

# Physician Practice Leaders' Perceptions of Medicare's Merit-Based Incentive Payment System (MIPS)



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**BACKGROUND:** Medicare's Merit-based Incentive Payment System (MIPS) is a major value-based purchasing program. Little is known about how physician practice leaders view the program and its benefits and challenges.

**OBJECTIVE:** To understand practice leaders' perceptions of MIPS.

**DESIGN AND PARTICIPANTS:** Interviews were conducted from December 12, 2019, to June 23, 2020, with leaders of 30 physician practices of various sizes and specialties across the USA. Practices were randomly selected using the Medical Group Management Association's membership database. Practices included small primary care and general surgery practices (1–9 physicians); medium primary care and general surgery practices (10–25 physicians); and large multispecialty practices (50 or more physicians). Participants were asked about their perceptions of MIPS measures; the program's effect on patient care; administrative burden; and rationale for participation.

**MAIN MEASURES:** Major themes related to practice participation in MIPS.

**KEY RESULTS:** Interviews were conducted with 30 practices representing all US census regions. Six major themes emerged: (1) MIPS is understood as a continuation of previous value-based payment programs and a precursor to future programs; (2) measures are more relevant to primary care practices than other specialties; (3) leaders are conflicted on whether the program improves patient care; (4) MIPS creates a substantial administrative burden, exacerbated by annual programmatic changes; (5) incentives are small relative to the effort needed to participate; and (6) external support for participation can be helpful. Many participants indicated that their practice only participated in MIPS to avoid financial penalties; some reported that physicians cared for fewer patients due to the program's administrative burden.

**CONCLUSIONS:** Practice leaders reported several challenges related to MIPS, including irrelevant measures, administrative burden, frequent programmatic changes, and small incentives. They held mixed views on whether the program improves patient care. These findings may be useful to policymakers hoping to improve MIPS.

**KEY WORDS:** physician payment; administrative burden; value-based purchasing; Merit-based Incentive Payment System.

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## INTRODUCTION

The Merit-based Incentive Payment System (MIPS) is a major value-based purchasing program that influences payment for more than three hundred thousand physicians across the USA each year. The program was established by the Medicare Access and CHIP Reauthorization Act (MACRA) and measures performance in four domains: quality, costs, practice improvement, and promoting interoperability (effective use of electronic health records). The Centers for Medicare and Medicare Services (CMS) evaluates performance across these domains and adjusts part B fee-for-service reimbursement 2 years later. For example, based on 2017 performance, 2019 payment rates were adjusted by up to  $\pm 4\%$ . (Actual positive adjustments were lower because the program is budget-neutral and there were more high-performers than low-performers in 2017.) Payment adjustments are set to increase substantially to  $\pm 9\%$  by 2022.

Since the inception of MIPS, physicians, researchers, and policymakers have raised many concerns about the program, including that it increases administrative burden, distracts from other worthwhile activities, and does not accurately capture quality.<sup>1–4</sup> The Medicare Payment Advisory Commission has recommended eliminating MIPS altogether,<sup>5</sup> and recent studies suggest that the program may disadvantage small and independent practices, and those that serve a high proportion of low-income patients.<sup>6, 7</sup>

Despite these concerns, there is little rigorous data on physician practice leaders' views of the program to guide policy. Prior studies have examined physicians' views of alternative payment models more generally,<sup>8</sup> or perceptions of MIPS within a single specialty.<sup>9</sup> A survey of physicians conducted in 2017, several months after the MIPS started, found low familiarity with the program.<sup>10</sup> But knowledge and views of

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MIPS, now in its fourth calendar year, have likely changed as practices have gained more experience with the program.

In this study, we chose to use in-depth, semi-structured interviews to examine practice leaders' views of MIPS. We used interviews because MIPS is a complex program and we believed that interviews, which allow respondents to clarify views and provide detailed comments, would result in a deeper exploration than would surveys. To our knowledge, this is the first qualitative study of practice leaders' perceptions of MIPS with random selection of participants across multiple specialties and regions of the country. In an effort to inform current and future value-based payment policy discussions, we examined the views of practice leaders about the MIPS program, its benefits and challenges, and how it could be improved.

