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Report to Congressional Committees

October 2021

MEDICARE

Provider Performance and Experiences under the Merit-based Incentive Payment System

GAO@100

A Century of Non-Partisan Fact-Based Work

GAO-22-104667

GAO@100 Highlights

Highlights of GAO-22-104667, a report to congressional committees

October 2021

MEDICARE

Provider Performance and Experiences under the Merit-based Incentive Payment System

Why GAO Did This Study

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) changed how Medicare pays for physician services, moving from a payment system that largely rewarded volume and complexity of health care services to the Quality Payment Program, which is a payment incentive program intended to reward high-quality, efficient care. Providers participate in the Quality Payment Program through one of two tracks: MIPS or advanced alternative payment models. MIPS was designed to incentivize high-quality care through performance-based payment adjustments. About 950,000 providers (about half of all Medicare Part B providers) were eligible to participate in MIPS in 2019.

Congress included a provision in MACRA for GAO to examine the MIPS program. This report describes (1) the distribution of MIPS performance scores and related payment adjustments, and (2) stakeholders' perspectives on the strengths and challenges of the MIPS program.

GAO analyzed MIPS data for performance years 2017 through 2019—the most recent year available at the time of GAO's analysis. GAO also interviewed officials from CMS and 11 selected professional organizations that represent MIPS-eligible providers of various specialties. GAO identified stakeholders through research and its analysis of the MIPS data.

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

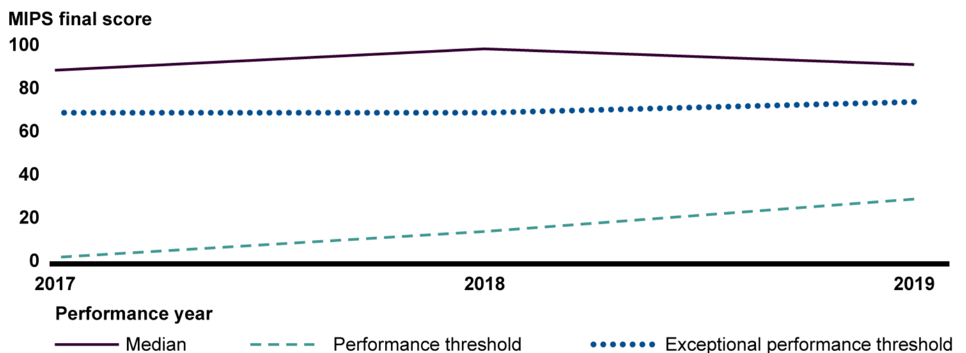
View GAO-22-104667. For more information, contact Jessica Farb at (202) 512-7114 or FarbJ@gao.gov

What GAO Found

The Centers for Medicare & Medicaid Services (CMS) administers the Merit-based Incentive Payment System (MIPS) under the Medicare program. Under this system, MIPS-eligible providers receive a "final score" based on their performance on certain measures in four categories, such as quality and cost of care. This final score is compared to a performance threshold and is used to determine if providers receive a negative, neutral, or positive payment adjustment applied to future Medicare payments. Providers may receive a larger positive adjustment if their final score surpasses a higher threshold, known as the exceptional performance threshold. In addition, eligible providers who do not submit required performance data may receive a negative adjustment.

Analysis of CMS data shows that final scores were generally high and at least 93 percent of providers earned a small positive adjustment in 2017 through 2019, with the largest payment adjustment in any year being 1.88 percent. Median final scores were well above the performance threshold across each of the 3 years (see figure). About 72 to 84 percent of providers earned an exceptional performance bonus, depending on the year.

Median Final Scores Relative to Performance and Exceptional Performance Thresholds, Performance Years 2017 through 2019



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-22-104667

Stakeholders GAO interviewed identified some strengths and challenges related to the MIPS program. For example, two of the 11 stakeholders stated that bonus points, such as those that may be added to the final scores for small practices, helped increase scores for certain providers who might otherwise be disadvantaged. Eight stakeholders questioned whether the program helps to meaningfully improve quality of care or patient health outcomes. For example, they said that the design of the program may incentivize reporting over quality improvement, with providers choosing to report on quality measures on which they are performing well, rather than on measures in areas where they may need improvement. According to CMS, the MIPS Value Pathways (MVP)—a new way of meeting reporting requirements in 2023—will help to address some of these challenges by standardizing performance measurement across specific specialties, medical conditions, or episodes of care. The development of clinically cohesive sets of measures and activities should minimize providers' selection burden in choosing measures and activities to report for each MVP, officials said.

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Abbreviations

APM	alternative payment model
CMS	Centers for Medicare & Medicaid Services
COVID-19	Coronavirus Disease 2019
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MIPS	Merit-based Incentive Payment System
MVP	MIPS Value Pathway
NPI	National Provider Identifier
QPP	Quality Payment Program
SURS	Small, Underserved, and Rural Support
TIN	Tax Identification Number

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**441 G St. N.W.
Washington, DC 20548**

October 1, 2021

The Honorable Ron Wyden
Chairman
The Honorable Mike Crapo
Ranking Member
Committee on Finance
United States Senate

The Honorable Frank Pallone, Jr.
Chairman
The Honorable Cathy McMorris Rodgers
Republican Leader
Committee on Energy and Commerce
House of Representatives

The Honorable Richard Neal
Chairman
The Honorable Kevin Brady
Republican Leader
Committee on Ways and Means
House of Representatives

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) changed how Medicare pays for physician services, moving from a payment system that largely rewarded volume and complexity of health care services provided to a payment incentive program that ties payments to the quality and efficiency of care. MACRA repealed the sustainable growth rate formula for determining Medicare payments for certain health care providers' services and established two tracks for financially incentivizing high quality, efficient care.[1] The two tracks—which the Centers for Medicare & Medicaid Services (CMS) implemented on January 1, 2017 and named the Quality Payment Program (QPP)—are:

[1]Pub. L. No. 114-10, § 101, 129 Stat. 87, 89. The sustainable growth rate was a system used to update Medicare physician fees and to moderate the growth in spending for physician services. For more information, see GAO, *Medicare Physician Payments: Concerns about Spending Target System Prompt Interest in Considering Reforms,* GAO-05-85 (Washington, D.C.: Oct. 8, 2004).

- **Merit-based Incentive Payment System (MIPS),** in which eligible providers earn performance-based payment adjustments for the services rendered to Medicare beneficiaries;[2] and
- **Advanced alternative payment models (Advanced APM),** in which participating providers are encouraged to share in the financial rewards and risk of caring for beneficiaries.[3]

In 2019, about 950,000 providers (about half of all Medicare Part B providers) were eligible to participate in MIPS. MIPS-eligible providers are assessed on their performance in four categories—(1) quality, (2) improvement activities, (3) promoting interoperability, and (4) cost.[4] Based on their performance, providers receive a MIPS final performance score that determines the payment adjustment that is applied to the provider's future Medicare Part B payments. The payment adjustments may be negative (resulting in a payment decrease), neutral (no change in payment), or positive (payment increase). For example, providers who do not submit any information about their performance may receive a negative payment adjustment, unless CMS has exempted their participation.

Questions have been raised about certain elements of the MIPS program. For example, the Medicare Payment Advisory Commission questioned the comparability of providers' MIPS scores because the final scores

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[2]MACRA consolidated three Medicare legacy payment incentive programs—Promoting Interoperability program, Physician Quality Reporting System, and Value-based Payment Modifier—under MIPS. See Pub. L. No. 114-10, § 101(b), 129 Stat. 87, 91. The Promoting Interoperability program was established to encourage eligible professionals, hospitals, and critical access hospitals to adopt, implement, upgrade, and demonstrate meaningful use of certified electronic health record technology. The Physician Quality Reporting System encouraged physicians (through financial incentives or penalties) to report information on quality of care. The Value-based Payment Modifier program provided differential payments to physicians by assessing the quality and cost of the care they provided.

[3]An APM is a payment approach that gives added incentive payments to providers to provide high-quality and cost-efficient care. See 42 C.F.R. § 414.1305 (2020) (definition of APM). An Advanced APM is an APM that CMS determines meets the criteria set forth in regulation pertaining to use of certified electronic health record technology, quality measures, and financial risk. See 42 C.F.R. § 414.1415 (2020) (advanced APM criteria).

