



May 2018

MEDICARE

Small and Rural Practices' Experiences in Previous Programs and Expected Performance in the Merit-based Incentive Payment System

GAO Highlights

Highlights of [GAO-18-428](#), a report to congressional requesters

Why GAO Did This Study

In 2017, CMS phased out three legacy payment incentive programs and consolidated them into MIPS to further incentivize efficient, high quality care. Stakeholders have raised questions about small and rural physician practices' readiness and ability to participate in MIPS.

GAO was asked to review a number of aspects related to small and rural practices' participation in legacy programs and in MIPS. This report describes (1) how small and rural physician practices performed in legacy Medicare programs and the projected effect of MIPS; (2) stakeholders' views on challenges that small and rural practices experienced in Medicare legacy programs and on how CMS can aid small and rural practices' participation in MIPS; and (3) CMS's efforts to help small and rural practices participate in MIPS.

GAO analyzed the most recently available CMS data on legacy programs and MIPS. GAO interviewed 23 stakeholders, including small and rural physician practices, and physician associations; and CMS officials. GAO identified stakeholders through research and referrals from other stakeholders interviewed.

The Department of Health and Human Services provided technical comments on a draft of this report, which GAO incorporated as appropriate.

View [GAO-18-428](#). For more information, contact James Cosgrove at (202) 512-7114 or cosgrovej@gao.gov.

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What GAO Found

According to 2015 data from the Centers for Medicare & Medicaid Services (CMS)—the most recent available at the time of GAO's review—small physician practices with 15 or fewer providers in rural or non-rural areas were more likely to receive a negative payment adjustment in legacy Medicare payment incentive programs GAO reviewed than were larger practices. These legacy programs, which paid physicians in part based on reporting quality information and providing high-quality, efficient care rather than the traditional approach of paying only based on the volume of care, have been consolidated into the Merit-based Incentive Payment System (MIPS) in 2017. MIPS is designed to further incentivize efficient, high-quality care. CMS projected the effect of MIPS in 2017 and 2018 for practices using legacy program data and estimated that a higher percentage of larger practices would be successful in MIPS (defined by GAO as positive or neutral payment adjustments) than small practices. CMS also projected that small practices would be more successful in MIPS than they had been in the legacy programs. CMS assumed that small practices would increase their participation in MIPS because of the flexibilities built into the program that would help make practices successful. If CMS assumed that small practices would participate in MIPS at historical legacy program participation rates, a lower percentage of small practices would be expected to receive a positive or neutral payment adjustment under MIPS.

Based on interviews with 23 stakeholders, GAO identified challenges faced by small and rural practices that participated in Medicare legacy programs. GAO categorized challenges into three categories.

Examples of Challenges Faced by Small and Rural Physician Practices, by Key Topic Area

Category	Example of challenge
Technology	Practices may purchase electronic health record systems that are not the best suited to meet their needs
Financial and staff resources	Practices lack the financial resources to hire additional staff to manage program participation
Legacy program requirements	Practices with fewer staff to monitor changing program requirements may have difficulty staying current

Source: GAO analysis of stakeholder interviews. | GAO-18-428

In addition, stakeholders suggested actions related to the design of MIPS, technical assistance, and outreach and education efforts that CMS could take to improve small and rural practice participation.

CMS officials told GAO that they heard challenges and suggestions related to small and rural practices' participation in MIPS similar to those GAO heard for legacy programs. Additionally, CMS officials told GAO that CMS has actions underway that they believe address these challenges. For example, CMS has developed educational resources; contracted with organizations to provide technical assistance to small and rural practices; and incorporated flexibility into MIPS, such as allowing practices with 10 or fewer providers to participate as a virtual group that can work together and share resources.

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
EHR	electronic health record
HHS	Department of Health and Human Services
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MIPS	Merit-based Incentive Payment System
PQRS	Physician Quality Reporting System
SURS	Small, Underserved, and Rural Support
VM	Value-based Payment Modifier

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May 31, 2018

Congressional Requesters

In 2016, traditional Medicare expenditures for services provided by physicians totaled approximately \$70 billion, which represented about 10 percent of all Medicare expenditures in that year. These Medicare expenditures for physician services have historically been paid on a fee-for-service basis, which means that each distinct service is generally paid for separately. We have reported that this system of payment largely rewards physicians for the volume and complexity of health care services they provide to beneficiaries, rather than the value of those services.¹

Medicare has taken steps to shift from volume-based to value-based payment. Between 2007 and 2013, the Centers for Medicare & Medicaid Services (CMS) launched three payment incentive programs that were intended to reward physicians with additional payments for reporting quality measures and providing high-quality, efficient care. CMS further expanded these efforts when they created the Quality Payment Program in response to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).² Specifically, the Quality Payment Program created two tracks for paying physicians based on the value of care they provided—Advanced Alternative Payment Models and the Merit-based Incentive Payment System (MIPS)—and required most physicians to participate in one of the two tracks.³ CMS projected that the majority of Quality Payment Program participants—90 percent in 2018—would participate in MIPS, which among other elements, consolidated the three Medicare legacy payment incentive programs.

Physicians that participate in MIPS will be assessed based on their performance in four categories: quality, cost, improvement activities, and

¹GAO, *High-Risk Series*, [GAO-17-317](#) (Washington, D.C.: Feb. 15, 2017).

²Pub. Law No. 114-10, § 101, 129 Stat. 87, 89.

³Advanced Alternative Payment Models are designed to encourage providers to share in the financial rewards and risk of caring for beneficiaries and must meet certain requirements.

advancing care information.⁴ Depending on their performance, physicians may be subject to a positive, neutral, or negative payment adjustment. The maximum negative payment adjustment will be 4 percent in 2019 (the first year of MIPS payment adjustments) and will increase annually until 2022, when the maximum negative adjustment will be 9 percent for any subsequent years. Because MIPS is required to be budget neutral, the positive payment adjustment percentages will be calculated each year to offset the total amount of negative payment adjustments.⁵ CMS anticipates that about two-thirds of Medicare payments to physicians in 2020 will be under MIPS.

CMS and other stakeholders have raised questions about small and rural practices' readiness and ability to participate in MIPS. In particular, CMS and other stakeholders have noted that small and rural physician practices may be less equipped to manage any administrative, technological, or financial challenges associated with MIPS. For instance, small practices might not have as many resources, such as office staff, to ensure the practice is meeting MIPS reporting requirements compared to larger practices. MACRA appropriated funding for technical assistance totaling \$100 million for fiscal years 2016 through 2020 specifically to aid small and rural practices as they participate in MIPS.⁶ CMS is using these funds to contract with 11 organizations that provide technical assistance to small and rural providers, including providing educational resources and assisting practices with understanding MIPS expectations, timelines, and scoring.

The experience of small and rural practices in the previous Medicare payment incentive programs (hereafter referred to as legacy payment incentive programs) may offer some insights into how they may perform in MIPS and the challenges they may face. Specifically, MIPS will consolidate components of three legacy payment incentive programs—the Physician Quality Reporting System (PQRS), the Value-based Payment Modifier (VM), and the Medicare Electronic Health Record

⁴CMS recently indicated that it had renamed the advancing care information performance category to the promoting interoperability performance category. However, for our report, we refer to this category as the advancing care information category as this was the category's name at the time of our review.

⁵Physicians who meet certain performance criteria in MIPS can receive an additional payment adjustment beyond the standard maximum payment adjustment percentage.

⁶Pub. Law No. 114-10, § 101(c)(11), 129 Stat. 87, 110.

(EHR) Incentive program, also known as the Medicare Meaningful Use program. PQRS is a quality reporting system that encourages physicians (through financial incentives or penalties) to report information on quality-of-care, whereas VM provides differential payments to physicians by assessing the quality and cost of the care they provide. The Medicare EHR Incentive program provides incentive payments to physicians (and other providers) to promote the adoption and meaningful use of health information technology and qualified EHR systems.⁷

You requested that we review issues related to small and rural practices' participation in legacy programs and in MIPS. This report describes

1. how small and rural physician practices performed in legacy Medicare payment incentive programs and the projected effect of MIPS on those practices;
2. stakeholders' views on the challenges that small and rural practices experienced participating in the legacy Medicare payment incentive programs and on how CMS can aid small and rural practices' participation in MIPS; and
3. CMS's efforts to help small and rural practices participate in MIPS.

To describe how small and rural physician practices performed in legacy Medicare payment incentive programs and the projected effect of MIPS on those practices, we obtained the latest data available at the time of our audit work from CMS for two of the three Medicare legacy programs and reviewed CMS estimates of the projected effect of MIPS.⁸ Specifically, we obtained performance years 2014 and 2015 summary data from CMS on providers' participation in PQRS by practice size (practices with 15 or fewer providers and practices with more than 15 providers) and

⁷CMS recently issued a proposed rule renaming the Medicare EHR Incentive program to the Promoting Interoperability program. 83 Fed. Reg. 20164, 20516 (May 7, 2018) (preamble VIII.D.2.). However, for our report, we refer to this program as the Medicare EHR Incentive program as this was the program's name at the time of our review.

⁸Providers could choose to participate in the Medicare or Medicaid EHR Incentive program, with generally similar standards and incentives, but providers could not participate in both. We do not report on provider performance in the Medicare EHR Incentive program as the available data would not have been representative of providers' performance in both of CMS's EHR Incentive programs and, therefore would not provide detailed insight into how providers might perform in related aspects of MIPS. While data are available on the Medicare EHR Incentive program, similar data on the Medicaid EHR Incentive program would require obtaining data from each state's Medicaid program.

geographic status (rural and non-rural).⁹ We also obtained detailed data from CMS on providers' performance in VM for calendar years 2014 and 2015, including practice size, rural status, and their eligibility for MIPS in year 1 and year 2.¹⁰ For both the PQRS and VM data, we report information at the provider level rather than at the practice level.¹¹ To describe the projected effect of MIPS on small and rural practices, we reviewed estimates of the projected effect of MIPS provided in the final rules for years 1 and 2 and interviewed CMS officials.¹²

To assess the reliability of the PQRS and VM data on participation and performance, we conducted a series of tests to identify missing data and other anomalies. These analyses were informed by our review of CMS published reports on the PQRS and VM programs and interviews with knowledgeable officials from CMS. We also conducted a series of logic

⁹The providers' rural status for the PQRS participation data was determined based on whether the provider's location was in an area classified as rural by the Health Resources and Services Administration's Area Health Resource File.

The 2015 PQRS data were the most recent data available at the time of our review. In addition, we analyzed 2014 PQRS data because CMS had incorporated 2014 data in its estimate of the projected effect of MIPS on small practices.