## METHODS

### Setting and Study Design

We conducted 45- to 60-min semi-structured telephone interviews with leaders (physician-executives or senior non-physician practice administrators) of physician practices across the USA. In total, leaders of 185 practices were invited and 30 were interviewed about their views of the MIPS program, including perceptions of MIPS measures; the program's effect on patient care; the level of administrative burden; strategies and rationale for participation; and overall impressions and suggestions for improvement. Because MIPS is a relatively new and complex program, we elected to use interviews instead of surveys to examine practice leaders' perceptions, which we believed would allow us to explore nuanced viewpoints and probe deeper when needed. Interviews focused on the 2019 participation year and were conducted between December 12, 2019, and June 23, 2020. All interviews were conducted by at least one faculty member (D.K., L.P.C., A.M.B., or D.G.); a research assistant took notes. The project was deemed exempt by the Institutional Review Board at Weill Cornell Medical College.

We identified practices and administrative contacts using the Medical Group Management Association's membership database.<sup>11</sup> Practices were categorized by size, specialty, and census region. Small practices were defined as having 1–9 physicians; medium practices as having 10–25 physicians; and large practices as having 50 or more physicians. Practices were classified as being primary care or general surgery if at least 80% of their physicians practiced in the dominant specialty. Multispecialty practices were those that self-reported as having multiple primary care, medical, and/or surgical specialties. Additional details can be found in the eMethods in the [Supplement](#).

### Participant Recruitment

Practices were randomly selected within each category (small primary care, medium primary care, small general surgery,

medium general surgery, large multispecialty) and invited via email (Supplement, eDocument 1). Leaders of small practices were offered a \$1000–\$1500 incentive to participate; those in medium or large practices were offered \$500. Practices were sent 2 follow-up emails and received 2 phone calls if they did not respond to initial requests. Before each interview, practices were asked to confirm the number and specialty of physicians; their participation in MIPS during the 2019 calendar year; and whether they reported through a MIPS Alternative Payment Model (APM).

### Interview Protocol

The interview protocol was developed through a literature review of MIPS and other value-based purchasing programs and prior research experience of the investigative team members.<sup>1–3, 6, 9, 10, 12, 13</sup> It was then refined through pilot interviews with physician leaders and health care quality experts. It included questions on general impressions of the MIPS program; perceived benefits and challenges; the relevance of MIPS measures; if and how the program could be improved; how participating in the program affected patient care; whether MIPS had led practices to consider administrative changes, such as hiring new employees or interacting with other health care organizations; and other open-ended questions about the program. Each practice also asked about the share of its patients insured by Medicare, or the percentage of overall revenue it received from Medicare. The protocol also included many questions about how much it cost practices to participate in the MIPS program, the results of which are presented in a separate paper. The protocol is available in the Supplement, eDocument 2.

### Analysis

We identified main themes guided by a framework analysis.<sup>14</sup> Transcripts were created based on detailed notes taken during each interview. A preliminary codebook was developed through independent and inductive coding of 10 transcripts by three research team members (D.K., Y.Q., and E.O.). These codes were discussed with the entire research team and iteratively refined as additional transcripts were coded. Two investigators (Y.Q. and E.O.) then deductively coded all interviews using qualitative analysis software (Atlas.ti, Version 8.4.4). The coders met with each other and D.K. to discuss findings and discrepancies were resolved.