[4]By law, certain Medicare providers, known as MIPS-eligible clinicians, are subject to MIPS. See 42 U.S.C. § 1395w-4(q)(1)(C); 42 C.F.R. § 414.1310(a) (2020) (applicability). For the purposes of this report, we refer to MIPS-eligible clinicians as "providers."

The promoting interoperability performance category promotes patient engagement and electronic exchange of information using certified electronic health record technology.

reflect a mix of different, self-chosen measures that providers report to CMS.[5] In addition, the Commission questioned whether MIPS would actually help improve the quality of care, because the design of the program evaluates clinical outcomes, patient experience, and cost measures independently of each other, whereas the Commission believes these measures are dependent on the totality of care and should be evaluated together in value-based programs.

MACRA includes a provision for us to review the MIPS program.[6] This report describes

1. the distribution of MIPS final scores and related payment adjustments; and
2. stakeholders' perspectives on the strengths and challenges of the MIPS program.

To describe the distribution of MIPS final scores and related payment adjustments, we analyzed CMS data on MIPS performance category scores, final scores, and payment adjustments from performance years 2017 through 2019 (the most recent year of data available at the time of our study).[7] To establish the reliability of the MIPS data CMS provided, we reviewed related documentation; interviewed CMS officials about the data; conducted checks for missing, duplicative, or erroneous data; and compared our results with published data. Based on these activities, we determined that the data we used were sufficiently reliable for the purposes of our reporting objective.

To describe stakeholders' perspectives on the strengths and challenges of the MIPS program, we interviewed officials from CMS and a non-

[5]Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: Mar. 15, 2018).

[6]Pub. L. No. 114-10, § 101(c)(2)(A), 129 Stat. 87, 113. This report will focus on MIPS, including MIPS APMs.

A forthcoming GAO report will address Advanced APMs in rural and health professional shortage areas. See Pub. L. No. 114-10, § 101(c)(2)(D), 129 Stat. 87, 114.

[7]For the purposes of this report, we use the term "performance year" to mean the period of time in which CMS assesses provider performance, which may range from a continuous 90-day period within a calendar year to the full calendar year. See 42 C.F.R. § 414.1320 (2020) (MIPS performance period). Providers report data for the performance year by March 31 of the following year. In this report, we use the term "year" to refer to a "performance year," unless otherwise specified as a "payment year."

generalizable sample of 11 selected professional organizations that represent MIPS-eligible providers of various specialties. We selected nine of these stakeholder groups because they represented specialties that had among the largest numbers of providers overall or among small practices from 2017 through 2019 and varied in other key characteristics.[8] Specifically, these stakeholder groups were selected for variability in 1) their specialty's average final scores relative to the overall average final scores across each of the 3 years; 2) physician and non-physician specialties; 3) patient-facing and non-patient facing specialties; and 4) inclusion of at least at least one newly MIPS-eligible provider type as of 2019. The remaining two stakeholder groups were selected to provide a general perspective from providers, including those in rural areas.

We conducted this performance audit from December 2020 through October 2021 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

Providers' Eligibility to Participate in MIPS

By law, certain Medicare providers, known as MIPS-eligible clinicians, are subject to MIPS. Specifically, MIPS applies adjustments to payments for professional services furnished by certain provider types—such as physicians, nurse practitioners, and physical therapists.[9] However, certain

[8]These stakeholder groups represented the following nine specialties: cardiology, diagnostic radiology, emergency medicine, general surgery, internal medicine, pathology, physical therapy, podiatry, and nurse practitioner.

[9]For the purposes of this report, we refer to MIPS-eligible clinicians as providers. In 2021 and subsequent years, eligible types of providers include physicians, osteopathic practitioners, chiropractors, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, physical therapists, occupational therapists, clinical psychologists, qualified speech-language pathologists, qualified audiologists, and registered dietitians or nutrition professionals. Eligible physicians include doctors of medicine, osteopathy, dental surgery, dental medicine, podiatric medicine, and optometry. MIPS-eligible providers may be individuals or groups of these providers. See 42 C.F.R. § 414.1305 (2020) (definition of MIPS-eligible clinician). A covered professional service is one for which payment is made under, or based on, the Medicare Physician Fee Schedule. For the purposes of this report, Part B payments refer to Medicare Part B payments made under, or based on, the Medicare Physician Fee Schedule.

providers are excluded, such as those serving a low volume of Medicare patients and those opting to participate in an Advanced APM instead of MIPS.[10] Specific criteria for eligibility have changed over time, such as the threshold for exclusion due to low volume. For example, for 2017, providers must have billed more than $30,000 for Part B covered professional services and seen more than 100 Part B patients. For 2018, this low-volume threshold was increased, such that providers must have billed more than $90,000 for Part B services and seen more than 200 Part B patients. Beginning in 2019, a third criterion was added, such that providers must have rendered more than 200 covered professional services to Part B patients.

Eligibility to participate in MIPS is assessed for each provider based on their National Provider Identifier (NPI) tied to a single Taxpayer Identification Number (TIN).[11] According to CMS, in 2017, about 54 percent of the approximately 2 million Medicare Part B providers were eligible to participate in MIPS; in 2018, about 49 percent of the 1.8 million providers were eligible to participate, and in 2019, about 49 percent of about 2 million providers were eligible.

Methods of Participation

Providers may participate in MIPS as individuals, as part of a group, as part of a virtual group, or as part of a MIPS APM entity. The method by which a provider participates in MIPS may affect how measures are reported and the resulting final scores and payment adjustments.

- **Individuals.** A provider who participates as an individual collects and reports measures and activities based on their individual performance; the resulting final score and payment adjustment is also therefore based on the provider’s individual performance.
- **Groups.** Providers may choose to participate in MIPS as part of a group, which is defined as a single TIN with two or more providers (at least one of whom must be eligible to participate in MIPS), who have reassigned their Medicare billing rights to the TIN. The group collects

[10]In 2021 and subsequent years, the low-volume threshold excludes a provider who 1) charges less than or equal to $90,000 in covered services, 2) furnishes covered services to 200 or fewer patients, or 3) furnishes 200 or fewer covered services. MIPS-eligible providers who meet the criteria to be a qualifying or partial qualifying APM participant through participation in an Advanced APM are exempted from MIPS. See 42 C.F.R. § 414.1305 (2020) (definitions).

[11]An NPI is a unique 10-digit number used to identify providers. A TIN is either the Social Security Number or Employer Identification Number that an individual or organization uses to report tax information to the Internal Revenue Service.

and reports measures and activities based on the aggregated performance of the providers billing under the TIN; as such, measures reported may not be specific to all specialties within the group. All providers participating as part of the group are eligible to receive the same final score.

- **Virtual groups.** Since 2018, providers have had the option of participating as a virtual group. A virtual group is a participation option available to solo providers and practices with 10 or fewer providers that allows them to submit aggregated data as a group, despite billing under different TINs.
- **MIPS APMs.** An APM is a payment approach that gives added incentive payments to provide high-quality, cost-efficient care to a specific clinical condition, care episode, or population. A subset of APMs determined by CMS are considered MIPS APMs. Individual providers, groups, or combinations of these may form an APM entity, which participates in a MIPS APM under an agreement with CMS. Those providers who are part of the APM entity may be collectively scored as an APM entity group and all APM entity group members are eligible to receive the same final score and payment adjustment.

MIPS Performance Categories, Bonus Points, and Final Score

In general, providers are scored on their performance and activities in four performance categories for the year. In the calculation of a final score, scores from the four performance categories are weighted according to certain percentages specified in statute and regulations.[12] Providers may also qualify for certain category weighting exceptions—which allow them to be exempt from one or more performance categories

[12]MACRA specified that improvement activities shall be weighted at 15 percent and promoting interoperability at 25 percent. Pub. L. No. 114-10, § 101(c)(1), 129 Stat. 87, 103 (codified as amended at 42 U.S.C. § 1395w-4(q)(5)(E)). MACRA provided CMS with flexibility to set the relative weights for the quality and cost categories. Performance category weights have changed over time. For example, for providers participating as individuals or groups in 2017, quality was weighted at 60 percent of the final score; for 2021, quality was weighted at 40 percent. Decreases in the quality category weight corresponded with increases in the cost category weight from 0 to 20 percent. See 42 C.F.R. § 414.1380(c)(1) (2020) (performance category weights).

in a given year and have the exempted categories' weights redistributed—if they meet certain criteria.[13]

Performance Categories

The four performance categories on which providers may be scored are quality, improvement activities, promoting interoperability, and cost.[14]

- **Quality.** The quality performance category measures health care processes, outcomes, and patient experiences of their care. Providers are generally required to submit data for at least six quality measures related to the care they provided to their patients during the year. Measures reflect performance on specific processes or outcomes, but may not reflect the overall quality of a provider's care.

