

With the Merit-Based Incentive Payment System, Pay for Performance Is Now National Policy

Effective 1 January 2017, 600 000 clinicians who care for adults with fee-for-service (Part B) Medicare insurance are subject to the mandatory Quality Payment Program's financial incentives for high-quality, high-value care. This complex policy was established under the Medicare Access and CHIP Reauthorization Act of 2015, which passed with strong bipartisan support. Clinicians can participate in the Quality Payment Program through the Merit-Based Incentive Payment System (MIPS)—the default track—or through Advanced Alternative Payment Models, such as risk-bearing accountable care organizations. Under MIPS, the Centers for Medicare & Medicaid Services (CMS) will assign penalties or rewards to 500 000 clinicians in all specialties, making it the largest pay-for-performance initiative in history (1).

MIPS consolidates and replaces the Physician Quality Reporting System, the Electronic Health Record Incentive Program, and the Value-based Payment Modifier program. Under MIPS, CMS will assign performance scores based on quality of care; use of certified electronic health record technology; the cost of care; and, in a newly added dimension, participation in practice-based improvement activities. Clinicians will attempt to meet performance standards in the first year; submit data, be assigned performance scores, and receive feedback in the second year; and see adjustments to total Medicare payments for services provided in the third year. Clinicians can participate as individuals or members of a group, regardless of specialty or practice site. Performance will be publicly reported. To assign rewards and penalties, CMS will compare performance scores with the mean or median value. The maximum penalty or reward will increase from 4% in 2019 to 9% in 2022 and after. Exceptional performers can earn additional rewards during the first 6 years (1).

The first year of MIPS is a transition year with special requirements. Quality of care, use of electronic health records, participation in improvement activities, and costs will contribute 60%, 25%, 15%, and 0% of the performance score, respectively. To be eligible for the maximum reward, individual clinicians can submit data on up to 6 quality measures and 5 electronic health record measures and complete 4 improvement activities. To avoid a penalty, clinicians need only report data on 1 quality or electronic health record measure or complete 1 improvement activity. Details of the policy will change over time (1).

Research offers insight into the potential effects of MIPS on quality of care. Mendelson and colleagues examined 69 recent studies that evaluated pay-for-performance initiatives (2). Most of the initiatives focused on primary care, particularly prevention (for ex-

ample, flu shots), screening (for example, breast and cervical cancer), and management of chronic conditions (for example, diabetes and hypertension). Typically, the initiatives targeted care processes or intermediate outcomes, addressed underuse of necessary care, and involved rewards; few initiatives focused on patient-important outcomes, overuse, or penalties. Some incentives were directed at individual clinicians, whereas others focused on groups. After implementation, performance on process measures frequently improved, intermediate outcomes sometimes improved, and patient-important outcomes seldom improved. Most of the studies had major methodological limitations, such as lack of a control group, and the more rigorous studies reported less favorable findings (2). Other recent systematic reviews reached similar conclusions and also found that pay-for-performance initiatives emphasized primary care, care processes and intermediate outcomes, underuse, and rewards (3-5).

Given that research has emphasized primary care, little is known about the effects of pay for performance on specialty care. Furthermore, the collective experience with quality measurement and improvement is better-developed for primary care than for specialty care. For example, most of the quality measures in 2 major public reporting programs—the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set and CMS's Physician Quality Reporting System—relate to primary care (6, 7). Few CMS-approved measures exist for many specialties, including hospital medicine, oncology, palliative care, allergy and immunology, and dermatology. For specialties with few quality measures, CMS will reweight MIPS performance scores to emphasize participation in improvement activities (1). In May 2016, CMS published an ambitious Quality Measure Development Plan that prioritizes patient-reported outcomes; patient experience; care coordination; and appropriateness of care, including overuse (8). Yet, developing quality measures with desired attributes may be challenging, particularly in fields where only small, low-quality studies have examined commonly used clinical practices. Even after new measures have been developed, it will take years to refine them, understand quality deficits, and design effective improvement strategies.

In addition to effects on specialty care, another area of uncertainty is how clinicians will respond to the MIPS incentive design. To date, the relationship between design of pay-for-performance incentives and effectiveness has not been empirically examined. Prior pay-for-performance initiatives have emphasized rewards, whereas MIPS also includes penalties, which tend to have stronger effects on human behavior (9). Simple choices and immediate feedback are generally

more influential than complex choices and delayed feedback (9), yet MIPS is an elaborate policy that applies incentives 2 years after care is provided. Furthermore, MIPS incentives will be distributed across all Part B reimbursements (1), rather than as a lump sum that might be more likely to draw the attention of busy clinicians.

If MIPS succeeds at influencing clinician behavior, unintended consequences will be another important question. Systematic reviews on pay for performance have found inconsistent evidence of gaming, such as changing documentation to improve quality scores; spillover effects, such as influencing care that is not subject to incentives; and risk selection, such as focusing on healthier patients (3-5). A unique aspect of MIPS is that clinicians can choose to participate as individuals or in groups. This creates an incentive for physician practices to selectively exclude clinicians with lower performance scores. Clinicians may be deterred not only from treating patients who are sicker or less adherent to treatment recommendations but also from affiliating with clinicians who treat such patients, which could exacerbate socioeconomic disparities in care.

Despite the current broad-reaching implications of MIPS, the number of clinicians affected may diminish over time. In the first 6 years, CMS plans to pay an additional 5% to clinicians who participate in Advanced Alternative Payment Models (1). Also, 30% of Medicare beneficiaries are now enrolled in Medicare Advantage plans, and enrollment continues to climb (10); clinicians may follow the beneficiaries in shifting away from fee-for-service Medicare. Nonetheless, whether clinicians participate in MIPS, Advanced Alternative Payment Models, or Medicare Advantage, they can continue to expect Medicare payments for professional services to be linked to performance on measures of quality and value.

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Disclosures: Disclosures can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M16-2947.

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Ann Intern Med. 2017;166:368-369. doi:10.7326/M16-2947

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