## RESULTS

We interviewed leaders of 30 practices that participated in the MIPS program in 2019, i.e., 9 small primary care practices, 6 small general surgery practices, 4 medium primary care practices, 4 medium general surgery practices, and 7 large multispecialty practices (Table 1). No significant differences were observed between respondents and non-respondents

**Table 1 Characteristics of Practices Interviewed about participation in the Merit-based Incentive Payment System in 2019**

Practice type	Number of practices (no. (%))	Mean size <sup>a</sup> (physicians)	Mean APPs	Medicare share <sup>b</sup> (%)—mean
Overall	30 (100)	31.5	17.5	21.9%
Region				
Northeast	6	7.2	1.7	24.7%
South	10	19.0	8.3	23.3%
Midwest	7	65.1	49.6	20.9%
West	7	36.6	12.1	18.5%
APM status				
APM	14 (46.7)	23.9	8.4	21.6%
Non-APM	16 (53.3)	38.2	25.4	22.2%
Specialty				
Small	9 (30.0)	4.1	2.4	22.4%
Primary Care				
Medium	4 (13.3)	12.0	3.8	19.4%
Primary Care				
Small	6 (20.0)	5.8	2.0	22.7%
General Surgery				
Medium	4 (13.3)	19.0	7.8	27.8%
General Surgery				
Large	7 (23.3)	107.0	63.6	18.6%
Multispecialty				

Abbreviations: APM, Alternative Payment Model; APPs, advanced practice practitioners

<sup>a</sup>Mean size was defined as the number of unique physicians in the practice

<sup>b</sup>Medicare share indicates the proportion of Medicare fee-for-service revenue or Medicare fee-for-service patients in the practice

(eTable 1). Practices were located in all US census regions. In total, 46.7% of practices reported through a MIPS APM; the mean fee-for-service Medicare share was 21.9%. The analysis resulted in 6 major themes. They are presented along with illustrative quotations in Table 2.

**Theme 1: MIPS Is Seen as a Continuation of Prior Value-Based Purchasing Programs—and a Marker of Things to Come**

Many participants reported that they saw MIPS as the next phase in the evolution of Medicare VBP programs. In particular, participants reported that the Meaningful Use program had previously motivated practice changes and prepared them for aspects of the MIPS program: “For us, it all started with Meaningful Use and that’s kind of morphed into MIPS. With Meaningful Use, certain things were required or recommended and we worked those into our practice and carried them forward. It’s just kind of second nature now.” Another respondent said: “I think when we first started doing this, there was a lot to do. Now we have our interfaces set up and we have been doing this for three or four years. But the initial setup was tremendous.”

Participants also reported that the decision to invest additional time and resources into MIPS participation was partially influenced by a belief that similar VBP programs will be introduced by both public and private insurance programs in the future: “We slowly realized that it’s not just MIPS, or even Medicare. This stuff is now coming from all insurers and