  Providers have a variety of quality measures from which they may choose to report, such as MIPS clinical quality measures and qualified clinical data registry measures, among others. MIPS clinical quality measures are grouped into specialty measure sets; some of these measures are specific to a provider's specialty, while others are broadly applicable across multiple specialties. For example, one MIPS clinical quality measure for 2021, specific to thoracic surgeons, measured the percentage of patients aged 18 years and older who underwent coronary artery bypass graft surgery and required postoperative intubation for more than 24 hours. Another measure for 2021 that was available to 30 specialties measured the percentage of visits for patients aged 18 years and older who were screened for tobacco use one or more times within 12 months and who received tobacco cessation intervention if identified as a tobacco user. Qualified clinical data registries are entities with the flexibility to develop and track their own quality measures—which, like MIPS

[13]There are several circumstances in which CMS will redistribute the weight of one or more performance categories. For example, providers may apply to have categories reweighted in certain extreme and uncontrollable circumstances. Applicants in this circumstance must indicate that rare events entirely outside their control caused them to either (1) be unable to collect or submit information necessary for a performance category or (2) impacted their normal processes in a way that affected their performance on cost or administrative claims measures. CMS may also grant automatic exceptions without an application in certain circumstances.

[14]CMS renamed the advancing care information category to promoting interoperability beginning in 2018. Providers who participate as part of a MIPS APM entity are not scored on cost since they are already responsible for cost through their APMs.

clinical quality measures, may be specialty-specific—and which are approved by CMS along with the entity at certain periodic points.[15]

- **Improvement activities.** The improvement activities performance category assesses how much a provider or group participates in activities that are designed to improve clinical practice, care delivery, and outcomes. Providers select from a list of activities for the year and attest that they performed the activity for at least a continuous 90-day period (or as otherwise specified in the activity description) during the year.[16] For example, one of the measures available for 2021 was whether the provider completed the Centers for Disease Control and Prevention's antibiotic stewardship course.
- **Promoting interoperability.** The promoting interoperability performance category promotes patient engagement and electronic exchange of health information using certified electronic health record technology. Electronic health records must meet certain established standards and other criteria to qualify for use as certified electronic health record technology. Measures relate to the use of that technology. For example, one of the measures for 2021 was the percentage of eligible prescriptions that were electronically prescribed. Providers are generally required to report the entire set of measures applicable to their certified electronic health record technology.[17]
- **Cost.** The cost performance category measures Medicare payments made for care provided to patients. Providers do not submit measures for this category; instead, CMS uses Medicare Part A and B claims to calculate cost measure performance. For example, one of the measures for 2021—Total Per Capita Cost—was an average of per capita Medicare Part A and B expenditures across all of the provider's attributed patients.

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[15]For more information on qualified clinical data registries, see GAO, *Clinical Data Registries: HHS Could Improve Medicare Quality and Efficiency through Key Requirements and Oversight,* GAO-14-75 (Washington, D.C.: Dec. 16, 2013).

[16]For group and APM entity reporting, a group, virtual group, or MIPS APM entity can attest to an activity when at least 50 percent of the providers in the group, virtual group, or MIPS APM entity performed the same activity during any continuous 90-day period (or as otherwise specified in the activity description) during the year.

[17]Individual measures within the promoting interoperability category have their own exclusion criteria. Providers who meet exclusion criteria for a particular measure are not required to complete that measure. See 42 C.F.R. § 414.1375 (2020) (promoting interoperability category requirements).

Bonus Points

Some providers may qualify to have certain bonus points added to their final scores. For example, since 2018, providers may have up to five bonus points added to their final scores based on a combination of the medical complexity of their patients and the proportion of their patients who were dually eligible for both Medicaid and Medicare—a bonus called the "complex patient bonus."[18] In the preamble to the 2018 final rule, CMS stated that the bonus is part of a short-term strategy to address the effect patient complexity may have on MIPS scoring while continuing to work with stakeholders on methods to account for patient risk factors.[19] Additionally, for 2018 only, small practices of 15 or fewer providers could receive five bonus points added to their final scores if they submitted data for at least one performance category (quality, improvement activities, or promoting interoperability)—a bonus called the "small practice bonus." Beginning in 2019, small practices that submit at least one quality measure receive six bonus points added to their quality category score instead of the final score.[20]

Final Scores

Final scores are generally computed by summing the weighted performance category scores and any applicable bonus points for the year, resulting in a final score on a scale from 0 to 100 points. As such, final scores reflect a composite of performance across different categories and do not reflect performance in any one category.

Payment Adjustments

The provider's final score for a performance year is used to determine the payment adjustment that is applied to the provider's Medicare Part B payments made 2 years later (i.e., the payment year). Before each performance year, CMS sets a performance threshold for the year against

[18]See 42 C.F.R. § 414.1380(c)(3) (2020). CMS doubled the value of the complex patient bonus to a maximum of 10 points for 2020 in response to an anticipated increase in patient complexity due to the Coronavirus Disease 2019 (COVID-19). See 85 Fed. Reg. 84,472, 84,911 (Dec. 28, 2020). CMS subsequently proposed to continue capping the value of the complex patient bonus at a maximum of 10 points for performance years 2021 and future years. See 86 Fed. Reg. 39,104, 39,585-86 (proposed July 23, 2021) (proposing to amend 42 C.F.R. §§ 414.1380(c)(3)(iv), (viii)).

[19]See 82 Fed. Reg. 53,568, 53,771 (Nov. 16, 2017).

[20]In addition to the quality category bonus for small practices that submit at least one quality measure, some providers may also qualify for other bonus points that are added to the quality and promoting interoperability performance categories.

which the final score will be compared.[21] If the final score falls below the performance threshold, the provider receives a negative adjustment—that is, a negative percentage adjustment applied to the amount that Medicare pays the provider under the Medicare Physician Fee Schedule, resulting in a lower payment to the provider than they would have received without the adjustment. If the final score is equal to the performance threshold, the provider receives a neutral adjustment, resulting in no change to the amount Medicare pays the provider under the Medicare Physician Fee Schedule; and if the final score exceeds the performance threshold, the provider receives a positive adjustment to the amount that Medicare pays the provider, resulting in a payment increase.[22]

Payment adjustments are computed based on final scores in a generally linear fashion, so higher scores receive higher payment adjustments.[23] Under statutory budget neutrality requirements, positive adjustments resulting in increased payments to providers must be offset by negative adjustments resulting in lower payments to other providers participating in the MIPS program. The maximum negative adjustment in a given payment year is specified in statute, ranging from negative 4 percent based on performance year 2017 to negative 9 percent based on performance years 2020 and subsequent years.[24] The maximum positive

[21]For performance years 2019 through 2021, the Bipartisan Budget Act of 2018 required CMS to gradually and incrementally increase the performance threshold to an estimated performance threshold for 2022. Pub. L. No. 115-123, § 51003(a)(1)(D)(iv), 132 Stat. 64, 294 (codified as amended at 42 U.S.C. § 1395w-4(q)(6)(D)(iv)). CMS subsequently estimated the performance threshold for 2022 to be 74.01. CMS later proposed a performance threshold of 75 points for performance year 2022. See 86 Fed. Reg. 39,104, 39,590 (proposed July 23, 2021) (proposing to amend 42 C.F.R. § 414.1405).

