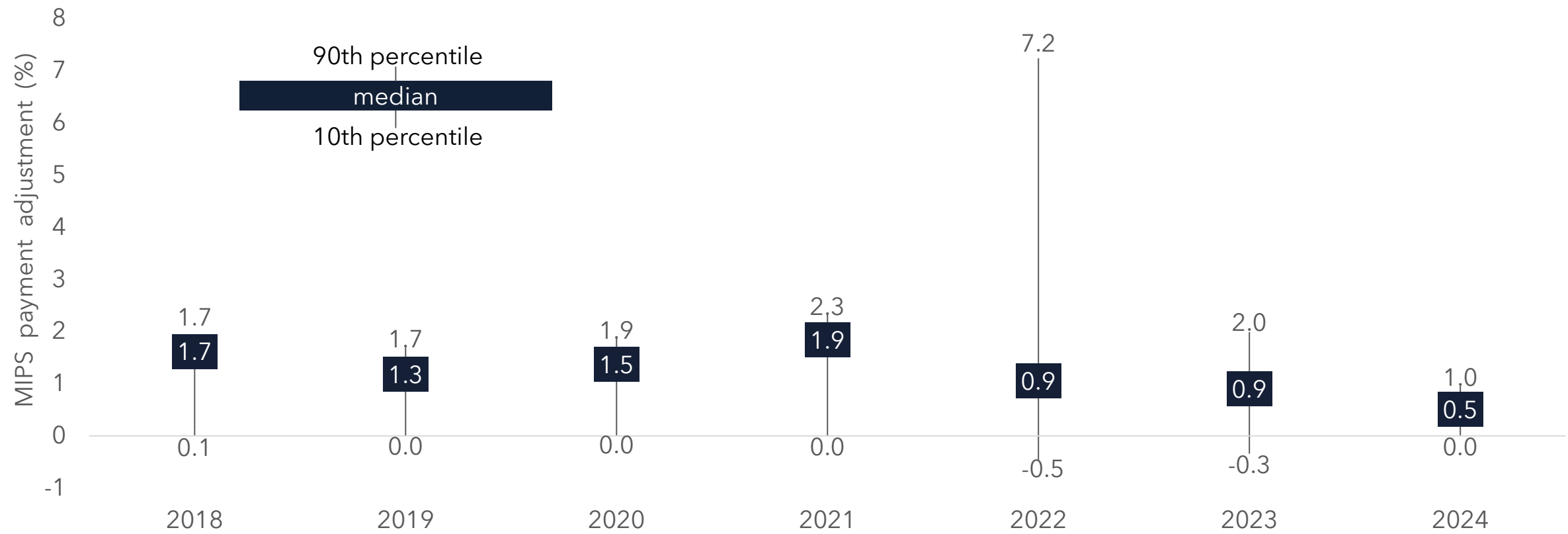
Clinicians chose from 100s of measures, and scores are high

Performance category	2026 Requirement	Number of measures available for scoring in 2026	2024 median unweighted category score
Quality	Report total of 6 measures; at least 1 must be an outcome or high-priority measure	764 quality measures, which have different (and sometimes multiple) collection types	79%
Improvement activities	Attest to 2 activities	95 activities	100%
Promoting interoperability	Submit CMS EHR certification ID, attestations, and report at least 17 related measures	Required attestations including 17 required measures and 10 bonus measures	100%
Cost	CMS calculates measures based on Medicare claims data	35 claims-based cost measures (2 population-based measures, 33 episode-based cost measures)	75%

Note: EHR (electronic health records). The number of quality measures include 195 measures listed in CMS measure management look up tool and 569 QCDR measures not included in the look-up tool.

Source: CMS' Quality Payment Program website; CMS's 2024 QPP Experience report.

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.