**Table 2 Major Themes and Illustrative Quotes Summarizing Practice Leaders’ Perceptions of MIPS**

Major theme	Illustrative quotes
MIPS as a continuation of prior VBP programs—and a marker of things to come	<p>“We felt that this was the direction that eventually we’re going to be forced to go anyway...”</p> <p>“I think when we first started doing this, there was a lot to do. Now we have our interfaces set up and we have been doing this for three or four years. But the initial setup was tremendous.”</p> <p>“For us, it all started with Meaningful Use and that’s kind of morphed into the MIPS. With Meaningful Use, certain things were required or recommended and we worked those into our practice and carried them forward. It’s just kind of second nature now.”</p> <p>“We slowly realized that it’s not just MIPS, or even Medicare. This stuff is now coming from all insurers and payors...It’s more and more a part of where health care is going.”</p> <p>“For surgeons, there are not a lot of measures. We basically choose by what we score the highest on.”</p> <p>“There are very specific specialties [for which] a lot of this primary care data collection isn’t an appropriate form. Let’s have less quality measures to report and make them meaningful to us, and we will be able to report them better.”</p> <p>“As a multispecialty group... finding measures that the whole group could meet together was a concern.”</p> <p>“Being a general surgery practice, we would never do any of these. They are so far from what we can even make work.”</p> <p>“MIPS has absolutely hurt. I see no benefit for patient care.”</p> <p>“I feel like it has improved care but it’s very costly. It takes so much time to gather all that information that you cannot see as many patients.”</p> <p>“There are positives and negatives. The end result—which is keeping patients healthy, closing gaps, keeping people out of hospital—that goal is what internal medicine is all about. But the hoops that we have to jump through are sometimes very onerous.”</p> <p>“It feels like MIPS helps patient care. In the beginning, that was hard to see. But I can now that it’s come full circle. It’s becoming less of a burden—maybe there are less things to do, or maybe we’ve figured it out.”</p> <p>“MIPS is hindering. Making sure they are checking all those boxes. It becomes more about that than the actual patient. But it’s also improved things in a positive way; there are certain things that we</p>
Measures are more relevant for primary care than general surgery or subspecialists	<p>“For surgeons, there are not a lot of measures. We basically choose by what we score the highest on.”</p> <p>“There are very specific specialties [for which] a lot of this primary care data collection isn’t an appropriate form. Let’s have less quality measures to report and make them meaningful to us, and we will be able to report them better.”</p>
Mixed perceptions on whether MIPS improves patient care	<p>“MIPS has absolutely hurt. I see no benefit for patient care.”</p> <p>“I feel like it has improved care but it’s very costly. It takes so much time to gather all that information that you cannot see as many patients.”</p> <p>“There are positives and negatives. The end result—which is keeping patients healthy, closing gaps, keeping people out of hospital—that goal is what internal medicine is all about. But the hoops that we have to jump through are sometimes very onerous.”</p> <p>“It feels like MIPS helps patient care. In the beginning, that was hard to see. But I can now that it’s come full circle. It’s becoming less of a burden—maybe there are less things to do, or maybe we’ve figured it out.”</p> <p>“MIPS is hindering. Making sure they are checking all those boxes. It becomes more about that than the actual patient. But it’s also improved things in a positive way; there are certain things that we</p>

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Table 2. (continued)

Major theme	Illustrative quotes
Substantial administrative burden exacerbated by programmatic changes	wouldn't have paid attention to if not for MIPS." "Seems like CMS can't leave things the same ever..." "It's very hard to give CMS the info that they are looking for. It's complicated and time consuming. The docs are frustrated with the extra clicking and form filling out. The price that they are having to pay is burnout. It's just not rewarding." "Some doctors have retired instead of working part-time." "For us, the biggest part is that doctors can't see as many patients as they used to..."
Incentives are small relative to effort needed to participate	"I personally think that what we're doing is avoiding a penalty. Because we know we will be punished financially if we don't do everything perfectly." "Penalties make it unbearable not to participate. The carrot isn't enticing, but the stick is painful." "Financially for us it is not at all meaningful. What we received in MIPS payments doesn't cover the cost and time that we invest." "You spend a whole bunch of time and do a lot of work, and then you get a tiny adjustment. It's not really worth it."
Need for external support for MIPS participation	"We did bring in outside consultants. They ran around with us for a year. They helped us navigate through a lot of very arduous processes with all the extra boxes to collect." "There are obviously some practices that do not have resources we have, or the time to dedicate to this. I can't imagine not having the time to do adequate research on this stuff. I mean, it's very complicated to understand and it changes every year." "There was this program funded program by Medicare that was extremely helpful. Someone would meet with me like five times a year and help just muddle through the issues we were having."

payors...It's more and more a part of where health care is going." Another practice leader said reported that "we felt that this was the direction that eventually we're going to be forced to go anyway."

**Theme 2: MIPS Measures Are More Relevant for Primary Care Practices than for General Surgery or Multispecialty Practices**

During interviews with practices of different specialties, many leaders felt that current MIPS measures are more appropriate for primary care practices than other specialties. Leaders of general surgery practices reported that "for surgeons, there are

not a lot of measures. We basically choose by what we score the highest on. We don't really do tobacco counseling, breast cancer screening, flu vaccines." Another practice leader stated that "being a general surgery practice, we would never do any of these. They are so far from what we can even make work." The participant suggested that having fewer, more relevant measures would be helpful. Large multispecialty practices also reported challenges identifying measures to report on that seemed relevant to different specialists within their groups: "As a multispecialty group...finding measures that the whole group could meet together was a concern."