¹⁰The providers' rural status for the VM performance data was determined based on whether the provider's location was in an area classified as rural by the Health Resources and Services Administration's Area Health Resource File. As this rural status information was at the individual provider-level, we classified practices as being rural if at least 75 percent of providers within that practice were considered rural, which was consistent with how CMS defines rural practices for MIPS year 2. To determine a provider's eligibility for MIPS, we used data used by CMS to prepare the MIPS final rules for years 1 and 2 and considered providers eligible for MIPS if CMS projected a MIPS score for those providers.

The 2015 VM data were the most recent data available at the time of our review. In addition, we analyzed 2014 VM data to maintain consistency with our analysis of the PQRS data.

¹¹We report the PQRS data at the provider level because they were able to participate in PQRS individually and thus, individual providers within the same group practice might have successfully participated while other providers within the same practice might not have. Although the VM program was applied at the group practice level, we chose to report the VM data at the provider level to maintain consistency with the PQRS data. For the purposes of our analysis, we counted each unique provider/group practice combination as a separate provider. Because individual providers may bill under more than one group practice, our VM data analysis may include multiple entries for some individuals.

¹²See 81 Fed. Reg. 77008, 77522 (Nov. 4, 2016) (preamble, IV.C.3.) (discussion of estimated impacts on MIPS payments to clinicians for payment year 2019—year 1); 82 Fed. Reg. 53568, 53930 (Nov. 16, 2017) (preamble, IV.C.3.) (discussion of estimated impacts on MIPS payments to clinicians for payment year 2020—year 2).

tests, including comparing our data to CMS's previously published data on PQRS participation and VM performance. Using these methods, we determined that the data were sufficiently reliable for the purposes of our reporting objectives.

To describe stakeholders' views on challenges that small and rural practices experienced participating in the legacy Medicare payment incentive programs and on how CMS can aid small and rural practices' participation in MIPS, we interviewed 23 stakeholders. These stakeholders included physicians and practice managers in small and rural practices, associations that represent physician practices, groups that have done research on Medicare payment incentive programs, and CMS contractors that provide technical assistance to small and rural practices. We identified these stakeholders to interview by conducting internet searches on associations that represent small and rural practices and through referrals from other stakeholders we interviewed. We analyzed information that we collected from the interviews to identify key topic areas for challenges and suggestions. Although the challenges we identified may not all be unique to small and rural practices, in this report, we describe how the challenges may affect small and rural practices in particular. The 23 stakeholders we interviewed are a nonprobability sample and our findings from these interviews are not generalizable beyond the experiences of the stakeholders we interviewed; however, they can provide insights into the challenges faced by small and rural practices when participating in legacy payment incentive programs and suggestions for how to aid MIPS participation.

To describe CMS's efforts to help small and rural practices participate in MIPS, we reviewed information available to provide such help on CMS's website. We also interviewed 4 of the 11 CMS contractors that are providing technical assistance on MIPS participation specifically for small and rural practices.¹³ In addition, we interviewed CMS officials about the agency's efforts in key areas and about how it has considered or implemented changes to MIPS based on challenges and suggestions identified by the stakeholders we interviewed. When interviewing stakeholders about challenges faced in legacy programs and suggestions for improving performance in MIPS, we did not assess their awareness of

¹³We selected a nonprobability sample of CMS contractors that represented a variety of geographic areas, including those that supported providers in states with large rural populations and those states in which there were lower PQRS participation rates among practices.

CMS activities to improve small and rural practices' participation and performance. Therefore, it is possible that CMS had existing activities that would address a stakeholder-identified challenge, but the stakeholder was not aware of the actions. It is also possible that the stakeholder was aware of CMS activities, but did not think they were sufficient to address the stakeholder-identified challenge.

We conducted this performance audit from April 2017 to May 2018 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Medicare Legacy Payment Incentive Programs

PQRS

PQRS was implemented in 2007 to encourage providers to report information on the quality-of-care provided to beneficiaries for services paid under the physician fee schedule. Specifically, CMS generally required eligible providers to report on a specific number of measures.¹⁴ Providers who met quality-of-care reporting requirements in 2007 received an incentive payment. Beginning in 2013, providers who did not meet quality-of-care reporting requirements or who did not participate in PQRS received a negative payment adjustment of 1.5 percent for all 2015 physician fee schedule payments. If providers did not meet PQRS requirements or did not participate in PQRS, they received a negative payment adjustment, which in 2016 was 2.0 percent for all 2018 physician fee schedule payments.

VM program

The VM program began in 2013 to evaluate eligible providers' quality and cost of care given to Medicare beneficiaries. Specifically, the VM program

¹⁴Providers eligible to participate in PQRS included physicians; practitioners, such as physicians' assistants and nurse practitioners; and therapists. Providers could report their quality data either individually or as a group.

assessed quality using selected PQRS and other measures and assessed cost by evaluating providers on six measures, including Medicare spending per beneficiary.¹⁵ CMS categorized providers' performance as high, low, or average in terms of quality and cost relative to benchmarks, defined as the mean of the providers' performance. This VM categorization determined whether providers would receive a positive, neutral, or negative adjustment applied to their physician fee schedule payments at the start of the payment year, about 12 months after the end of the performance year (e.g., payments would be adjusted in 2017 for performance in 2015).¹⁶ CMS phased in the start date for VM based on provider size—physicians in groups with 100 or more providers were required to participate in 2013, physicians in groups with at least 10 providers were required to participate in 2014; and physicians in solo practices or in groups with at least 2 providers were required to participate in 2015.¹⁷

Medicare EHR Incentive program

The Medicare EHR Incentive program started in 2011 to foster providers' adoption of certified EHR systems that met capability, functionality, and security standards established by the Department of Health and Human Services' (HHS) Office of the National Coordinator for Health Information

¹⁵The VM program measures were not the same each year. For example, the Medicare spending per beneficiary measure was not used in 2013, but was used from 2014 to 2016.

¹⁶For example, a provider with a low-quality, average-cost VM categorization for performance year 2015 would have received a negative 2.0 percent payment adjustment to their physician fee schedule payments starting in January 2017. A provider with a high-quality, low-cost categorization would have received a positive payment adjustment of 4.0 percent times an adjustment factor, which was used to ensure that the total amount of the negative payment adjustments were offset by the total amount of the positive payment adjustments. In addition, providers that did not meet PQRS reporting requirements were subject to a negative payment adjustment, as successful participation in PQRS was a part of the quality assessment in the VM program.

¹⁷In the first year that practices of a certain size were eligible for VM, providers in practices of that size were only subject to neutral or positive payment adjustments based on their performance. However, if providers failed to meet PQRS reporting requirements, they were still subject to a negative payment adjustment. For instance, physicians in groups with 10 to 99 providers were first eligible for VM in 2014 but were only subject to neutral or positive payment adjustments for their performance in VM that year. Negative payment adjustments based on their performance in VM were applied for groups of this size in 2015. For performance years 2013 to 2015, only physicians within provider groups were required to participate in VM though provider group size was determined by including both physicians and non-physicians. In performance year 2016, certain non-physicians were required to participate in VM.

Technology.¹⁸ Providers could receive incentive payments by attesting that they used certified EHR systems and met criteria for meaningful use objectives and clinical quality measures, such as using secure electronic messaging to communicate with patients.¹⁹ Starting in performance year 2015, financial penalties were applied to providers' 2017 payments if they did not demonstrate meaningful use of an EHR system or chose not to participate in the program.

MIPS

MIPS is intended to give physicians further incentive to provide efficient, high-quality care and consolidates the three legacy payment incentive programs into a single program.

- **Eligibility.** Not all providers will be eligible for MIPS.²⁰ For example, in the first year of MIPS, providers were ineligible if they enrolled in Medicare within the previous year; were significantly participating in Advanced Alternative Payment Models (also referred to as qualifying alternative payment model participants); or did not meet a minimum threshold, called the low-volume threshold, which is defined for MIPS year 1 as providers or practices with Medicare billings less than or equal to \$30,000 or that cared for 100 or fewer Medicare beneficiaries.²¹ For MIPS year 2, a lower percentage of providers are expected to be eligible as the low-volume threshold was increased to billings of less than or equal to \$90,000 or that care for 200 or fewer Medicare beneficiaries. CMS estimated that between 43 and 47 percent of all Medicare providers were eligible for MIPS in the first

¹⁸In addition to the Medicare EHR Incentive program, CMS also implemented a Medicaid EHR Incentive program, with generally similar standards and incentives. To avoid duplication, providers could only participate in one of the EHR Incentive programs.

¹⁹In total, providers could earn up to \$44,000 over several years, with annual payments ranging from \$2,000 to \$18,000. Providers may have received larger annual payments if they began participating in the program in earlier years or if they predominantly served health professional shortage areas.

²⁰Those providers considered to be eligible for MIPS are physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists. Providers who are not eligible for MIPS and that do not participate in Advanced Alternative Payment Models will continue to be paid under the physician fee schedule, which will no longer have annual increases.

²¹Providers can participate in MIPS as an individual or as a group. The low-volume threshold was applied depending on how the provider chose to participate.

year, and that 40 percent were eligible for the second year.²² (See table 1.)

Table 1: Merit-based Incentive Payment System (MIPS) Eligibility Requirements and Number of Providers Excluded from Participation for Years 1 and 2

	MIPS year 1	MIPS year 2
Eligibility requirements	To participate in MIPS, providers or practices must: <ul style="list-style-type: none"> • Not be newly enrolled (meaning enrolled within previous year) in Medicare • Not be significantly participating in an Advanced Alternative Payment Model^a • Exceed a minimum level—called the low-volume threshold—by having billings to Medicare Part B of more than \$30,000 and providing care to more than 100 Medicare beneficiaries 	To participate in MIPS, providers or practices must: <ul style="list-style-type: none"> • Not be newly enrolled (meaning enrolled within previous year) in Medicare • Not be significantly participating in an Advanced Alternative Payment Model^a • Exceed a minimum level—called the low-volume threshold—by having billings to Medicare Part B of more than \$90,000 and providing care to more than 200 Medicare beneficiaries
Centers for Medicare & Medicaid Services (CMS) estimate of total number of providers eligible for MIPS participation	592,119 - 642,119 ^b	604,006 ^b
Percentage of Medicare providers eligible for MIPS	43 to 47 percent	40 percent
CMS estimate of total number of providers excluded from MIPS participation	538,782 - 588,782 ^c	693,033 ^c

Source: CMS's Final Rules for MIPS years 1 and 2. | GAO-18-428

Notes: Providers can participate in MIPS as individuals or as a group. The low-volume threshold was applied depending on how the provider chose to participate.