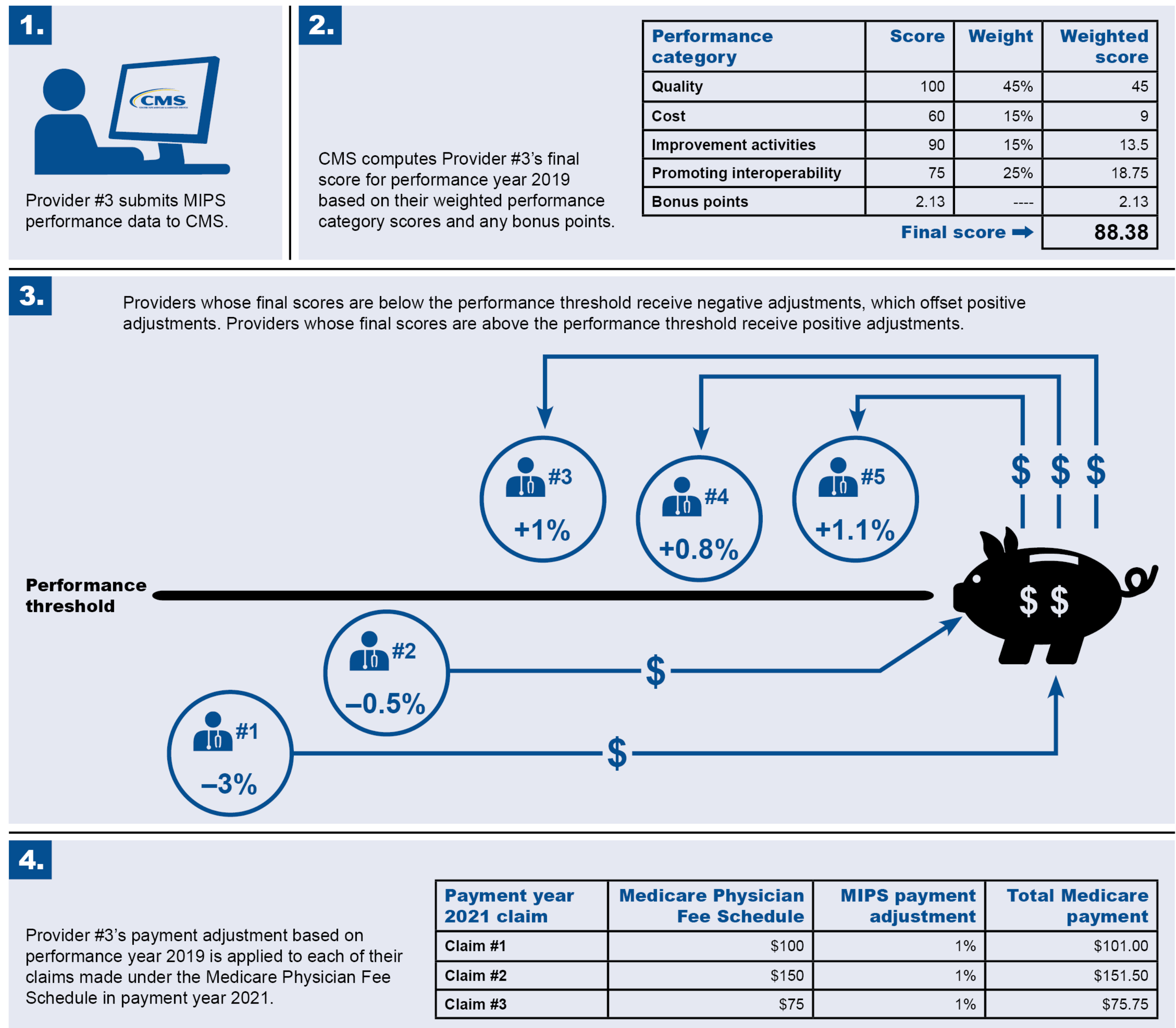
[22]Since final scores are based on unique TIN and NPI combinations, the resulting payment adjustment also applies to the Medicare Part B payments made to the same TIN and NPI combination in the payment year. If the provider (NPI) begins work with a new employer (TIN) after the year in which the final score was earned, the provider's Medicare Part B payments under their new employer will be adjusted based on the provider's highest payment adjustment earned in the performance year.

[23]Final scores between 0 and one-fourth of the performance threshold for the year receive the maximum possible negative adjustment for the year. Providers who do not submit any data when they are required to participate are usually subject to the maximum negative adjustment for the year, though some providers may receive points for the cost performance category since it does not require data submission. The remainder of scores below the performance threshold scale linearly to near-zero. See 42 C.F.R. § 414.1405(b)(2) (2020).

[24]MACRA specified the base adjustment for each payment year. Pub. L. No. 114-10, § 101(c)(1), 129 Stat. 87, 106 (codified as amended at 42 U.S.C. § 1395w-4(q)(6)(B) (applicable percent defined)).

adjustment depends on savings generated through negative adjustments and the number of providers whose final score exceeds the performance threshold. If there is a large number of providers qualifying for positive adjustments and a small number of providers receiving negative adjustments, the size of the positive adjustments could be small. Conversely, if there were a very large number of providers receiving negative adjustments and few providers qualifying for a positive adjustment, the size of the positive adjustment could potentially be scaled to as large as triple the potential payment adjustment percentage specified in statute. See figure 1 for a summary of the overall process from data submission to payment adjustments being applied.

Figure 1: Illustrative Example of Medicare Payment under Selected MIPS Processes



Performance category	Score	Weight	Weighted score
Quality	100	45%	45
Cost	60	15%	9
Improvement activities	90	15%	13.5
Promoting interoperability	75	25%	18.75
Bonus points	2.13	----	2.13
		Final score ➡	88.38

Payment year 2021 claim	Medicare Physician Fee Schedule	MIPS payment adjustment	Total Medicare payment
Claim #1	$100	1%	$101.00
Claim #2	$150	1%	$151.50
Claim #3	$75	1%	$75.75

Legend: CMS=Centers for Medicare & Medicaid Services; MIPS=Merit-based Incentive Payment System.

Source: GAO analysis of CMS documentation. | GAO-22-104667

Notes: The performance threshold is the value against which the final score for the year is compared to determine whether the resulting payment adjustment will be negative, neutral, or positive. The provider's final score for a performance year is used to determine the payment adjustment that is

applied to the provider's Medicare Part B payments made 2 years later (i.e., the payment year). Payment adjustments are applied to each of the provider's covered professional services in the payment year for which payment is made under, or based on, the Medicare Physician Fee Schedule. Providers in the figure are hypothetical examples and are shown for illustrative purposes only. The category weights shown generally applied to providers participating as individuals, groups, or virtual groups in performance year 2019.

Final scores that also meet or exceed an exceptional performance threshold set for the year qualify for a potentially larger positive payment adjustment than those that merely exceed the performance threshold. MACRA directed the Secretary of Health and Human Services to provide $500 million in exceptional performance bonuses annually for performance in 2017 through 2022, which are applied to payments made in 2019 through 2024.[25] The bonus is not subject to budget neutrality requirements and is awarded in the form of a larger payment adjustment. See table 1 for a summary of performance thresholds, exceptional performance thresholds, and potential payment adjustments.

Table 1: Performance Thresholds, Exceptional Performance Thresholds, and Potential Resulting Payment Adjustments, by Year, Performance Years 2017 through 2021

Year	Performance threshold	Exceptional performance threshold	Range of potential payment adjustment (percent)
2017	3	70	-4.00 to 4.00
2018	15	70	-5.00 to 5.00
2019	30	75	-7.00 to 7.00
2020	45	85	-9.00 to 9.00
2021	60	85	-9.00 to 9.00

Source: GAO analysis of Centers for Medicare & Medicaid Services documentation. | GAO-22-104667

Notes: The performance threshold is the value against which the final score for the year is compared to determine whether the resulting payment adjustment will be negative, neutral, or positive. The exceptional performance threshold is the value that the final score must meet or exceed to qualify for an exceptional performance bonus added to the payment adjustment. Final scores can range from 0 to 100. The maximum negative payment adjustment is specified in statute. Since payment adjustments, other than the exceptional performance bonus, are budget neutral, positive adjustments for some providers must be paid for by negative adjustments to others; therefore, the actual maximum positive payment adjustment may differ based on the distribution of scores in each performance year. Payment adjustments are applied to Medicare Part B payments made to the provider 2 years after the performance year, so a payment adjustment earned based on 2017 performance is applied to payments for 2019.