**Theme 3: Practice Leaders Held Mixed Perceptions About Whether MIPS Improves Patient Care**

Whether MIPS improves patient care was the question about which opinions differed most among participants. In an analysis of transcripts completed by two coders (Y.Q. and E.O.), 3 practices expressed consistently positive views of MIPS; 22 practices expressed intermediate or ambivalent views; and 5 practices expressed consistently negative views (Table 3). Four of the 5 practices with consistently negative views were small practices of 9 or fewer physicians; no other consistent pattern emerged. Some participants suggested that MIPS is beneficial in theory, but the complexity of the program renders it ineffectual and burdensome. Participants who reported

Table 3 Ranking of Practice Leaders' Views of the Merit-based Incentive Payment System (MIPS)

Practice attitude	Practice name	Practice type
Positive	Practice 1	Small Primary Care
	Practice 2	Small General Surgery
	Practice 3	Large Multispecialty
Intermediate	Practice 4	Small Primary Care
	Practice 5	Small Primary Care
	Practice 6	Small Primary Care
	Practice 7	Small Primary Care
	Practice 8	Small Primary Care
	Practice 9	Small Primary Care
	Practice 10	Medium Primary Care
	Practice 11	Medium Primary Care
	Practice 12	Medium Primary Care
	Practice 13	Medium Primary Care
	Practice 14	Small General Surgery
	Practice 15	Small General Surgery
	Practice 16	Small General Surgery
	Practice 17	Medium General Surgery
	Practice 18	Medium General Surgery
	Practice 19	Medium General Surgery
	Negative	Practice 20
Practice 21		Large Multispecialty
Practice 22		Large Multispecialty
Practice 23		Large Multispecialty
Practice 24		Large Multispecialty
Practice 25		Large Multispecialty
Practice 26		Small Primary Care
Practice 27		Small Primary Care
Practice 28		Small General Surgery
Practice 29		Small General Surgery
Practice 30		Medium General Surgery

Note. Two coders independently reviewed each transcript and assigned a favorability rating (favorable, intermediate, or unfavorable). There was concordance on 28 of 30 interviews; 2 discrepancies were resolved through discussion

MIPS improved care cited greater attention to activities that might otherwise have been neglected—annual wellness visits, chronic disease management, services for hearing-impaired patients—while those who had negative views of the program felt such measures were irrelevant to their practice or required burdensome data collection and reporting activities they were already engaged in.

One participant, emblematic of practice leaders who had negative views of MIPS, said: “MIPS has absolutely hurt. I see no benefit for patient care.” The views of practice leaders with more moderate views were captured by a participant who reported that “the end result—which is keeping patients healthy, closing gaps, keeping people out of hospital—that goal is what internal medicine is all about. But the hoops that we have to jump through are sometimes very onerous.” Some reported that, with time, the potential benefits of MIPS accrue, whereas the initial burdens, related to startup costs of investing in a data collection and reporting infrastructure, decrease: “It feels like MIPS helps patient care. In the beginning, that was hard to see. But I can now see that it’s come full circle. It’s becoming less of a burden—maybe there are less things to do, or maybe we’ve figured it out.”

But even participants who reported that MIPS may have improved patient care felt that the program was burdensome: “I feel like it has improved care but it’s very costly. It takes so much time to gather all that information that you cannot see as many patients.” One participant noted, “my time is a big cost. I would say, \$30,000 a year of my salary would probably be attributed to [MIPS] directly”; another reported that expense of participation was equivalent to a “full-time person with benefits—probably like a \$50,000 is needed to make this work.”

#### **Theme 4: MIPS Creates Substantial Administrative Burden which is Exacerbated by Frequent Programmatic Changes**

Nearly all participants reported substantial administrative burden associated with MIPS participation, and many described yearly changes to the program as a particular source of frustration. These include introduction or removal of quality measures; changes in weighting of MIPS score domains; new requirements and incentives; and uncertainty around the size of rewards and penalties. One participant said that “it seems like CMS can’t leave things the same ever.” Several practices reported that the program’s administrative burden results in physicians seeing fewer patients, which has implications both for patient access and for practice revenue. Finally, some interviewees suggested that MIPS-related burdens create burnout for some physicians: “The docs are frustrated with the extra clicking and form filling out. The price that they are having to pay is burnout. It’s just not rewarding.” They reported that, because of MIPS, some senior physicians have chosen to retire rather than continue working part-time.