This table uses CMS's estimates of providers eligible for MIPS participation based on eligibility requirements published prior to the passage of the Bipartisan Budget Act of 2018. Therefore, the data used do not reflect modifications to the Medicare payments included in the MIPS eligibility determination that were included in the Bipartisan Budget Act of 2018. See Pub. L. No. 115-123, § 51003(a), 132 Stat. 64, 294.

^aSignificant participation in an Advanced Alternative Payment Model is defined as receiving 25 percent of the provider's Medicare payments or seeing 20 percent of the provider's Medicare beneficiaries through an Advanced Alternative Payment Model.

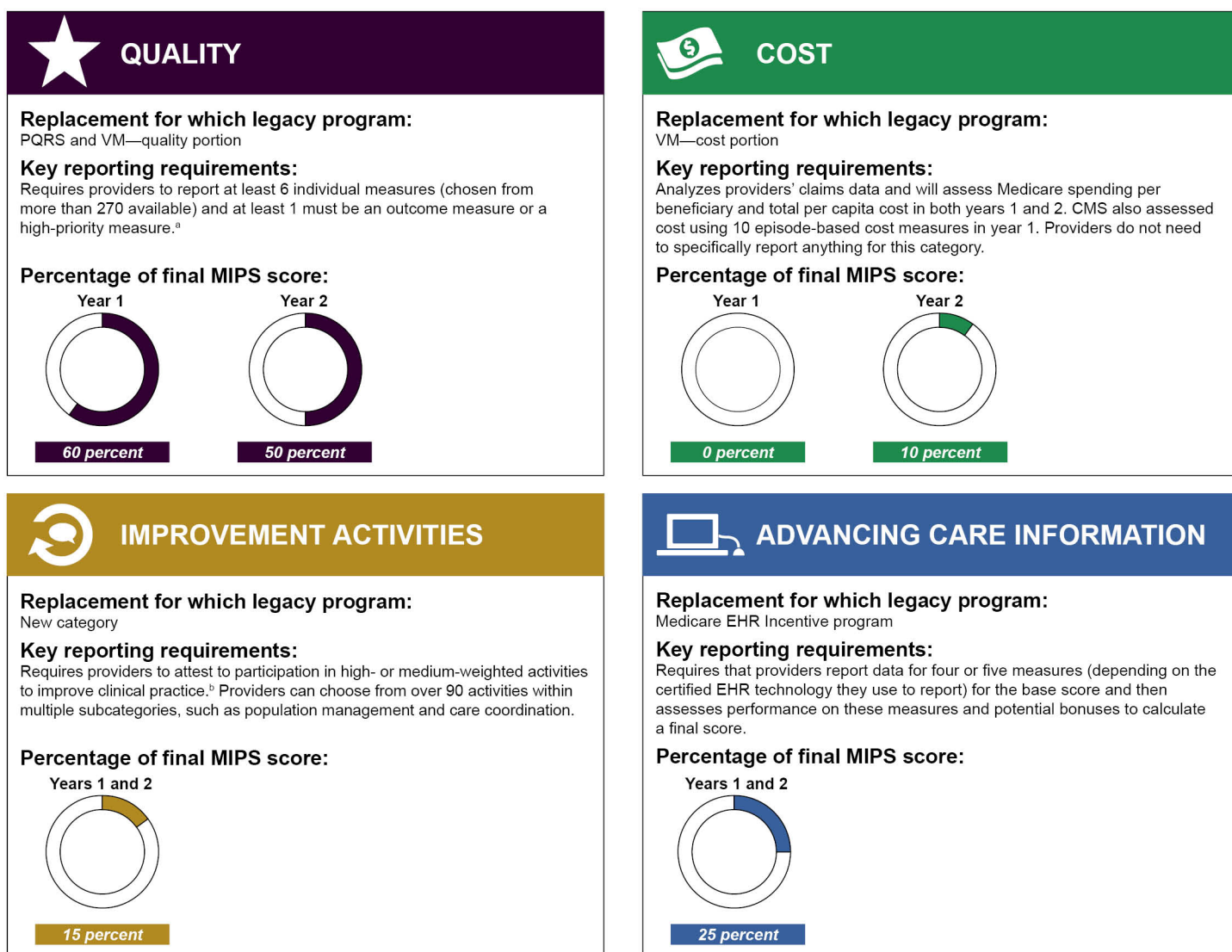
^bAlthough CMS increased the low-volume threshold between MIPS year 1 and year 2 (which excluded many more providers from participating in MIPS year 2), the number of providers in Medicare increased between 2017 (MIPS year 1) and 2018 (year 2). As a result, while the overall total number of providers eligible for MIPS participation did not decrease significantly between MIPS years 1 and 2, the percentage of providers eligible did.

^cCMS also excluded clinician types that were not eligible to participate in MIPS, which accounted for 199,308 providers in year 1 and 233,289 in year 2.

²²In addition, CMS estimated that, in year 1, about 5 to 9 percent of all Medicare providers would participate in Advanced Alternative Payment Models, the other track of the Quality Payment Program, and that 5 percent would in year 2.

- Performance categories.** Under the MIPS program, providers or practices will generally be assessed in four performance areas: Quality, Cost, Advancing Care Information, and Improvement Activities. Among the four categories, the requirements for reporting and the weight of the category in the final MIPS score vary (and in some cases, change over the first few years). (See fig. 1.)

Figure 1: Details on the Merit-based Incentive Payment System (MIPS) Performance Categories



Legend: EHR= electronic health record; PQRS= Physician Quality Reporting System; VM= Value-based Payment Modifier.

Source: Centers for Medicare & Medicaid Services. | GAO-18-428

Note: CMS recently renamed the advancing care information performance category to the promoting interoperability performance category. However, we refer to this category as the advancing care information category as this was the category's name at the time of our review.

^aIn MIPS year 1, providers were allowed to “pick-your-pace,” meaning that they could opt to participate in a testing mode by submitting one quality measure, or participate by reporting on at least six quality measures for a partial year (at least 90 days) or a full year.

^bImprovement activities are weighted as high or medium, where high-weighted activities are eligible for more points in this performance category than medium-weighted ones.

- **Payment adjustments.** Depending on their MIPS score, practices may receive a positive payment adjustment, no payment adjustment (neutral), or a negative payment adjustment, which are applied to their payments under the physician fee schedule.²³ MIPS is required to be budget neutral, so the funding for the positive payment adjustments will be offset by the negative payment adjustments. Payment adjustments are applied a full calendar year after the end of the performance year. For example, performance in MIPS year 1—calendar year 2017—will be applied to payments for calendar year 2019.

²³Providers who meet certain performance criteria in MIPS may receive additional incentive payment adjustments beyond the standard maximum payment adjustment percentage available annually for 5 years.

Small Practices, Whether in Rural Areas or Not, Did Not Perform as Well as Larger Practices in Medicare Legacy Programs, and CMS Projects This Will Continue in MIPS

In 2015, Small Practices,
Regardless of Whether
Located in Rural Areas,
Did Not Perform as Well
as Larger Practices in
Medicare Legacy
Programs

According to 2015 PQRS data from CMS, both rural and non-rural small practices were roughly half as likely as larger practices to successfully participate in PQRS, meaning that the practices met the PQRS reporting requirements, and therefore avoided a negative adjustment to their payments under the physician fee schedule.²⁴ (See table 2.) In general, providers' success in PQRS seemed to be more influenced by practice size than whether practices were located in a rural area. Specifically, among smaller and larger practices, those located in rural areas and those located in non-rural areas had similar rates of successful participation. We also found similar patterns in the 2014 PQRS participation data (for additional details on 2014 PQRS participation rates, see table 10 in app. I).

²⁴Our data analysis is at the individual provider level. However, for simplicity, we refer to these providers in our analysis as practices based on their size.

In 2014 and 2015, practices needed to successfully report PQRS data but were not assessed on their actual performance on the quality measures that they submitted. If practices submitted data that did not meet the PQRS requirements or if practices did not participate in PQRS, they were subject to a negative payment adjustment that was applied to their 2016 and 2017 payments, respectively. Providers that successfully participated in PQRS were no longer eligible for incentive payments after the 2014 performance year.

Table 2: Providers' Participation Rates in Physician Quality Reporting System (PQRS), by Practice Size and Rural Status, 2015

Numbers in percent

	Successful participation	Unsuccessful participation ^a	Did not participate ^a
Small practices with 15 or fewer providers			
Rural	35.5	14.4	50.1
Non-rural	36.0	11.5	52.5
Practices with more than 15 providers			
Rural	74.0	5.5	20.5
Non-rural	78.4	5.7	15.9

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-18-428

Notes: We also completed this analysis for 2014 and found that the results were similar to those for 2015.

Our data analysis is at the individual provider level. However, for simplicity, we refer to these providers in our analysis as practices based on their size.

^aPractices needed to successfully report PQRS data but were not assessed on their actual performance on the quality measures that they submitted. If practices unsuccessfully participated in PQRS (meaning they submitted data that did not meet the PQRS requirements) or if practices did not participate in PQRS in 2015, they were subject to a negative payment adjustment that was applied to their 2017 payments. Providers that successfully participated in PQRS were no longer eligible for incentive payments after the 2014 performance year.

Similarly, in the VM program for 2015, small practices were generally less likely than larger practices to perform well—that is, less likely to receive either a positive or neutral payment adjustment. Specifically, about 44 percent of small providers, both rural and non-rural, performed well in VM compared to 73 and 74 percent of larger practices located in rural and non-rural areas, respectively. (See table 3.) Most of the practices that performed well received a neutral payment adjustment, as very few practices (about 1 percent for practices of each size and rural status) received a positive payment adjustment in 2015. We also found similar patterns in the VM performance data for 2014 (see table 13 in app. I for additional details on 2014 VM performance).

Table 3: Providers' Performance Rates in Value-based Payment Modifier (VM) Program, by Practice Size and Rural Status, 2015

Numbers in percent

	Received positive or neutral payment adjustment ^a	Received negative payment adjustment ^b
Small practices with 15 or fewer providers		
Rural	43.7	56.3 ^c
Non-rural	44.2	55.8 ^c
Practices with more than 15 providers		
Rural	73.0	27.0
Non-rural	74.3	25.7

Source: GAO analysis of the Centers for Medicare & Medicaid Services data. | GAO-18-428

Note: We also completed this analysis for 2014 VM data and the results were similar. Table 13 in app. I contains additional details on 2014 VM participation rates.