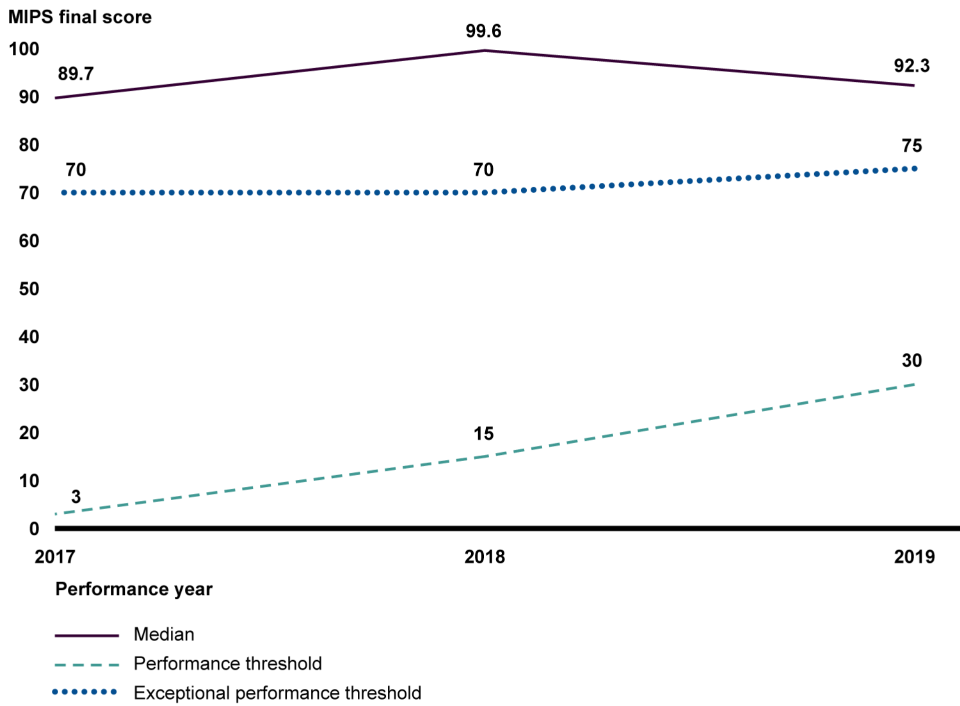
[25]Pub. L. No. 114-10, § 101(c)(1), 129 Stat. 87, 109 (codified as amended at 42 U.S.C. § 1395w-4(q)(6)(F)(iv) (additional incentive payment adjustments)). For the purposes of this report, we refer to additional incentive payment adjustments earned by meeting the exceptional performance threshold as "exceptional performance bonuses."

MIPS Final Scores Were Generally High, and over 90 Percent of Providers Earned a Small Positive Adjustment in 2017 through 2019

Our analysis of CMS data shows that MIPS final scores were generally high from 2017 through 2019, with most MIPS-eligible providers qualifying for a positive payment adjustment. Across the 3 years, median final scores ranged from about 89.7 to 99.6 (out of a possible 100)—well above the performance threshold (see fig. 2).[26] At least 93 percent of providers qualified for a positive payment adjustment in any year, and no more than 4.8 percent of providers qualified for a negative payment adjustment. About 72 to 84 percent of providers received an exceptional performance bonus in a given year.

[26]The performance threshold is the value against which the final score for the year is compared to determine whether the resulting payment adjustment will be negative, neutral, or positive. The exceptional performance threshold is the value that the final score must meet or exceed to qualify for an exceptional performance bonus added to the payment adjustment. According to the preamble to the 2017 final rule, the performance threshold was set at 3 points for 2017 so that providers who submitted at least one quality measure during this first year would avoid a negative adjustment. See 81 Fed. Reg. 77,008, 77,016 (Nov. 14, 2016). The performance threshold increased in subsequent years.

Figure 2: Median Merit-based Incentive Payment System (MIPS) Final Scores Relative to Performance and Exceptional Performance Thresholds, Performance Years 2017 through 2019



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-22-104667

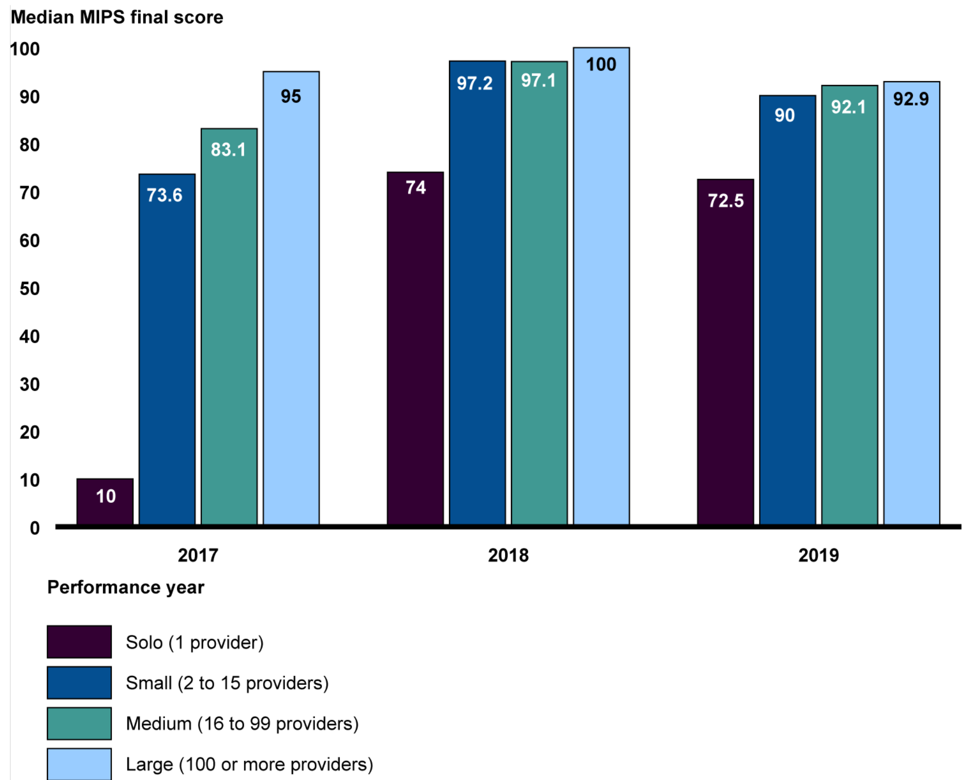
Notes: The performance threshold is the value against which the final score for the year is compared to determine whether the resulting payment adjustment will be negative, neutral, or positive. The exceptional performance threshold is the value that the final score must meet or exceed to qualify for an exceptional performance bonus added to the payment adjustment. The provider's final score for a performance year is used to determine the payment adjustment that is applied to the provider's Medicare Part B payments made 2 years later (i.e., the payment year).

Median MIPS final scores were generally high across the demographic characteristics we examined, though there were some exceptions. We examined median final scores by practice size, geographic location (i.e., rural, non-rural, health professional shortage areas, non-health professional shortage areas), method of participation in MIPS, whether or not providers received a complex patient bonus, and specialty (for tables, see app. I). Most of these demographic groups had median scores that exceeded the exceptional performance threshold. However, median final scores were lower for solo practices and providers participating as individuals than for larger practices and providers participating through other methods. Median final scores ranged from 10.0 to 74.0 for solo

practices (see fig. 3) and from 46.6 to 59.9 for providers participating as individuals (see fig. 4), depending on the year.[27]

[27]Final scores are generally based on performance in four categories and are not necessarily indicative of a provider's overall quality of care. Solo practices refer to a practice with only one provider, whereas participation as an individual is a method of participation in MIPS. Providers may choose to participate in MIPS as an individual regardless of the size of the practice in which they work; similarly, providers in solo practices could potentially choose to participate as individuals or as part of a virtual group or MIPS APM entity. In 2018, the median score for solo practices was 74, exceeding the exceptional performance threshold of 70 for that year. In all other cases, median scores for solo practices and providers participating as individuals were below the exceptional performance threshold for each year. About 26 to 38 percent of providers participating as individuals were solo practitioners, depending on the year. Most providers were part of larger practices or participated through other reporting methods in each year. For example, in 2019, only 6.4 percent of eligible providers participated as individuals and only 3.4 percent of eligible providers participated through solo practices.