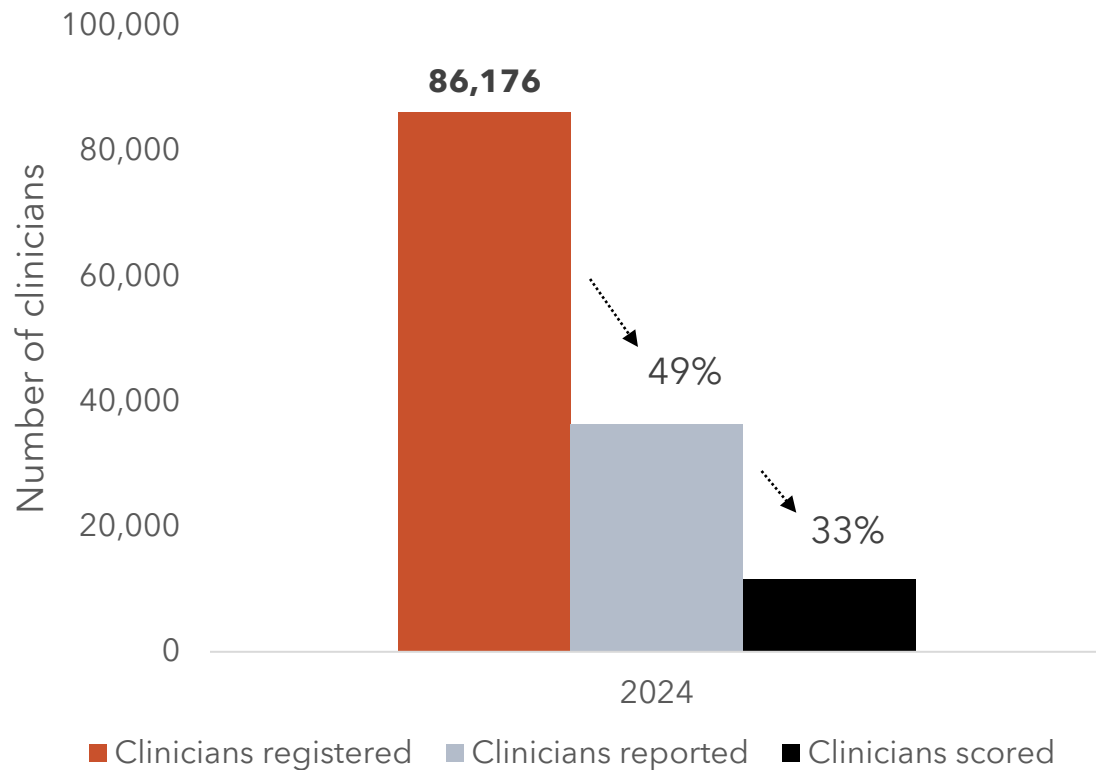
Source: MedPAC analysis of CMS’s 2019-2024 QPP public use file.

Studies have found that MIPS performance varies across categories of clinicians

- Low MIPS performers were more likely to be safety-net providers
- Positive MIPS performance associated with:
 - Practices located in urban areas and with larger patient populations
 - Communities with higher education levels and health care spending
- Findings suggest:
 - High MIPS scores may reflect the ability of physicians to collect, analyze, and report data
 - Clinicians caring for vulnerable populations are more likely to be penalized by MIPS scoring

Note: MIPS (Merit-based Incentive Program).
Source: Liao and Navathe. 2020. Liao et al. 2021. Joo et al. 2025.