^aFew practices, regardless of size or whether located in a rural area, received a positive payment adjustment, and there were few differences among small and larger practices. In 2015, the percentages were 1.0 percent for small and rural practices, 1.3 percent for small and non-rural practices, 1.1 percent for larger and rural practices, and 1.4 percent for larger and non-rural practices.

^bIn the VM program, if providers failed to meet PQRS reporting requirements, they would receive a negative VM payment adjustment, as successful participation in PQRS was a part of the quality assessment in the VM program. As a result, the percentages of practices that received a negative payment adjustment include practices that either received a negative payment adjustment because of their performance or because they did not meet PQRS reporting requirements.

^cIn 2015, practices with 1 to 9 providers were only subject to neutral or positive payment adjustments based on their performance in the VM program, unless they failed to meet PQRS reporting requirements, in which case they would receive a negative VM payment adjustment (as successful participation in PQRS was a part of the quality assessment in the VM program). As a result, the percentages of small practices that received a negative payment adjustment include practices with 10 to 15 providers that either received a negative payment adjustment because of their performance or because they did not meet PQRS reporting requirements and practices with 1 to 9 providers that received a negative payment adjustment in VM because they did not meet PQRS reporting requirements.

CMS Estimated That Small Practices Would Perform Better in MIPS than in Legacy Programs Due to the Types of Practices Excluded from MIPS and Certain Assumptions Used in Its Estimates

According to CMS’s estimates of the projected effect of MIPS in year 1, small practices are expected to have higher rates of successful performance, which we define as positive or neutral payment adjustments, compared to how practices did in the PQRS and VM programs in 2015. Specifically, CMS developed two estimates: the “standard” estimate, in which 90 percent of MIPS-eligible small practices would receive a positive or neutral payment adjustment, and the “alternative” estimate, in which 80 percent of MIPS-eligible small practices would receive a positive or neutral payment adjustment. For both estimates, the remaining MIPS-eligible small practices were estimated to receive a negative payment adjustment.²⁵ (See table 4.) CMS’s estimates also indicate that larger practices are expected to be more successful in MIPS year 1 than smaller practices, with 93 percent of practices with 25 to 99 providers and 99 percent of practices with 100 or more providers expected to be successful in MIPS.

Table 4: Centers for Medicare & Medicaid Services’ (CMS) Projected Merit-based Incentive Payment System (MIPS) Payment Adjustments, by Practice Size, for Year 1

Numbers in percent

Practice size and type of estimate ^a		Positive or neutral payment adjustments	Negative payment adjustments
1 to 9 providers	Standard	90.0	10.0
	Alternative	80.0	20.0
10 to 24 providers	Standard	90.0	10.0
	Alternative	83.7	16.3
25 to 99 providers		92.6	7.4
100 or more providers		98.5	1.5

Source: CMS final rule for MIPS year 1, 81 Fed. Reg. 77008, 77530, 77531 (Nov. 4, 2016) (preamble, IV.C.3., tables 62 and 63). | GAO-18-428

^aCMS prepared two estimates of the projected effect of MIPS for smaller practices. In the “standard” estimate, CMS projected that at least 90 percent of practices would participate in MIPS. In the “alternative” estimate, CMS projected that at least 80 percent of practices would. For smaller practices, these estimates of 90 and 80 percent were higher than the historical rate of participation in the legacy PQRS program. For practices eligible for MIPS in year 1, practices with 1 to 9 clinicians participated in PQRS in 2015 at a rate of 58.2 percent and practices with 10 to 24 clinicians participated at a rate of 83.7 percent.

CMS’s estimates that small practices would be more successful in MIPS than legacy programs are due, in part, to the assumption that many small practices that may not be successful in MIPS are excluded from having to

²⁵CMS used the small practice size grouping of 1 to 9 providers for its MIPS year 1 estimate, which differs from the 1 to 15 provider grouping we chose for our work.

participate. CMS officials told us that the low-volume threshold was established to ensure that those practices that are eligible for MIPS would have the ability to be successful. This is consistent with what we found when comparing small practices' performance based on MIPS eligibility; that small practices excluded from MIPS did not perform as well as those practices eligible for MIPS in Medicare legacy programs. For example, 27 percent of small practices that were not eligible for MIPS successfully participated in PQRS in 2015, compared to 51 percent of MIPS-eligible small practices. Similarly, 26 percent of small practices that were not eligible for MIPS received a positive or neutral adjustment in the 2015 VM program, compared to 49 percent of MIPS-eligible small practices. These patterns were also true for those eligible for MIPS in year 2.²⁶

CMS's estimates that 80 percent and 90 percent of MIPS-eligible small practices would receive a positive or neutral MIPS payment adjustment were also based on assumptions that smaller practices would increase their participation in MIPS over the historical rates of participation in PQRS.²⁷ For smaller practices, these assumptions were higher than the rates in which they successfully participated in PQRS. CMS officials said that they assumed small practices would have increased participation in MIPS because of (1) the trend of increased participation in PQRS (from 15 percent in 2007 to 69 percent in 2015) and (2) components of MIPS' design meant to encourage participation, such as the reduced data submission burden relative to the legacy programs, a gradual increase to the minimum score needed to receive a neutral payment adjustment, financial incentives for participation, and availability of support from technical assistance organizations. When CMS projected the effect of MIPS based on historical PQRS participation rates, it estimated that 62 percent of small practices (defined as practices with 15 or fewer providers) would have received a positive or neutral payment adjustment in year 1. This projection assumes that providers that participated in PQRS—including those that were successful and those that submitted

²⁶Our analysis was based on CMS data of providers eligible for MIPS participation in year 2 based on eligibility requirements published prior to the passage of the Bipartisan Budget Act of 2018. Therefore, the data used do not reflect modifications to the Medicare payments included in the MIPS eligibility determination that were included in the Bipartisan Budget Act of 2018. See Pub. L. No. 115-123, § 51003(a), 132 Stat. 64, 294.

²⁷Larger practice sizes had rates of successful participation in PQRS that were higher than the 80 percent and 90 percent assumptions, and CMS used the actual participation rates for those practice sizes.

data but were unsuccessful in meeting PQRS requirements—would participate in MIPS and avoid a negative payment adjustment.

Between MIPS years 1 and 2, the percentages of practices estimated to successfully perform in MIPS generally increased for practices of all sizes. Specifically, in its two estimates, CMS projected that 82 percent or 91 percent of small practices (defined as 1 to 15 providers) would receive a positive or neutral payment adjustment in MIPS year 2 compared with estimates of 80 percent and 90 percent in year 1 (defined in this year's estimate as 1 to 9 providers). In contrast, nearly all larger practices with 100 or more providers were expected to receive a positive or neutral payment adjustment (99.5 percent). (See table 5.) CMS officials told us that the increase in percentages of providers expected to successfully perform in MIPS year 2 was due, in part, to the changes in the low-volume threshold, resulting in fewer practices being eligible for MIPS. CMS officials also noted that the agency's year 2 estimates were enhanced by using additional legacy program performance data and by projecting hypothetical scores for all four MIPS performance categories, compared to the year 1 estimates that projected a score for only the Quality performance category.²⁸ In addition to these two estimates, CMS also provided us with an estimate of the projected effect of MIPS for year 2 using historical PQRS participation rates in which 73 percent of small practices (defined as practices with 15 or fewer providers) were estimated to receive a positive or neutral payment adjustment.

²⁸For its estimate of the projected effect of MIPS in year 1, CMS used 2014 and 2015 PQRS data and 2014 VM data. For its year 2 estimate, CMS used 2015 and 2016 PQRS data, 2014 and 2015 VM data, and 2015 and 2016 Medicare and Medicaid EHR Incentive programs data.

Table 5: Centers for Medicare & Medicaid Services' (CMS) Projected Merit-based Incentive Payment System (MIPS) Payment Adjustments, by Practice Size, for Year 2

Numbers in percent

Practice size and type of estimate ^a		Positive or neutral payment adjustments	Negative payment adjustments
1 to 15 providers	Standard	90.9	9.1
	Alternative	81.8	18.2
	Using historical participation rates	73.0	27.0
16 to 24 providers		93.0	7.0
25 to 99 providers		97.1	2.9
100 or more providers		99.5	0.5

Source: CMS final rule for MIPS year 2. 82 Fed. Reg. 53568, 53942, 53943 (Nov. 16, 2017) (preamble, IV.C.3., tables 78 and 79). | GAO-18-428

Note: This table uses CMS's estimates of providers eligible for MIPS participation based on eligibility requirements published prior to the passage of the Bipartisan Budget Act of 2018. Therefore, the data used do not reflect modifications to the Medicare payments included in the MIPS eligibility determination that were included in the Bipartisan Budget Act of 2018. See Pub. L. No. 115-123, § 51003(a), 132 Stat. 64, 294.

^aCMS prepared two estimates of the projected effect of MIPS. In the "standard" estimate, CMS projected that at least 90 percent of practices would participate in MIPS. In the "alternative" estimate, CMS projected that at least 80 percent of practices would. For smaller practices, these estimates of 90 and 80 percent were higher than the historical rate of participation in the legacy PQRS program. For practices eligible for MIPS in year 2, practices with 1 to 15 clinicians participated in PQRS in 2015 at a rate of 69.7 percent. CMS also prepared an estimate using historical participation rates, which we have included in the table for small practices. In the table, practices sizes in which the standard and alternative estimates were the same are not reported separately.

**Stakeholders
Reported Many
Challenges for Small
and Rural Practices in
Legacy Programs
That Are Likely to
Continue in MIPS,
and Suggested
Actions CMS Could
Take to Mitigate the
Challenges**

**Small and Rural Practices
Faced Challenges Related
to Technology, Financial
and Staff Resources, and
Legacy Program
Requirements, Which
Stakeholders Said Are
Likely to Continue in MIPS**

According to the 23 stakeholders we interviewed, small and rural practices faced challenges in Medicare legacy payment incentive programs that are likely to continue under MIPS. We identified eight challenges that can be categorized into three key topic areas: (1) technology, (2) financial and staff resources, and (3) legacy program requirements. (See table 6.) These eight challenges are discussed in detail in the sections that follow.