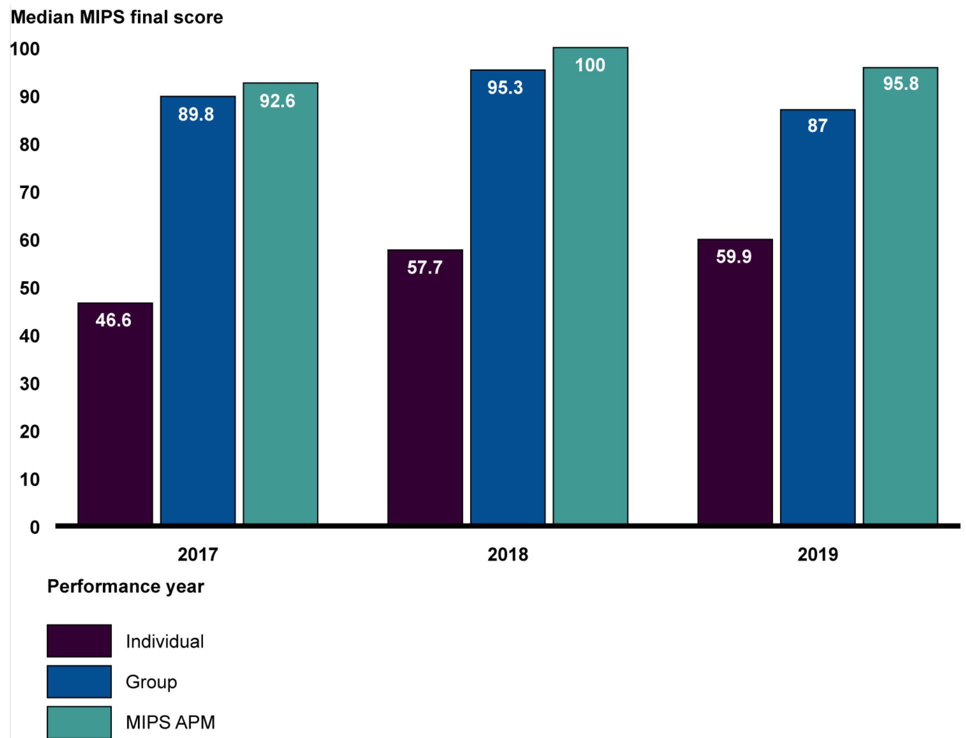
Figure 3: Median Merit-based Incentive Payment System (MIPS) Final Scores, by Practice Size, Performance Years 2017 through 2019



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-22-104667

Notes: The performance threshold is the value against which the final score for the year is compared to determine whether the resulting payment adjustment will be negative, neutral, or positive. The provider's final score for a performance year is used to determine the payment adjustment that is applied to the provider's Medicare Part B payments made 2 years later (i.e., the payment year). The performance threshold was 3 in 2017, 15 in 2018, and 30 in 2019.

Figure 4: Median Merit-based Incentive Payment System (MIPS) Final Scores by Method of Participation, Performance Years 2017 through 2019



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-22-104667

Notes: The performance threshold is the value against which the final score for the year is compared to determine whether the resulting payment adjustment will be negative, neutral, or positive. The provider's final score for a performance year is used to determine the payment adjustment that is applied to the provider's Medicare Part B payments made 2 years later (i.e., the payment year). The performance threshold was 3 in 2017, 15 in 2018, and 30 in 2019. Virtual groups were introduced as a method of participation in performance year 2018 but are not included here because of small numbers of final scores. In 2018, four final scores and payment adjustments were reported for virtual groups; in 2019, 75 final scores and payment adjustments were reported for virtual groups.

For each of performance years 2017 through 2019, the magnitude of positive adjustments providers earned to be applied to their Part B payments in the 2019 through 2021 payment years was small. Under statutory budget neutrality requirements, funds available for positive adjustments generally must be offset by savings generated through negative adjustments. Since relatively few providers earned negative adjustments in 2017, 2018, and 2019, relatively few funds were available to spread out over a large number of providers who earned positive

adjustments.[28] From 2017 through 2019, payment adjustments for providers who earned a positive adjustment ranged from as little as 0 percent to 1.88 percent, depending on the year (see table 2).[29] The median positive adjustment ranged from 1.27 to 1.66 percent from 2017 through 2019. See appendix I for tables of adjustment types by demographics. See appendix II for tables of quality scores by demographics, and for mean and median final scores and associated payment adjustments within ranges of quality and cost scores.

Table 2: Ranges of Negative and Positive Payment Adjustments Earned by Type and Year, Performance Years 2017 through 2019

Year	Negative	Positive without an exceptional performance bonus	Positive with an exceptional performance bonus
2017	-4.00 to -2.11	0.00 to 0.20[a]	0.28 to 1.88
2018	-5.00 to -0.01	0.00 to 0.20[a]	0.20 to 1.68
2019	-7.00 to 0.00[a]	0.00 to 0.00[a]	0.00 to 1.79[a]

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-22-104667

Notes: Payment adjustments are applied to Medicare Part B payments made to the provider 2 years after the performance year, so a payment adjustment earned based on 2017 performance is applied to payments for 2019. Negative adjustments decrease the payment; neutral adjustments (not displayed) make no change to the payment; and positive adjustments increase the payment. Final scores that meet an exceptional performance threshold qualify providers for a higher positive adjustment than those that qualify for a positive adjustment, but do not meet the exceptional performance threshold.

[a]According to CMS officials, in some cases, payment adjustments may be so small that they round to 0.00 percent.

The maximum positive payment adjustment for any of performance years 2017 through 2019 resulted in relatively small increases in Medicare payments. For example, a provider with $90,000 in Medicare Physician Fee Schedule payments would only see an increase of $1,692 in payment year 2019 if they received the maximum positive adjustment of 1.88 percent based on their performance in 2017. The range of positive payment adjustments for scores that did not qualify for an exceptional performance bonus ranged from 0 percent to 0.20 percent, depending on the year. For performance year 2019, positive payment adjustments associated with all scores above the performance threshold and below the exceptional performance threshold (11.5 percent of providers) were

[28]Positive adjustments based on performance in 2017 through 2019 included any earned exceptional performance bonus, which was not budget neutral.

[29]According to CMS officials, in some cases, payment adjustments may be so small that they round to 0.00 percent.

small enough to round to 0.00 percent due to the program's budget neutrality. Some scores that met or exceeded the exceptional performance threshold in 2019 also received payment adjustments for payment year 2021 that rounded to 0.00 percent.

Variation in payment adjustments may change in future years as the program's parameters continue to evolve. For example, CMS previously projected the 2022 performance threshold to increase to 74.01—close to the value of the 2019 exceptional performance threshold.[30] See appendix III for additional information on how payment adjustments would have changed if the higher 2022 performance threshold had been in effect in 2019.

Stakeholders Identified Some Strengths and Challenges Related to the MIPS Program

Officials we interviewed from the 11 stakeholder groups representing MIPS-eligible providers identified some examples of strengths related to the design of the MIPS program, such as bonus points that help increase the final or category scores of certain providers who might otherwise be disadvantaged. Stakeholders also identified some examples of challenges related to the MIPS program, such as a low return on investment—that is, low payment adjustments relative to the high financial or administrative costs incurred by participating providers.

Stakeholders Identified Strengths Related to the MIPS Program, Including Participation Exemptions and Bonus Points for Certain Participating Providers

Stakeholders from three of the 11 provider groups stated that certain design aspects of the MIPS program that reduced participation burden or increased scores helped to address some challenges for providers who might otherwise be disadvantaged. Specifically,

- **Performance category exemption.** Three stakeholder groups stated that category weighting exceptions—which allow providers to be exempt from reporting measures for one or more performance categories in a given year—helped to reduce participation burden for certain providers. For example, some providers, such as radiologists and pathologists, automatically qualify for the "promoting interoperability hardship" exception, and thus, are exempt from that

[30]See 84 Fed. Reg. 40,482, 40,802 (proposed Aug. 14, 2019). CMS subsequently proposed a performance threshold of 75 points for performance year 2022. See 86 Fed. Reg. 39,104, 39,590 (proposed July 23, 2021) (proposing to amend 42 C.F.R. § 414.1405).

category.[31] As a result, the category is reweighted from 25 percent to 0 percent and the amount of its original weight is redistributed to other categories. In the preamble to its 2017 final rule, CMS acknowledged that the exception was beneficial for certain providers who lack the ability to (1) affect their practices' health information technology decisions or (2) have the face-to-face patient interactions required for many of the measures in the promoting interoperability category.[32] In addition, one stakeholder group said that the "extreme and uncontrollable circumstances" exception helped to reduce participation burden by exempting providers from penalties as a result of events beyond their control. For example, for 2021, providers may apply for this exception to reweight any or all performance categories to 0 percent if they are unable to collect or report data for a performance category because of the Coronavirus Disease 2019 (COVID-19), which in some cases, will result in their final score being set equal to the performance threshold.[33] Our analysis of CMS data shows that in 2019, over 70 percent of providers had at least one category reweighted.