#### **Theme 5: MIPS Incentives Are Small Relative to the Effort Needed to Participate in the Program**

Many practices reported that MIPS financial incentives were insufficient to justify the level of effort needed to participate in the program. One participant stated that “financially for us it is not at all meaningful. What we received in MIPS payments doesn’t cover the cost and time that we invest.” Other practice leaders expressed similar concerns: “We were close to 100% performance and got a 1.6% positive payment adjustment. You spend a whole bunch of time and do a lot of work, and then you get a tiny adjustment. It’s not really worth it.” A number of practices reported that their decision to participate in MIPS was driven by a desire to avoid financial penalties, not obtain rewards for good performance: “I personally think that what we’re doing is avoiding a penalty. Because we know we will be punished financially if we don’t do everything perfectly.” For some practices, potential penalties were perceived as large and distressing: “Penalties make it unbearable not to participate. The carrot isn’t enticing, but the stick is painful.”

A major cost for many practices was hiring or repurposing staff; the level of investment varied by practice size. Small practices either hired or repurposed 1 additional employee to focus on MIPS (e.g., medical assistant or care manager), or added MIPS-related activities to existing responsibilities of the practice administrator. One administrator said: “Even in a small practice, there’s a need for someone—full time or part time—to manage this component. It is very time consuming for me to do this on top of what I already do.” Medium-sized practices generally hired or repurposed 1 or 2 staff members to focus on MIPS and other quality-reporting programs, while large multispecialty practices often devoted three or more people to such activities.

Another major cost was forgone revenue due to clinician time being spent on quality reporting instead of seeing patients. One small primary care practice reported a 6% decline in patient visits, equivalent to about \$200,000 a year. Another practice reported that, prior to MIPS, physicians saw an average of 22 patients per day; after implementation, they saw 16 to 18 patients per day.

#### **Theme 6: External Support for MIPS Participation Can Be Helpful**

Many practices reported interacting with external entities to support better MIPS performance. These entities included local hospitals, accountable care organizations, practice transformation networks supported by CMS, and consulting companies such as Aledade. Practices generally found such support helpful, particularly when they were developing data collection and reporting infrastructure early in the program: “We did bring in outside consultants. They ran around with us for a year. They helped us navigate through a lot of very arduous processes with all the extra boxes to collect.”

Several practice leaders reported that Medicare Practice Transformation Networks (PTN) were useful in understanding and participating in MIPS: “There was this program funded program by Medicare that was extremely helpful. Someone would meet with me like five times a year and help just muddle through the issues we were having.” A few larger practices reported feeling that they were in a relatively privileged position with regard to having the time and resources to engage external consultants and perform well in MIPS: “There are obviously some practices that do not have resources we have, or the time to dedicate to this. I can’t imagine not having the time to do adequate research on this stuff. I mean, it’s very complicated to understand and it changes every year.”

## DISCUSSION

Through interviews with leaders of 30 physician practices of different sizes and specialties across the USA, we identified 6 major themes with regard to participation in Medicare’s MIPS program. Practice leaders held varying views about whether MIPS improved patient care, but most felt that the program created high levels of administrative burden and that incentive payments were small relative to the effort needed to participate. Many practices reported that their primary motivation for participating in MIPS was to avoid financial penalties; some reported that experience with prior Medicare initiatives, especially the Meaningful Use program, was helpful in preparing them for MIPS. Many leaders of general surgery and multi-specialty practices reported that MIPS quality measures were not relevant to the care they provide. Support for data collection and reporting to MIPS from external entities, including hospitals, ACOs, Medicare-supported educational networks, and consulting companies, was useful for many practices.