Table 6: Challenges Raised by Stakeholders to Participation of Small and Rural Practices in Medicare Legacy Payment Incentive Programs, by Key Topic Area

Key topic area	Challenge
Technology	Issues with electronic health record (EHR) functionality, operation, and maintenance Lack of EHR vendor support and timely updates
Financial and staff resources	High costs of initial and ongoing investments needed for participation Staffing issues, such as <ul style="list-style-type: none"> Lack of financial resources to hire additional staff Lack of staff time to meet program reporting requirements Lack of experienced, qualified, or dedicated staff to enhance program participation
Legacy program requirements	Issues with measures required for program participation that some providers felt were not aligned with patient care Difficulties staying abreast of changes to program requirements and managing compliance with program requirements Challenges associated with timeliness of feedback and program changes Lack of provider control over certain performance metrics, including measurements related to patient behavior and measures related to care from other providers

Source: GAO analysis of information from 23 stakeholders interviewed. | GAO-18-428

Note: Some of these challenges are unique to small and rural physician practices, while other challenges may be experienced by all physician practices during their participation in Medicare legacy payment incentive programs. Our review did not distinguish between the two.

Some challenges reported were unique or specific to small and rural physician practices, while others might have been experienced by practices of all sizes but were particularly magnified for small and rural practices. For example, stakeholders reported that small and rural practices may face unique difficulties in managing cost measures because they see fewer patients, and one or a few patients with a high total cost of care may skew performance on cost measures for these practices. They said that other challenges, such as selecting a functional EHR system, may be shared by practices of all sizes but are magnified for small and rural practices because they tend to have fewer resources or less ability to leverage or share costs among a number of providers.

Stakeholders told us that all challenges experienced in legacy programs by small and rural practices will likely carry over into MIPS to some degree. Stakeholders told us that having an EHR system may be needed to successfully participate in MIPS, and as a result, many of the technological challenges of maintaining and operating an EHR system may continue under MIPS, especially for small practices. Financial and staff resources may continue to pose a challenge for small and rural practices in MIPS because of the need for staff time to report and the staff

expertise necessary to choose, track, and report on measures. Challenges pertaining to program design and requirements may continue due to the short time frame between CMS's finalized program requirements and the start of a performance measurement year about 2 months later. Since MIPS uses many of the same reporting and measurement mechanisms as the legacy programs, some stakeholders believe that small and rural practices may be less equipped to manage the administrative, technological, and financial burdens that they may face as they participate in MIPS.

Technology

EHR systems can play a role in everything from coordinating care among providers to population health management (i.e., taking actions to improve the health outcomes of a certain population). Stakeholders reported that the challenges for practices in selecting an EHR system that is best suited to meet their reporting needs, maintaining an EHR system, and obtaining support from vendors may be magnified for small and rural practices.

- **Issues with EHR functionality, operation, and maintenance.** Some stakeholders reported difficulties associated with purchasing an EHR system that matches the practice's needs and with the day-to-day operation and maintenance of that system. Specifically, some stakeholders told us that small and rural practices may have limited financial resources and thus purchase less expensive EHR systems that may not meet their functionality needs. Stakeholders told us that purchasing an EHR system is a major financial investment and that selecting an EHR system that does not meet a practice's needs can create challenges for completing certain activities required for legacy programs and MIPS, such as measuring quality, sending summaries of care, and accessing data in "real time." Additionally, some stakeholders we interviewed said that the differences among EHR systems may create challenges, such as when an EHR system is unable to submit data to CMS or exchange information with another provider's EHR system. A few stakeholders also told us that small and rural practices may not be able to perform needed EHR maintenance tasks. For example, some stakeholders said that EHR servers and security systems require staff attention, which may be challenging in smaller practices with fewer support staff.
- **Lack of EHR vendor support and timely updates.** Some stakeholders reported that small and rural practices rely more heavily on EHR vendors for support than other practices because they have fewer staff. However, these stakeholders reported that the EHR vendors may be less willing or unable to fully provide the support the

practices need. Stakeholders told us that EHR vendors may provide updates to technology certification requirements for legacy programs to large practices first since this would likely generate more revenue. As a result, if small and rural practices are delayed in receiving needed certification updates, they may not meet requirements for the Medicare EHR Incentive program and thus fail to qualify for incentive payments.

Financial and Staff Resources

To participate in legacy programs or in MIPS, stakeholders told us that practices of all sizes needed to make an upfront financial investment in technology, such as purchasing an EHR system, and staffing. They said that these investments are especially challenging for small and rural practices for several reasons, including that the practices may have smaller amounts of revenue with which to fund these investments or fewer providers to share the investment costs.

- **High costs of initial and ongoing investments that are needed for participation.** Some stakeholders reported that initial EHR investment costs can be significant, with one stakeholder estimating a new EHR system can cost \$400,000. Stakeholders told us that ongoing investments in EHR systems also may be costly. For example, according to stakeholders, vendors routinely charge fees for services, such as adding certain measures into an EHR system or upgrading to new certification standards. Additionally, practices need to make capital investments to upgrade their EHR systems to perform well on certain legacy program measures, such as connecting with patients electronically through a portal. Some stakeholders told us that because small and rural practices tend to have fewer resources, paying for EHR vendor support may affect small and rural practices disproportionately and make it more difficult for them to be successful in legacy programs. One administrator in a small practice reported that, for her practice, participating in PQRS resulted in a loss of net revenue because of the associated ongoing costs, such as payments to use a registry to report PQRS data.
- **Staffing issues, such as lack of experienced, qualified, or dedicated staff to enhance program participation; lack of financial resources to hire additional staff; and lack of staff time to meet program reporting requirements.** Stakeholders reported that practices had to take on additional responsibilities if they wanted to successfully participate in legacy programs, which was particularly challenging for small and rural practices that had few staff and, according to some stakeholders, did not have the financial resources

to hire additional staff. For example, one stakeholder noted that because small and rural practices have few staff, they often require employees to perform multiple roles, which limits the staff's ability to gain expertise in the new responsibility areas. In contrast, larger practices can hire specialized staff in areas like quality improvement and reporting, which makes it easier for the larger practices to successfully participate in legacy programs. Another stakeholder noted that because small and rural practices have fewer staff than larger practices, they are less able to make staff available to attend education events or to conduct planning activities that can aid program performance. Finally, some stakeholders told us that rural practices may not have professionals available in their communities with the technical skills the practices seek to assist with participation.

Legacy Program Requirements

Stakeholders noted that small and rural practices reportedly struggled with a variety of requirements in legacy programs. Some stakeholders told us that required measures in the legacy programs were not aligned with patient care. In addition, some stakeholders told us that it was challenging to keep informed on legacy programs' changes each year. Stakeholders also told us that small and rural practices faced challenges with keeping up to date on annual changes to legacy program requirements, including the lack of timely performance feedback from CMS, and performance measures that were outside of practices' immediate control.

- **Issues with measures required for program participation that some providers felt were not aligned with patient care.** Some stakeholders told us they did not find the measures tracked for legacy programs to be aligned to the way in which they provided patient care and that the measures in legacy programs were not the best way to accurately assess the quality of patient care. A few stakeholders told us they viewed PQRS and VM as reporting programs and that they were an impediment because they required collection of information that they would not typically collect when providing care, which resulted in some practices deciding not to participate in the legacy programs. A specialist told us that PQRS's required cross-cutting measures that involved asking patients about flu shots and smoking cessation were not pertinent to the care he provided as a psychiatrist.
- **Difficulties staying current with program requirement changes and managing compliance with program requirements.** Some stakeholders said it was challenging for providers to understand program requirements because of a lack of consistency over time and

the complexity of the legacy programs. Other stakeholders noted that program requirements seemed to change each year, and keeping up with the changes proved burdensome, especially if a practice did not have staff devoted to this work. For example, one stakeholder said that some quality measures were removed from the PQRS program, and practices might have been reporting on these measures without knowing that they were no longer in use, resulting in unsuccessful participation. Some stakeholders cited particular difficulty for providers in managing program compliance in VM because practices did not have the knowledge or available data to understand how they would score on the measures related to the cost of care. Other stakeholders told us that many practices were unaware that the VM program had started.

- **Challenges associated with timeliness of feedback and program changes.** Some stakeholders told us the lag time between reporting information to CMS under legacy programs and receiving feedback on the provider's performance was challenging because practices lacked data and information needed to make behavioral changes that would enhance performance. We also heard from stakeholders that CMS released feedback to practices for VM and PQRS in the middle of a performance year, which was too late to adjust practice policies or behaviors to improve the practice's performance. For example, one stakeholder told us that in the VM program, practices were encouraged to examine their patients' hospital readmissions but lacked complete data to fully understand what might be contributing to the patients' readmissions. Additionally, stakeholders said that the timing of when CMS would finalize the legacy program requirements for each performance year was challenging for providers, as it was often just a few months prior to the start of the next performance year. These stakeholders told us the compressed timing left practices little time to learn about the program changes and take steps to improve performance.
- **Lack of provider control over certain performance metrics, including measurements related to patient behavior and measures related to care from other providers.** Some stakeholders reported challenges associated with performance metrics when some elements of a measure were outside of a provider's direct control. For example, stakeholders told us that small and rural practices had little control of patient engagement with online EHR portals in the Medicare EHR Incentive program because patients may simply not want to use the portal. In addition, we heard from stakeholders that small and rural practices might be wary of being held accountable for other providers' care, as some measures under VM evaluated the per capita costs of

beneficiary care, which included the costs of care provided by all health care providers for a beneficiary.

Stakeholders Made Suggestions for CMS to Aid Small and Rural Practices in MIPS Program Design, Outreach and Education, and Technical Assistance

The 23 stakeholders we interviewed made a variety of suggestions for CMS to aid small and rural practices' participation in MIPS. We identified three key topic areas for these suggestions: MIPS program design; outreach and education; and technical assistance. These suggestions are discussed in detail in the sections that follow.

MIPS Program Design

Stakeholders made suggestions about actions CMS could take to change program requirements under MIPS to help small and rural practices. These suggestions fell in a number of areas related to the timeliness of feedback, minimizing changes to and the complexity of program requirements, and considering policy changes to encourage MIPS participation.

- **Providing timely information about program requirements.** Some stakeholders we spoke to recommended that CMS should finalize MIPS program requirements made through rule-making earlier in the year, allowing practices time to incorporate upcoming changes. For example, one practice administrator at a small practice suggested that CMS provide timely information on program requirements so that practices can make any necessary changes needed for MIPS participation.
- **Increasing EHR functionality and standardization.** Some stakeholders suggested that there should be increased functionality of and uniform standards for EHR systems. One stakeholder suggested that the availability of all MIPS measures in each EHR system, instead of just a limited set of measures, would give practices greater flexibility. Another stakeholder advocated for vendors to provide EHR systems that are guaranteed to be interoperable with other vendors' EHR systems. According to this stakeholder, EHR systems that are interoperable may, as an added benefit, help CMS meet its goal of information-sharing about patients to better coordinate care.
- **Maintaining MIPS measures over time for continuity and testing measures to ensure a benefit to patient care.** Some stakeholders suggested that CMS should focus on keeping specific quality measures constant over time so that practices can be consistent in

what measures they track and be able to measure progress.²⁹ Additionally, some stakeholders suggested testing measures to ensure a benefit to patient care and providing information to providers on how these measures are beneficial.