New optional MIPS Value Pathways are rarely being used for scoring



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

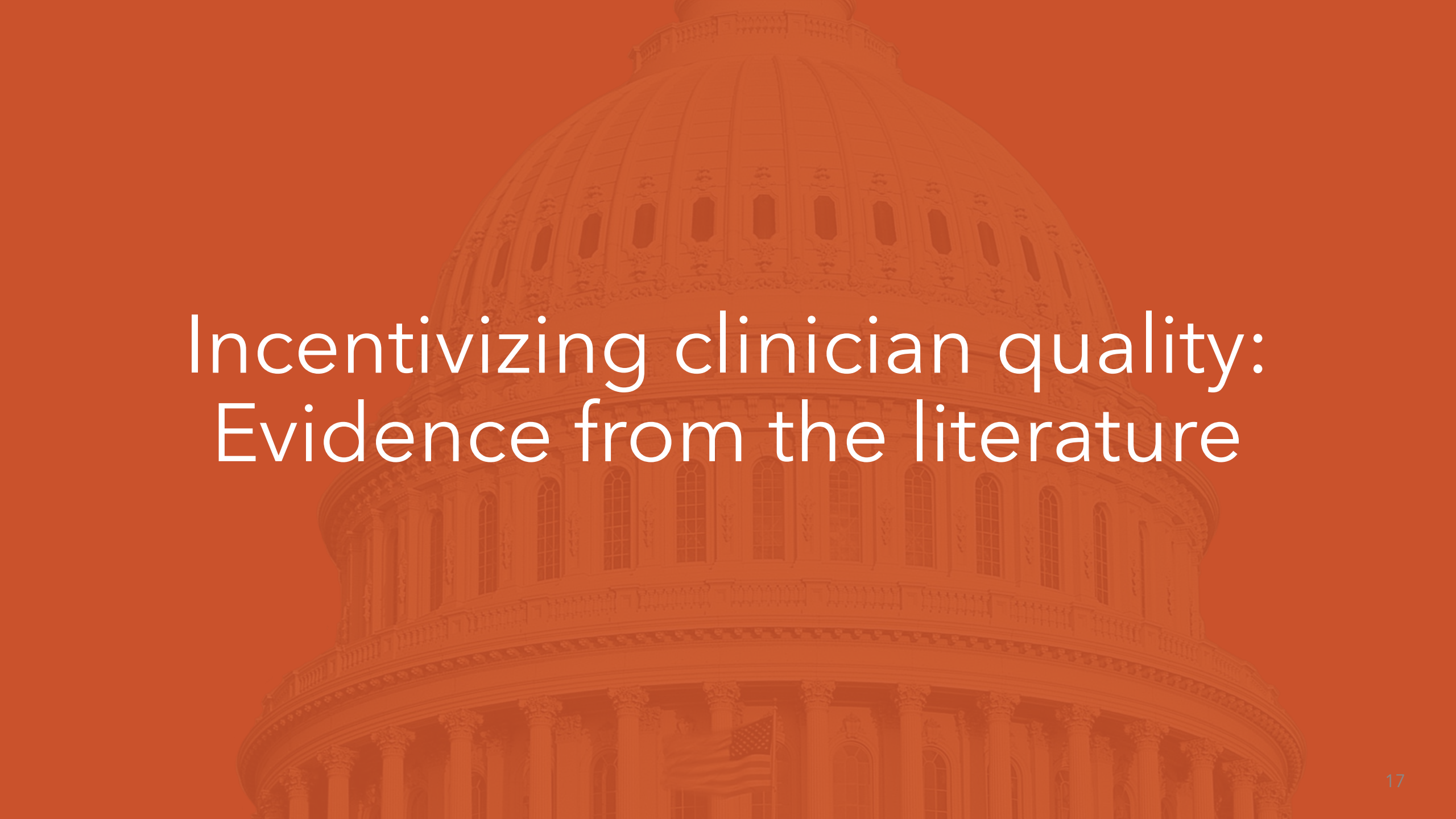
- CMS established optional MIPS Value Pathways (MVPs) in 2023
- Each MVP includes a subset of measures and activities related to a given specialty or medical condition
- 27 MVPs available in 2028
- CMS proposed making MVPs mandatory in 2029, but final timing will be made in future rulemaking

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

Many flaws in MIPS persist

MIPS flaws identified by MedPAC (2018)	Experience with MIPS to date
Burdensome and complex	Clinicians report that MIPS reporting requirements are burdensome; complex reporting and scoring requirements
Quality and payment adjustments determined at individual clinician level	Vast majority of MIPS-eligible clinicians (91%) are now scored as a group or APM entity
Many clinicians not evaluated due to insufficient number of cases	Estimated 11% of clinicians are ineligible for MIPS and 6% of MIPS-eligible clinicians do not report
Clinicians evaluated and compared on dissimilar measures	Clinicians chose from 100s of measures and scores are high
Because of self-chosen measures and low-performance thresholds, most clinicians receive a small, positive payment adjustment	Most clinicians receive relatively small positive MIPS payment adjustments

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



Incentivizing clinician quality: Evidence from the literature

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

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

Evidence of impact of clinician P4P is mixed; better-quality studies more likely to demonstrate no effect

- We identified 12 systematic reviews of P4P programs
 - Included studies ranged in scope from national initiatives to local demonstrations, including some Medicare quality programs
 - We focused on studies of clinicians
- Consensus across reviews: Effects of clinician P4P on quality measures were small, if extant
 - Reviews consistently found effects likelier to be observed for process measures than outcome measures
 - Several reviews found higher quality studies more likely to find no impact of P4P programs on a range of quality measures

Note:

P4P (pay-for-performance).