- **Low-volume threshold exemption.** Two stakeholder groups stated that the MIPS low-volume threshold—the minimum Medicare Part B patient, billing, and service volume requirements for participation in MIPS—reduced participation burden for smaller practices. Stakeholders added that practices that treated a low volume of Medicare patients likely would not have benefited from reporting MIPS

[31]Providers who are non-patient facing or based in an ambulatory surgery center or hospital qualify to have their promoting interoperability category automatically reweighted as long as they do not submit data for that category. Other providers may apply for the promoting interoperability hardship exception if they meet certain criteria, such as insufficient Internet connectivity or decertified electronic health record technology.

[32]See 81 Fed. Reg. 77,008, 77,238-29 (Nov. 4, 2016).

[33]For providers who qualify for this exception in 2021 and participate as individuals, groups, or virtual groups, if more than two performance categories are reweighted to 0 percent for the year, the providers' final score will be set equal to the performance threshold. For MIPS APM participants that qualify for this exception, all performance categories are reweighted and thus, their final scores will be set equal to the performance threshold.

CMS may also grant automatic exceptions in certain circumstances. For example, in 2020, CMS automatically granted extreme and uncontrollable circumstances exceptions because of COVID-19 to all providers participating as individuals. As a result, providers had their cost category reweighted to 0 percent. Additionally, if they did not submit data for a given category, the category was also reweighted to 0 percent. Other providers participating through groups, virtual groups, or MIPS APM entities were eligible to apply for the exception.

data and participating in the program because any MIPS payment adjustments would have applied to too little Medicare revenue. Between 2017 and 2019, CMS raised the low-volume threshold for MIPS-eligible providers, resulting in an increased number of providers exempt from participating in the MIPS program.[34]

- **Bonus points.** Two stakeholder groups stated that small practice bonuses and complex patient bonuses—first implemented in 2018—helped to increase scores for certain providers who might otherwise be disadvantaged.[35] Specifically, the small practice bonuses may have helped, in part, to increase the final scores of solo and small practices.[36] In addition, our analysis of CMS data shows that in 2018 and 2019, about 99 percent of participating providers received a complex patient bonus of up to five points.

Stakeholders Identified Challenges Related to the MIPS Program's Performance Feedback, Effect on Quality of Care, and Return on Investment for Participating Providers

Stakeholders from the 11 provider groups that we interviewed discussed various challenges for providers participating in the MIPS program. Specifically,

- **Performance feedback.** While CMS offers feedback on providers' scores and performance in each category, 10 stakeholder groups stated that the feedback was not timely or meaningful for certain providers.[37]

[34]According to CMS, the total number of Medicare Part B providers (TIN and NPI combinations) who were exempt from the MIPS program—including those who did not meet the low-volume threshold—increased from about 900,000 (46 percent of Part B providers) in 2017 to about 1 million (52 percent) in 2019.

[35]Providers who were awarded the small practice bonus had either five or six points added to their quality category score or final score, depending on the year. In 2018, solo and small practices that submitted data for at least one performance category received a bonus of five points added to their final score. Beginning in 2019, solo and small practices that submitted data for at least one quality measure received a bonus of six points added to their quality category score, which was a weighted percentage of the final score.

Providers may also be awarded up to five complex patient bonus points, depending on a combination of the medical complexity of the provider's patients and the proportion of patients who were dually eligible for both Medicaid and Medicare. The minimum complex patient bonus was 0.28 points in 2018 and 0.38 points in 2019.

[36]CMS has also made MIPS technical assistance available to small practices to help increase their final scores. For more information about this technical assistance, see appendix IV.

[37]CMS's feedback includes information on providers' MIPS final scores, payment adjustment, measure-level and activity-level data and scores, and performance category-level scores and weights.

- *Feedback is not timely.* Some stakeholders said that CMS's feedback on the previous year arrives 6 months into the current year, which does not allow providers enough time to modify their performance to improve their scores in the current year. For example, providers are required to submit data for 2021 to CMS by March 31, 2022, and CMS provides final feedback on providers' 2021 performance in July of 2022. CMS officials said that on April 1, 2022, providers may obtain preliminary feedback on their scores based on the data they submitted. However, according to CMS, the scores are subject to change when more data become available or are finalized, such as claims data for cost scores. Some stakeholders we interviewed stated more frequent or real-time feedback would be helpful so that providers may identify potential issues and modify their performance within the current year. For example, one stakeholder group stated that real-time feedback would allow them to identify and modify their practices to address issues, such as overuse of emergency rooms or patients not filling needed prescriptions. According to CMS, the agency allows providers 3 months after the end of the year to submit data, and for the agency to provide feedback on performance during the full year. CMS officials noted that the agency cannot provide more timely feedback unless providers submit more data throughout the performance year, which may be an added burden for some providers.
- *Feedback is not meaningful.* Stakeholders said that CMS could provide more meaningful information during performance feedback, such as comparative data on how providers are performing relative to other providers of similar specialty or practice size. In addition, stakeholders noted that, because larger multi-specialty practices may choose to report measures that would maximize their MIPS scores, the reported measures (and thus, performance feedback) may not be clinically relevant to all specialties within the practice.

  According to the preamble to CMS's 2022 proposed rule, the agency plans to address this challenge, in part, by implementing the MIPS Value Pathways (MVP) in performance year 2023.[38] If the rule is finalized as proposed, MVPs will allow providers the option of reporting on a group of activities and measures from the four MIPS performance categories that are relevant to a specific

[38]See 86 Fed. Reg. 39,337 (proposed July 23, 2021).

specialty, medical condition, or episode of care.[39] Under the proposal, in 2023, providers may register to report data and receive feedback on one of seven MVPs related to the following clinical topics: (1) anesthesia, (2) chronic disease management, (3) emergency medicine, (4) heart disease, (5) lower extremity joint repair, (6) rheumatology, and (7) stroke care and prevention.[40] According to the proposal, CMS plans to add more MVPs in future years.

In addition, CMS proposes to allow subgroup reporting for MVPs to allow the agency to provide more comprehensive and granular feedback to providers.[41] For example, this proposal would allow a specialty within a large multi-specialty group to register as a subgroup and receive more clinically meaningful feedback on its measures and activities in the quality, improvement activities, and cost performance categories.[42] According to CMS, MVPs would allow CMS to provide meaningful, comparative data and feedback to providers by comparing the performance of similar providers who report on the same MVP.

- **Quality of care and patient outcomes.** Eight stakeholder groups questioned whether the MIPS program helps to meaningfully improve quality of care or patient health outcomes. For example,
  - *Providers may be incentivized to prioritize reporting over quality improvement.* Stakeholders stated that the design of the MIPS

[39]CMS proposes to implement the MVP framework in 2023 as another way for providers to meet MIPS reporting requirements.

[40]According to the preamble to CMS's 2021 final rule, the agency considered several factors in developing MVPs, such as the availability of, appropriateness of, and linkages between measures and activities from the four MIPS categories and how the MVP provides opportunities to improve the quality of care in the area measured. See 85 Fed. Reg. 84,472, 84,849-50 (Dec. 28, 2020).

[41]MVPs will be available to individual providers, single specialty groups, multispecialty groups, and APM entities. CMS proposes to define a subgroup as a subset of a group which includes at least one MIPS-eligible provider and is identified by a combination of the group TIN, the unique subgroup identifier, and each eligible provider's NPI. Under the proposal, for 2023 and 2024, multispecialty groups would have the option of forming subgroups—such as based on specialty—for participating; subgroups are proposed to be mandatory for multispecialty groups beginning in 2025. Subgroup scores would be publicly reported separately from group scores. See 86 Fed. Reg. 39,337, 39,355, 39,357, 39,579 (proposed July 23, 2021).