- **Minimizing changes to and complexity of MIPS.** Stakeholders we spoke with suggested that CMS should avoid making too many changes to MIPS, which may make MIPS more complex and burdensome for practices. One stakeholder told us that creating continuity where possible, for example, by allowing practices to report in the same way each year, would be helpful to practices. Another stakeholder suggested that a lengthier transition period for initially participating in MIPS would help small and rural practices have sufficient time to gain familiarity and experience in the complexities of MIPS reporting. In addition, some stakeholders told us that CMS should strive to keep MIPS as simple as possible as it will be difficult for practices to follow complex requirements, including those for eligibility and reporting.
- **Making policy changes, such as allowing practices to opt-in to MIPS participation.** Some stakeholders made suggestions to CMS about policy changes that could be made to increase the ability of small and rural practices to participate in MIPS. These included an option to allow practices to “opt-in” to MIPS and participate if they were below the low-volume threshold (and thus would normally be exempt from required participation in MIPS) but felt they could succeed in MIPS. Otherwise, according to some stakeholders, practices that are not eligible for MIPS because they do not exceed the low-volume threshold would only have minimal increases in Medicare payments. Other stakeholders called for additional policy changes, such as creating virtual regions where practices could work together toward a particular care goal, such as increasing vaccination rates among a specific population.

Outreach and Education

Stakeholders indicated that CMS could enhance its outreach and education efforts for the MIPS program by changing some elements of its communications strategy.

²⁹Quality measures track a number of things related to care, such as whether certain care was given to patients with diabetes.

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- **Making relevant communication efforts, including making website updates apparent, providing useful website content, and creating opportunities for questions.** Some stakeholders suggested that CMS could improve its communications efforts in terms of timing and useful content, for example, by announcing changes to key documents on the CMS or Quality Payment Program website and increasing the frequency of communication near the end of the year to coincide with upcoming deadlines for MIPS reporting. One stakeholder suggested that CMS update the frequently asked questions on the CMS website resources area with questions recently received by Small, Underserved, and Rural Support (SURS) contractors, which are contractors who provide free technical assistance to small and rural practices. Officials from a specialty association suggested that CMS allow more time for questions during its listening sessions, and allow participants to submit questions before each call to be answered by CMS during the listening sessions so that all participants can hear CMS's responses to difficult questions.

Technical Assistance

Stakeholders we spoke with suggested changes in the types of technical assistance that CMS offers and the manner in which it is delivered, including contracting with physician associations to provide technical assistance through existing channels and increasing the availability of personalized assistance for practices.

- **Contracting with membership organizations to provide technical assistance through existing channels.** Some stakeholders suggested that CMS should work with physician associations to provide technical assistance directly to small and rural practices because they already regularly communicate with thousands of their provider members. One specialty association also noted that some contractors tend to contact associations like theirs for assistance with technical assistance efforts because of the association's existing relationship with physician members. The specialty association suggested that CMS should revise contracting requirements for its contractors to ensure that, when applicable, the role of specialty societies as subcontractors is formalized.
- **Increasing the availability of personalized assistance for practices.** Some stakeholders told us personalized technical assistance to small and rural providers is important for them to be able to succeed in MIPS. Although stakeholders noted that the Quality Payment Program website has a wealth of resources, one stakeholder

noted that these materials are written at a high level and may not answer specific questions. Some stakeholders, both physicians and SURS contractors, said personalized assistance seemed to be the most beneficial type of technical assistance because practices can ask specific questions. One stakeholder also noted that CMS assistance is especially important for small and rural practices because they do not usually have the level of administrative support staff to understand new programmatic requirements that large practices usually have.

CMS Has Several Efforts Underway to Help Small and Rural Practices Participate in MIPS That May Address Some Stakeholder-Identified Challenges and Suggestions

CMS Has Incorporated Flexibilities in the Program Design and Requirements to Transition Practices into MIPS

CMS has incorporated several design elements to assist practices as they begin participating in MIPS that are intended to offer flexibility and ease the transition from the legacy payment incentive programs. (See table 7.) These efforts are in a number of areas including flexibility in providers' selecting a participation level, eligibility criteria for MIPS participation, incorporating a transition period for the Cost performance category, allowing providers to form virtual groups, and additional scoring or exceptions specifically for small practices.

Table 7: Examples of CMS’s Efforts Related to Flexibilities in the Merit-based Incentive Payment System (MIPS) Program Design and Requirements

Flexibility in selecting participation level for MIPS year 1	Providers could pick among three different levels of participation: (1) the “test” pace where they submit a minimum amount of data for 2017 to gain familiarity with the program and avoid a negative payment adjustment; (2) the “partial year” pace where providers could submit data for 90 days within 2017 to earn a positive or neutral payment adjustment; and (3) the “full year” pace where providers could submit a full year of data for 2017 to possibly earn the largest positive payment adjustment.
MIPS eligibility criteria	Excludes providers from required participation if they do not exceed the low-volume threshold (meaning they have less than a certain number of Medicare patients or total billings within a given year), are newly enrolled, or if they are participating in an Advanced Alternative Payment Model. ^a
Incorporating a transition period for the Cost performance category	The MIPS performance category for Cost will be rated at 0 percent for MIPS year 1; 10 percent for year 2; and 30 percent by year 6. ^b
Virtual groups	Allows small practices to form virtual groups, which are composed of solo providers or practices with 10 or fewer providers, to come together “virtually” to participate in MIPS. Virtual groups will participate in MIPS as a group and all providers within the virtual group will receive a score based on their collective performance in MIPS.
Additional scoring or exceptions for small practices	Includes additional points for small practices related to data completeness for the Quality category, enhanced hardship exceptions for the Advancing Care Information category, and additional 5 bonus points added to the MIPS final score for small practices if submitting data on at least one category.

Source: The Centers for Medicare & Medicaid Services (CMS). | GAO-18-428

^aThe low-volume threshold excluded providers from MIPS participation if they had provided care to 100 or fewer Medicare patients and had \$30,000 or less in Medicare Part B allowed charges for MIPS year 1 and had provided care to 200 or fewer Medicare patients and \$90,000 or less in allowed charges for MIPS year 2. In MIPS years 1 and 2, providers are considered to be significantly participating in an Advanced Alternative Payment Model if they have received 25 percent of their Medicare payments or if 20 percent of their Medicare patients are seen through an Advanced Alternative Payment Model that meets specific criteria.

^bThe Bipartisan Budget Act of 2018 provides CMS with additional flexibility regarding the weighting of the Cost performance category, requiring that the category should account for 30 percent of the MIPS score by year 6, instead of year 3 as previously established under the Medicare Access and CHIP Reauthorization Act of 2015. See Pub. L. No. 115-123, § 51003(a), 132 Stat. 64, 294.

According to CMS, many of these efforts are intended to lower the barriers for participation and to reduce the burden of MIPS for small practices and those located in rural areas. For example, CMS officials said that virtual groups will allow small practices to work together and share resources to participate in MIPS. Additionally, some small practices may not have enough beneficiaries to be reliably assessed on certain performance measures, and forming a virtual group would allow the practices to combine their beneficiary totals, helping them to be reliably assessed on those performance measures. CMS reported that the added flexibility of virtual groups will enhance small practices’ ability to successfully participate in MIPS.

CMS officials said that they have heard challenges and suggestions similar to the ones we identified and that many of their efforts related to the design of MIPS are responsive to these challenges and suggestions. Some of the design elements of MIPS—such as the low-volume threshold and the exceptions granted for small practices—may help address staffing resource challenges raised by stakeholders. For example, small practices that are granted an exception to the Advancing Care Information category may not have to devote as many staff resources to MIPS participation as they would not need to report data for the category’s measures. Stakeholders also suggested that CMS could help practices by altering certain MIPS requirements or by minimizing changes to MIPS measures. In response, CMS officials told us that instead of requiring providers to meet a number of Advancing Care Information category requirements, CMS will review whether providers make progress on a few key uses of EHR technology, such as engaging with patients via EHR systems and exchanging health information with other providers. In terms of the stakeholder suggestion to increase the oversight of EHR vendors and standardization of EHR products, CMS officials said that, to address this issue, CMS allows providers to use an older version of EHR-certified technology in MIPS year 2 and to apply for hardship exceptions. These efforts may help providers that have difficulty selecting or incorporating an EHR system into their practice. CMS officials also said that additional vendor oversight activities may be performed by HHS’s Office of the National Coordinator for Health Information Technology, which has primary responsibility for certifying technology used by EHR vendors.

CMS Has Conducted Outreach and Developed Educational Resources for MIPS, Including Some Specifically for Small and Rural Practices

CMS has a number of outreach and educational efforts to inform practices about MIPS. (See table 8.) One of these efforts is a website for the broader Quality Payment Program, which contains several different resources and tools related to MIPS. In addition, there are resources on the MIPS section of the website that outline support available to small and rural practices. Several stakeholders that we interviewed stated that CMS’s Quality Payment Program website has been a helpful resource. In addition, CMS has conducted many seminars that provide specific information on a number of topics related to MIPS.

Table 8: Examples of CMS’s Efforts Related to Outreach and Education for Participation in the Merit-based Incentive Payment System (MIPS)

Online resources for the Quality Payment Program	<p>The Quality Payment Program website has several elements, such as</p> <ul style="list-style-type: none"> • an overview of MIPS; • information about the four MIPS performance categories; • tools to explore the measures related to the Quality, Improvement Activities, and Advancing Care Information performance categories; • material related to what data needs to be reported; • an interactive section for small and rural practices to identify support available to them, including how to contact the organizations that provide support; and • the ability to check whether a specific provider is required to participate in MIPS, using the provider’s identification number (called the National Provider Identifier). <p>In addition, CMS’s main website has a resource library with links to many educational resources, including seminars.</p>
Seminars	<p>CMS offers webinars and other presentations that provide specific information on MIPS eligibility, performance categories, and related measures. During these sessions, CMS provides opportunities to answer providers’ questions, including during the presentation itself and also via a chat function.</p> <p>CMS has also solicited feedback from providers and other stakeholders through listening sessions and clinician roundtables about various aspects of MIPS.</p>

Source: The Centers for Medicare & Medicaid Services (CMS). | GAO-18-428

CMS officials told us that the agency has focused on making sure that MIPS resources are easy to understand as they have heard outreach and education challenges and suggestions similar to ones we identified. Stakeholders suggested that CMS could enhance its outreach and education efforts by making website updates more apparent and providing for additional opportunities to ask questions during CMS seminars. However, CMS officials told us that they already provide several avenues for providers to ask questions, including during the Q&A portion of seminars and through a chat function during the seminars (where the provider can get a response to the question from a CMS official in real time). In addition, CMS posts the transcripts from the chats on its website so that other providers can view the responses. CMS also collects and posts trending questions on its website and holds office hour sessions to respond to questions from providers.