Sources:

de Bruin et al. 2011, Flodgren et al. 2011, Emmert et al. 2012, Eijkenaar et al. 2013, Damberg et al. 2014, Kondo et al. 2016, Ogundeji et al. 2016, Doran et al. 2017, Markovitz and Ryan 2017, Mendelson et al. 2017, Scott et al. 2018, Zaresani and Scott 2021.

Effects of P4P may be sensitive to program design and implementation

- Some evidence that performance may be associated with
 - Implementation processes
 - Engagement of clinicians in program development
 - Size of incentives
 - Organizational and socioeconomic characteristics
- Performance is sensitive to choice of metrics
 - Clinical quality and patient experience vs. efficiency/cost
 - Dose-response relationship between activity and outcome

Note:

P4P (pay-for-performance).

Sources:

Damberg et al. 2014, Kondo et al. 2016, Markovitz and Ryan 2017, Ogundeji et al. 2016, Damberg et al. 2019, Doran et al. 2017, Martin et al. 2020.

Potential unintended consequences of paying for clinician performance

- Financial incentives may encourage detrimental behaviors, e.g., selective data reporting, over-focusing on measures being scored, patient selection
- Relative targets may ensure rewards accrue to already well-resourced, high performers
- Clinicians in qualitative studies have reported that while incentives can support internal motivation to provide high-quality care, they can also:
 - Interfere with clinical judgment and sense of autonomy
 - Create tensions within teams

Sources: Bellé 2015, Brosig-Koch et al. 2025, Green 2014, Bernz et al. 2026, Deci et al. 1999, Doran et al. 2017, Lester et al. 2011, Martin et al. 2020, Siciliani 2009, Arnold 2016, Lohman et al. 2015, Khullar et al. 2021, Martin et al. 2020, NORC at the University of Chicago 2024.

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

Summary

- Majority of clinicians are being scored as a group in MIPS, but other flaws persist:
 - Burdensome and complex
 - Some clinicians are ineligible for MIPS or choose not to report
 - Clinicians choose from 100s of measures, and scores are high
 - Most clinicians receive relatively small, positive MIPS payment adjustments
- Experience to date shows that MIPS may not be equitable: performance varies across categories of clinicians, including those caring for vulnerable populations
- MVPs have potential to improve the ability to compare clinicians, but rarely used

Note: MIPS (Merit-based Incentive Payment System), MVP (MIPS value pathways).

Summary (continued)

- Some challenges are inherent to measuring and paying for quality, and go beyond MIPS
- Consensus across systematic reviews of clinician P4P find effects on quality were small, if extant, and better-quality studies were more likely to demonstrate no effect
 - Effects of P4P may be sensitive to design and implementation
 - Potential unintended consequences of clinician P4P
 - Administrative burden and cost associated with P4P

Note: MIPS (Merit-based Incentive Payment System), P4P (pay-for-performance).

Potential analytic work

- Further analysis of MIPS participation and performance data, e.g.:
 - Performance across individual-level and group-level reporting
 - Quality measures and collection types being scored
 - Distribution of performance across measures and change over time
 - Characteristics of clinicians reporting MVPs
- Stakeholder interviews about experiences with MIPS, including benefits and challenges
- Lessons from other experiences in performance incentives

Note: MIPS (Merit-based Incentive Payment System), MVP (MIPS value pathways).

Discussion

- What value is the Medicare program and its beneficiaries getting from current clinician quality incentive programs? Do the benefits outweigh the costs?
- How can the Medicare program balance quality measurement with administrative burden/costs, reliability of data, and benefits to beneficiaries? What types of approaches will be practical, feasible, and improve beneficiary care?
- Feedback on potential analytic plan?



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