Our study builds on other qualitative research on practices’ views of MIPS. A study based on interviews with 20 primary care physicians in 2017 and 2018 found that participants had mixed perceptions about MIPS.<sup>9</sup> The most commonly cited advantage was that the program encouraged the development of quality monitoring and improvement systems, while a key disadvantage was the high administrative burden leading to professional burnout and potential harm to vulnerable patients. A 2017 online survey of 1431 members of the American College of Physicians (primarily general internists) found that 60% of respondents had little familiarity with MIPS; nonetheless, the majority believed that the program, which was just beginning at that time, would improve health care quality.<sup>10</sup> To our knowledge, no peer-reviewed studies have since examined the views about MIPS among physician practice leaders in multiple specialties.

We found that many practices reported that MIPS payments are not commensurate with the effort needed to participate. For some practices, this concern may be alleviated by the larger financial incentives of the MIPS program in the years to come.

(Practices concerned about potential losses will also be subject to larger financial penalties.) In the first year of MIPS, payment rates were adjusted by up to  $\pm 4\%$ ; however, because the program is budget neutral and there were more high- than low-performers, actual adjustments ranged from  $-4$  to  $1.9\%$ .<sup>6, 9</sup> These percentages are set to increase, and by 2022, practices could receive payment adjustments of up to  $\pm 9\%$  based on performance in 2020.<sup>15</sup>

The high level of administrative burden created by MIPS is particularly concerning given reports that it may reduce the number of patients that physicians can care for, and evidence that many MIPS quality measures are either not valid or of uncertain validity.<sup>1</sup> Nonetheless, a number of practice leaders reported that MIPS may improve some aspects of patient care by, for example, encouraging more regular interaction with patients and development of quality improvement programs. Consistent with prior research,<sup>10, 16</sup> practice leaders in this study were generally in favor of the idea of VBP, but many reported that the complexity of the program diminished their enthusiasm for these payment models.

Our findings suggest that policymakers could consider several levers to mitigate the challenges described by practices. First, given that many leaders of practices outside of primary care reported a paucity of relevant measures, CMS could introduce specialty-specific measures and make peer comparisons within specialties instead of across all physicians. This may allow for more meaningful participation and fairer comparisons. Second, given the high level of administrative burden reported by practice leaders, policymakers could consider using measures that require little or no data entry, such as those relying on claims data. Third, policymakers could consider additional financial and technical support for practices, especially small and independent practices, which some leaders reported as helpful for navigating changes to the MIPS program.

## LIMITATIONS

This study has several limitations. First, views of leaders of these 30 practices may not be generalizable to other practices. However, a strength of the study is that participants were randomly selected and represent practices of different sizes, specialties, and regions of the country. Furthermore, both the response rate and number of participants are comparable to or greater than other qualitative studies of CMS quality programs.<sup>9, 17</sup> Second, while we interviewed several practice types, physicians in other specialties may have different perspectives of MIPS. Third, it is possible that practice leaders who had relatively strong views about MIPS were more likely to agree to be interviewed; however, this concern is mitigated by an analysis of interview transcripts that revealed that most practices had mixed views about the program and nearly equal numbers had consistently “favorable” or “unfavorable” views (eTable). Fourth, the end of the study period coincided with the start of the COVID-19 pandemic, which may have introduced sampling bias, with better-resourced practices (i.e., those able to

remain open) participating. This concern is mitigated because most practices (19 of 30) were interviewed before March 2020, and because practice recruitment was paused during April and May when many practices were temporarily closed. Furthermore, the study explored leaders' views of 2019 participation, so experiences in 2020 were not included.

## CONCLUSIONS

Physician practice leaders report a number of challenges with MIPS, including high administrative burden, frequent programmatic changes, and incentive payments that do not cover the level of effort needed to participate. They held mixed views on whether the program improves patient care. General surgery and multi-specialty practices reported that MIPS measures were less relevant than did primary care practices. Some practices reported that experience with previous VBP programs and support from external entities, including those supported by Medicare, were helpful for MIPS participation. These findings may be helpful for policymakers hoping to improve the MIPS program.

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### Additional Contributors: None

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