CMS and Its Contractors Provide Technical Assistance to Practices

CMS and its contractors provide technical assistance to help providers with understanding MIPS’ requirements and how to successfully participate, through two primary efforts: a Quality Payment Program Service Center and technical assistance contractors. (See table 9.)

Table 9: Examples of the CMS’s Technical Assistance Efforts to Aid Participation in the Merit-based Incentive Payment System (MIPS)

Quality Payment Program Service Center	Provides support to providers’ programmatic and administrative questions via email and phone related to MIPS (and other parts of the Quality Payment Program).
Small, Underserved, and Rural Support (SURS) Contractors	<p>Provides free technical assistance to small and rural practices through a number of activities, including:</p> <ul style="list-style-type: none"> • Education about the MIPS program, including expectations, timelines, feedback reports, scoring, and performance measures; • Evaluation of practices’ readiness to participate in MIPS; • Assistance with health information technology; • Support for changes to structure, management, and strategic planning for practices; and • Coordination of peer-to-peer learning and partnerships. <p>The Medicare Access and CHIP Reauthorization Act of 2015 appropriated a total of \$100 million in funding over 5 years, which CMS used to contract with 11 organizations, called SURS contractors.^a</p>

Source: The Centers for Medicare & Medicaid Services (CMS). | GAO-18-428

^aPub. Law No. 114-10, § 101(c)(11), 129 Stat. 87, 110.

According to CMS officials, CMS has efforts in this area to address some of the challenges that were identified by stakeholders we interviewed. For example, some stakeholders told us that small practices may not have staff available to determine how to enhance program participation. CMS’s contractors that are providing technical assistance to small practices may be able to help these practices by providing individualized support, such as helping a practice select the most relevant MIPS measures to report. In addition, stakeholders told us that CMS should consider providing additional individualized support to small practices for MIPS. CMS officials said that helping practices is a priority for the agency but that it often has to figure out how to balance the funding available for technical assistance with the needs of practices.

Agency Comments

We provided a draft of this report to HHS for comment. HHS provided technical comments, which we incorporated as appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies of this report to the Secretary of Health and Human Services and the CMS administrator. In addition, the report is available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or cosgrovej@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix II.

A handwritten signature in black ink, appearing to read 'James Cosgrove', written in a cursive style.

James Cosgrove
Director, Health Care

List of Requesters

The Honorable Orrin Hatch
Chairman
Committee on Finance
United States Senate

The Honorable Pat Toomey
Chairman
Subcommittee on Health Care
Committee on Finance
United States Senate

The Honorable Chuck Grassley
The Honorable Mike Crapo
The Honorable Pat Roberts
The Honorable Michael Enzi
The Honorable John Cornyn
The Honorable John Thune
The Honorable Richard Burr
The Honorable Johnny Isakson
The Honorable Rob Portman
The Honorable Dean Heller
The Honorable Tim Scott
The Honorable Bill Cassidy
United States Senate

Appendix I: Detailed Data on Medicare Legacy Payment Incentive Programs for 2014 and 2015

This appendix contains detailed information on two Medicare legacy payment incentive programs—the Physician Quality Reporting System (PQRS) and the Value-based Payment Modifier (VM) program—for 2014 and 2015. The tables present this information by practice size and rural status. Additionally, this appendix contains detailed PQRS participation and VM performance information based on whether providers were eligible for the Merit-based Payment Incentive Program (MIPS) in years 1 and 2.

Table 10: Providers' Participation Rates in Physician Quality Reporting System (PQRS), by Practice Size and Rural Status, 2014 and 2015

	Total providers	Percentage of practices that successfully participated in PQRS	Percentage of practices that were unsuccessful in PQRS participation ^a	Percentage of practices that did not participate in PQRS ^a
2014 participation				
Small practices with 15 or fewer providers				
Rural	81,300	34.0	10.6	55.4
Non-rural	418,215	33.5	9.8	56.8
Practices with more than 15 providers				
Rural	114,481	63.2	3.6	33.1
Non-rural	678,870	73.5	4.4	22.1
Total	1,292,866			
2015 participation				
Small practices with 15 or fewer providers				
Rural	79,540	35.5	14.4	50.1
Non-rural	411,247	36.0	11.5	52.5
Practices with more than 15 providers				
Rural	119,829	74.0	5.5	20.5
Non-rural	723,924	78.4	5.7	15.9
Total	1,334,540			

Source: GAO analysis of data from the Centers for Medicare & Medicaid Services. | GAO-18-428

Notes: Data analysis is at the individual provider level; however, for simplicity, we refer to these providers as practices based on their size. Participation percentages were calculated within each practice size and rural status groupings. For example, the percentage of small and rural practices that successfully participate in PQRS is based on the total number of practices that were small and rural.

Providers that attempted to submit PQRS data, but were not successful, or did not participate in PQRS were subject to a negative payment adjustment.

^aPractices needed to successfully report PQRS data but were not assessed on their actual performance on the quality measures that they submitted. If practices unsuccessfully participated in

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PQRS (meaning they submitted data that did not meet the PQRS requirements) or if practices did not participate in PQRS in 2014 or 2015, they were subject to a negative payment adjustment that was applied to their 2016 or 2017 payments, respectively. Providers that successfully participated in PQRS were no longer eligible for incentive payments after the 2014 performance year.

Table 11: Providers' 2015 Participation Rates in Physician Quality Reporting System (PQRS), for Small Practices Eligible for the Merit-based Incentive Payment System (MIPS) for Year 1 and Year 2, by Rural Status

	Total providers	Percentage of practices that successfully participated in PQRS	Percentage of practices that were unsuccessful in PQRS participation ^a	Percentage of practices that did not participate ^a
2015 PQRS participation for providers eligible for MIPS year 1				
Small practices with 15 or fewer providers				
Rural	30,699	46.4	18.2	35.4
Non-rural	150,971	51.4	13.3	35.4
2015 PQRS participation for providers eligible for MIPS year 2^b				
Small practices with 15 or fewer providers				
Rural	17,054	54.0	16.8	29.2
Non-rural	93,621	58.3	12.4	29.2

Source: GAO analysis of data from the Centers for Medicare & Medicaid Services (CMS). | GAO-18-428

Notes: Data analysis is at the individual provider level; however, for simplicity, we refer to these providers as practices based on their size.

Due to limitations in the PQRS data we received from CMS, we were unable to compare the rates of successful participation in PQRS for MIPS-eligible small and large practices. However, we were able to compare differences in the rate of successful participation in PQRS for small practices based on whether these practices were MIPS-eligible, which is outlined in the table. Participation percentages were calculated within each practice size and rural status groupings. For example, the percentage of small and rural practices that successfully participate in PQRS is based on the total number of practices that were small and rural.

Providers that attempted to submit PQRS data, but were not successful, or did not participate in PQRS were subject to a negative payment adjustment.

^aPractices needed to successfully report PQRS data but were not assessed on their actual performance on the quality measures that they submitted. If practices unsuccessfully participated in PQRS (meaning they submitted data that did not meet the PQRS requirements) or if practices did not participate in PQRS in 2015, they were subject to a negative payment adjustment to their 2017 payments. Providers that successfully participated in PQRS were no longer eligible for incentive payments after the 2014 performance year.

^bAnalysis for this table was based on CMS data of providers eligible for MIPS participation in year 2 based on eligibility requirements published prior to the passage of the Bipartisan Budget Act of 2018. Therefore, the data used do not reflect modifications to the Medicare payments included in the MIPS eligibility determinations that were included in the Bipartisan Budget Act of 2018. See Pub. L. No. 115-123, § 51003(a), 132 Stat. 64, 294.

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Table 12: Providers' 2015 Participation Rates in Physician Quality Reporting System (PQRS), for Small Practices That Were Not Eligible for the Merit-based Incentive Payment System (MIPS) for Year 1 and Year 2, by Rural Status

	Total providers	Percentage of practices that successfully participated in PQRS	Percentage of practices that were unsuccessful in PQRS participation^a	Percentage of practices that did not participate^a
2015 PQRS Participation for providers not eligible for MIPS year 1				
Small practices with 15 or fewer providers				
Rural	48,841	28.7	11.9	59.4
Non-rural	260,276	27.1	10.5	62.4
2015 PQRS Participation for providers not eligible for MIPS year 2^b				
Small practices with 15 or fewer providers				
Rural	62,486	30.5	13.7	55.8
Non-rural	317,626	29.4	11.2	59.4

Source: GAO analysis of data from the Centers for Medicare & Medicaid Services (CMS). | GAO-18-428

Notes: Data analysis is at the individual provider level; however, for simplicity, we refer to these providers as practices based on their size.

Due to limitations in the PQRS data we received from CMS, we were unable to compare the rates of successful participation in PQRS for MIPS-eligible small and large practices. However, we were able to compare differences in the rates of small practices participation in PQRS in 2015 for practices that were not MIPS-eligible, which is outlined in the table. Participation percentages were calculated within each practice size and rural status groupings. For example, the percentage of small and rural practices that successfully participated in PQRS is based on the total number of practices that were small and rural.

Providers that attempted to submit PQRS data, but were not successful, or did not participate in PQRS were subject to a negative payment adjustment.

^aPractices needed to successfully report PQRS data but were not assessed on their actual performance on the quality measures that they submitted. If practices unsuccessfully participated in PQRS (meaning they submitted data that did not meet the PQRS requirements) or if practices did not participate in PQRS in 2015, they were subject to a negative payment adjustment that was applied to their 2017 payments. Providers that successfully participated in PQRS were no longer eligible for incentive payments after the 2014 performance year.

^bAnalysis for this table was based on CMS data of providers eligible for MIPS participation in year 2 based on eligibility requirements published prior to the passage of the Bipartisan Budget Act of 2018. Therefore, the data used do not reflect modifications to the Medicare payments included in the MIPS eligibility determinations that were included in the Bipartisan Budget Act of 2018. See Pub. L. No. 115-123, § 51003(a), 132 Stat. 64, 294.

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Table 13: Providers' Performance Rates in Value-based Payment Modifier (VM) Program, by Practice Size and Rural Status, 2014 and 2015

	Total providers	Percentage of providers that performed well enough to receive a positive payment adjustment in VM^a	Percentage of providers whose performance led to a neutral payment adjustment^b	Percentage of providers whose performance or lack of participation led to a negative payment adjustment^c
2014 performance				
Small practices with 15 or fewer providers				
Rural	9,270	0.4	50.8	48.8 ^c
Non-rural	62,418	1.1	52.2	46.7 ^c
Practices with more than 15 providers				
Rural	52,561	0.3	62.8	36.9
Non-rural	749,001	0.9	66.7	32.4
Total	873,250			
2015 performance				
Small practices with 15 or fewer providers				
Rural	69,113	1.0	42.7	56.3 ^c
Non-rural	431,718	1.3	42.8	55.8 ^c
Practices with more than 15 providers				
Rural	80,038	1.1	71.9	27.0
Non-rural	1,000,146	1.4	72.9	25.7
Total	1,581,015			

Source: GAO analysis of data from the Centers for Medicare & Medicaid Services (CMS). | GAO-18-428

Notes: Performance percentages were calculated within each practice size and rural status grouping. For example, the percentage of small and rural practices that performed well enough to receive a positive payment adjustment in VM is based on the total number of practices that were small and rural.

Although the VM program was applied at the practice-level, we have reported this information at the provider-level.

The data we obtained from CMS did not have information to determine the rural status for 31 providers that were eligible for the 2014 VM data and 7,777 providers for the 2015 VM data. As a result, those providers are not included in this table.

This table includes all providers in practices that were eligible for the VM program, including those in specialties that were not subject to the VM payment adjustment.

^aPractices that had the following scoring in the VM program received a positive payment adjustment: Low-cost, average-quality; Low-cost, high-quality; and Average-cost, high-quality.

^bIn the data we received from CMS, practices that had the following scoring in the VM program received a neutral payment adjustment: Low-cost, low-quality; average-cost, average-quality; and high-cost, high-quality. We used this same categorization scheme, which does not reflect that, in the 2015 measurement year, practices with fewer than 10 practitioners would also have received a neutral payment adjustment for the following scoring: average-cost, low-quality; high-cost, average-quality; and high-cost, low-quality.

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^cIn the data we received from CMS, practices that had the following scoring in the VM program received a negative payment adjustment: average-cost, low-quality; high-cost, average-quality; and high-cost, low-quality. In addition, certain providers were only subject to a neutral or positive payment adjustment. For the 2014 VM program, these providers were in practices with 10 to 99 providers and for the 2015 VM program, these providers were in practices with 1 to 9 providers. However, in both 2014 and 2015, providers of any size that failed to meet PQRS reporting requirements were subject to a negative payment adjustment, as successful participation in PQRS was a part of the quality assessment in the VM program. As a result, the percentages of practices that received a negative payment adjustment include practices whose VM performance resulted in a negative payment adjustment and practices who did not meet PQRS reporting requirements.

Table 14: Providers' 2015 Performance Rates in Value-based Payment Modifier (VM) Program, by Practice Size and Rural Status for Providers Eligible for the Merit-based Incentive Payment System (MIPS) for Year 1 and Year 2

	Total providers	Percentage of providers that performed well enough to receive a positive payment adjustment in VM ^a	Percentage of providers whose performance led to a neutral payment adjustment ^b	Percentage of providers whose performance or lack of participation led to a negative payment adjustment ^c
2015 VM performance for providers eligible for MIPS year 1				
Small practices with 15 or fewer providers				
Rural	55,626	1.1	46.2	52.7 ^c
Non-rural	335,793	1.6	48.0	50.4 ^c
Practices with more than 15 providers				
Rural	79,795	1.1	71.9	27.0
Non-rural	994,353	1.4	73.0	25.6
Total	1,465,567			
2015 VM performance for providers eligible for MIPS year 2^d				
Small practices with 15 or fewer providers				
Rural	47,431	1.2	50.5	48.3 ^c
Non-rural	294,756	1.7	51.3	47.0 ^c
Practices with more than 15 providers				
Rural	79,466	1.1	72.1	26.8
Non-rural	991,312	1.4	73.1	25.5
Total	1,412,965			

Source: GAO analysis of data from the Centers for Medicare & Medicaid Services (CMS). | GAO-18-428

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Notes: Performance percentages were calculated within each practice size and rural status grouping. For example, the percentage of small and rural practices that performed well enough to receive a positive payment adjustment in VM is based on the total number of practices that were small and rural.

Although the VM program was applied at the practice-level, we have reported this information at the provider-level.

The data we obtained from CMS did not have information to determine the rural status for 3,620 providers that were eligible for MIPS year 1 and 2,690 providers for MIPS year 2. As a result, those providers are not included in this table.

This table includes all providers in practices that were eligible for the VM program, including those in specialties that were not subject to the VM payment adjustment.

^aPractices that had the following scoring in the VM program received a positive payment adjustment: low-cost, average-quality; low-cost, high-quality; and average-cost, high-quality.

^bIn the data we received from CMS, practices that had the following scoring in the VM program received a neutral payment adjustment: low-cost, low-quality; average-cost, average-quality; and high-cost, high-quality. We used this same categorization scheme, which does not reflect that, in the 2015 measurement year, practices with fewer than 10 practitioners would also have received a neutral payment adjustment for the following scoring: average-cost, low-quality; high-cost, average-quality; and high-cost, low-quality.

^cIn the data we received from CMS, practices that had the following scoring in the VM program received a negative payment adjustment: average-cost, low-quality; high-cost, average-quality; and high-cost, low-quality. In addition, in the 2015 VM program, practices with 1 to 9 providers were only subject to a neutral or positive payment adjustment. However, if practices with 1 to 9 providers failed to meet PQRS reporting requirements, they would have been subject to a negative payment adjustment as successful participation in PQRS was a part of the quality assessment in the VM program. As a result, the percentages of small practices that received a negative payment adjustment include practices with 10 to 15 providers who either received a negative payment adjustment because of their performance or because they did not meet PQRS reporting requirements and practices with 1 to 9 providers that received a negative payment adjustment in VM because they did not meet PQRS reporting requirements.

^dAnalysis for this table was based on CMS data of providers eligible for MIPS participation in year 2 based on eligibility requirements published prior to the passage of the Bipartisan Budget Act of 2018. Therefore, the data used do not reflect modifications to the Medicare payments included in the MIPS eligibility determinations that were included in the Bipartisan Budget Act of 2018. See Pub. L. No. 115-123, § 51003(a), 132 Stat. 64, 294.

Table 15: Providers' 2015 Performance Rates in Value-based Payment Modifier (VM) Program, by Practice Size and Rural Status for Providers Not Eligible for the Merit-based Incentive Payment System (MIPS) for Year 1 and Year 2

	Total providers	Percentage of providers that performed well enough to receive a positive payment adjustment in VM ^a	Percentage of providers whose performance led to a neutral payment adjustment ^b	Percentage of providers whose performance or lack of participation led to a negative payment adjustment ^c
2015 VM performance for providers not eligible for MIPS year 1				
Small practices with 15 or fewer providers				
Rural	13,487	0.3	28.4	71.3 ^c
Non-rural	95,925	0.6	24.8	74.6 ^c
Practices with more than 15 providers				
Rural	243	14.0	44.9	41.2
Non-rural	5,793	3.0	55.6	41.4
Total	115,448			
2015 VM performance for providers not eligible for MIPS year 2^d				
Small practices with 15 or fewer providers				
Rural	21,682	0.4	25.8	73.7 ^c
Non-rural	136,962	0.6	24.7	74.7 ^c
Practices with more than 15 providers				
Rural	572	5.9	42.3	51.7
Non-rural	8,834	2.5	50.9	46.5
Total	168,050			

Source: GAO analysis of data from the Centers for Medicare & Medicaid Services (CMS). | GAO-18-428

Notes: Performance percentages were calculated within each practice size and rural status grouping. For example, the percentage of small and rural practices that performed well enough to receive a positive payment adjustment in VM is based on the total number of practices that were small and rural.

Although the VM program was applied at the practice-level, we have reported this information at the provider-level.

The data we obtained from CMS did not have information to determine the rural status for 4,157 providers that were eligible for MIPS year 1 and 5,087 providers for MIPS year 2. As a result, those providers are not included in this table.

This table includes all providers that were in practices eligible for the VM program, including those in specialties that were not subject to the VM payment adjustment.

^aPractices that had the following scoring in the VM program received a positive payment adjustment: low-cost, average-quality; low-cost, high-quality; and average-cost, high-quality.

^bIn the data we received from CMS, practices that had the following scoring in the VM program received a neutral payment adjustment: low-cost, low-quality; average-cost, average-quality; and

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high-cost, high-quality. We used this same categorization scheme, which does not reflect that, in the 2015 measurement year, practices with fewer than 10 practitioners would also have received a neutral payment adjustment for the following scoring: average-cost, low-quality; high-cost, average-quality; and high-cost, low-quality.

^cIn the data we received from CMS, practices that had the following scoring in the VM program received a negative payment adjustment: average-cost, low-quality; high-cost, average-quality; and high-cost, low-quality. In addition, in the 2015 VM program, practices with 1 to 9 providers were only subject to a neutral or positive payment adjustment. However, if practices with 1 to 9 providers failed to meet PQRS reporting requirements, they would have been subject to a negative payment adjustment as successful participation in PQRS was a part of the quality assessment in the VM program. As a result, the percentages of small practices that received a negative payment adjustment include practices with 10 to 15 providers who either received a negative payment adjustment because of their performance or because they did not meet PQRS reporting requirements and practices with 1 to 9 providers that received a negative payment adjustment in VM because they did not meet PQRS reporting requirements.

^dAnalysis for this table was based on CMS data of providers eligible for MIPS participation in year 2 based on eligibility requirements published prior to the passage of the Bipartisan Budget Act of 2018. Therefore, the data used do not reflect modifications to the Medicare payments included in the MIPS eligibility determinations that were included in the Bipartisan Budget Act of 2018. See Pub. L. No. 115-123, § 51003(a), 132 Stat. 64, 294.

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

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Staff Acknowledgments

In addition to the contact named above, Gregory Giusto, Assistant Director; Christie Enders, Analyst-in-Charge; Todd Anderson; George Bogart; Margot Bolon; Beth Morrison; and Vikki Porter made key contributions to this report.

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