[42]CMS proposes to assess subgroup performance at the subgroup level for three performance categories (quality, improvement activities, and cost) and at the group level for the promoting interoperability category, and will publicly report subgroup-level performance beginning in 2024.

program may incentivize reporting over quality improvement, and thus, MIPS scores did not necessarily reflect the quality of care provided, but rather how well providers were complying with the reporting requirements of the program. For example, some stakeholders said that to maximize payment adjustments, providers may choose to report on performance measures on which they are performing well or that are easy to achieve, rather than measures in areas where they may need improvement or that are clinically relevant. This may help explain, in part, why our analysis of CMS data shows that over 90 percent of providers scored above the performance threshold from 2017 through 2019. Stakeholders added that, depending on the measures providers choose to report, they may be performing activities that are not clinically relevant to the patient. Specifically, one stakeholder group said that, to meet the reporting requirements of certain quality measures, providers may conduct some irrelevant screenings for patients. For example, to collect data for a particular measure, a physical therapist may evaluate all diabetic patients for proper footwear and sizing, even if the original purpose of their visit was to evaluate their finger. In addition, because providers may choose to report on quality measures on which they are performing well on, providers' performance on these measures may be so high and unvarying that meaningful distinctions and improvements can no longer be assessed, resulting in "topped out" measures.[43]

- *Some quality measures do not assess clinically common activities for certain specialties*. Stakeholders stated that some of the MIPS specialty-specific measures assessed activities that were infrequently performed or events that infrequently occurred. For example, one MIPS measure related to emergency medicine calls for providers to report information on the percentage of adult patients who were prescribed antibiotics to treat sinus infections. However, one stakeholder group said that emergency physicians were not frequently treating patients with sinus infections, but rather treating patients with sepsis, for which quality measures do not exist. As a result, the stakeholder group said these providers may not be assessed on measures or activities that are more clinically common for their specialty. In addition, some

[43]CMS considers a measure to be topped out if the median performance on the measure is 95 percent or higher. If this level of performance is sustained for 3 consecutive years, the measure may be removed in the fourth year. Before a measure is identified for removal, CMS also considers the effect of the removal to providers and the number of clinically relevant measures remaining in the program.

stakeholders said that the process for professional specialty organizations to develop new measures to meet CMS's requirements for use within MIPS is time-consuming and expensive. For example, one stakeholder group that worked with CMS for 3 years to convert seven pathology-specific registry measures for use within MIPS was not optimistic that any of the measures could be converted successfully for the program.

Stakeholders suggested that CMS could provide more information on how MIPS measures may improve quality of care or patient outcomes. According to the preamble to the 2022 proposed rule, the MVP framework will help to address some of these challenges by standardizing performance measurement across specific specialties, medical conditions, or episodes of care. The development of clinically cohesive sets of measures and activities should minimize providers' selection burden in choosing measures and activities to report for each MVP, according to CMS officials.

- **Return on investment.** Eight stakeholder groups stated that providers had a low return on investment for participating in MIPS—that is, low payment adjustments relative to the high financial or administrative costs incurred. Specifically, some stakeholders said that the small positive payment adjustments for meeting or exceeding the performance threshold do not financially incentivize their participation because the adjustments did not cover their financial or administrative costs.[44] For example, stakeholders said that providers may incur costs associated with investments in technological resources or with hiring or training staff to keep abreast of the complex annual changes to the program and report the necessary

[44]In 2019, the highest payment adjustment earned for providers who performed exceptionally well was 1.79 percent (see table 2).

data to CMS.[45] Specifically, one stakeholder group provided the hypothetical example of an exceptionally-well performing practice with $100,000 in Medicare Part B payments that received less than $2,000 in increased payments, but spent about $10,000 to get MIPS-specific reports from their electronic health record vendor to participate in the program. Some stakeholders added that as result of the low return on investment, some providers may be disinterested in participating in the MIPS program, opting instead to not report data and take a negative payment adjustment or relying on participation exemptions to qualify for a neutral adjustment.[46]

According to the preamble to the 2022 proposed rule, CMS anticipates that some providers may see greater returns on investment and higher payment adjustments starting in performance year 2022, when the performance threshold is proposed to be set at a higher bar of 75 points.[47] A higher performance threshold could be more difficult for some providers to meet, resulting in more providers qualifying for a negative payment adjustment. Under statutory budget neutrality requirements, the funds available for positive adjustments must come from savings generated through negative adjustments. With more providers qualifying for a negative adjustment and fewer providers qualifying for a positive adjustment, the size of the positive adjustments would be larger.

[45]Annual changes to the MIPS program may include, for example, changes in provider participation eligibility, performance measures, or category weights used to calculate the final score. Stakeholders added that, in particular, smaller practices may be more burdened by these financial or administrative costs compared with larger practices. For example, one study found that in 2019, small primary care practices of 1-9 physicians spent an average of about $18,500 in provider and staff time, information technology, and external vendor costs to participate in the MIPS program. In contrast, large multispecialty practices with 50 or more physicians spent an average of about $4,100 to participate in MIPS. See D. Khullar, A. M. Bond, E. M. O'Donnell, Y. Qian, D. N. Gans, and L. P. Casalino, "Time and Financial Costs for Physician Practices to Participate in the Medicare Merit-based Incentive Payment System: A Qualitative Study," *JAMA Health Forum*, vol. 2, no. 5 (2021). Another study reported that small practices of 1-9 physicians hired or repurposed one full-time staff member to manage the MIPS program, while larger practices of 50 or more physicians hired or repurposed three or more staff. See D. Khullar, A. M. Bond, Y. Qian, E. O'Donnell, D. N. Gans, and L. P. Casalino, "Physician Practice Leaders' Perceptions of Medicare's Merit-based Incentive Payment System (MIPS)," *Journal of General Internal Medicine* (2021).

[46]For example, certain providers who qualify for the "extreme and uncontrollable circumstances" exception in 2021, and have their final score set equal to the performance threshold, would qualify for a neutral payment adjustment based on that performance year.

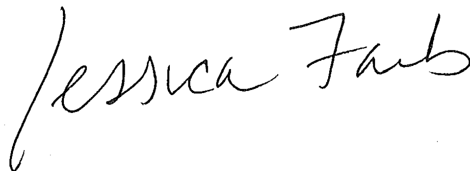
[47]CMS proposed this threshold using the mean final score from 2017.

Agency Comments

We provided a draft of this report to the Department of Health and Human Services for comment. The Department provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Health and Human Services, and other interested parties. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or farbj@gao.gov. Contact points for 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 V.



Jessica Farb
Managing Director, Health Care

Appendix I: Mean and Median Final Scores and Payment Adjustments, by Demographic Factors and Overall, Performance Years 2017 through 2019

Under the Merit-based Incentive Payment System (MIPS), MIPS-eligible providers receive payment adjustments based on their final scores.[1] Payment adjustments may be negative (resulting in a payment decrease), neutral (resulting in no change to payments), or positive (resulting in a payment increase). From 2017 through 2019, positive payment adjustments may have included an exceptional performance bonus based on the provider's final score. Providers' mean and median final scores and associated payment adjustments were generally high, both overall and across most of the demographics we examined. Tables 3 and 4 present mean and median final scores and associated payment adjustments, by demographic, for each of performance years 2017 through 2019. Tables 5 and 6 present the percentage of providers who received negative, neutral, and positive payment adjustments (with and without exceptional performance bonuses), by year and demographic.

Table 3: Mean and Median Final Scores and Associated Payment Adjustments by Practice Size, Geographic Location, Method of Participation, Complex Patient Bonus, and Overall, by Year, Performance Years 2017 through 2019

			Mean		Median	
Demographic	**Year**	**Score count (N)**	**Final score**	**Associated payment adjustment (percent)**	**Final score**	**Associated payment adjustment (percent)**
Overall	2017	1,059,440	74.65	0.52	89.71	1.33
	2018	889,604	87.00	1.07	99.63	1.66
	2019	954,664	85.61	0.81	92.30	1.27
Practice size						
Large (>99)	2017	568,847	86.08	1.13	94.99	1.61
	2018	481,114	92.35	1.32	100.00	1.68
	2019	534,776	89.03	1.04	92.92	1.31
Medium (16-99)	2017	279,399	69.36	0.20	83.13	0.98
	2018	253,423	84.18	0.94	97.05	1.54
	2019	258,069	84.86	0.76	92.13	1.26

[1]Final scores are calculated for each eligible Tax Identification Number (TIN) and National Provider Identifier (NPI) combination. The provider's final score for a performance year is used to determine the payment adjustment that is applied to the provider's Medicare Part B payments made 2 years later (i.e., the payment year). A single provider (as identified through the NPI) who participated in MIPS under multiple employers (as identified through the TIN) during a performance year may receive multiple final scores and payment adjustments. Payment adjustments earned under a TIN and NPI combination in the performance year are applied to the Medicare Part B payments made to the same TIN and NPI combination in the payment year. In this report, we use the term "year" to refer to a "performance year," unless otherwise specified as a "payment year."

Demographic	Year	Score count (N)	Mean: Final score	Mean: Associated payment adjustment (percent)	Median: Final score	Median: Associated payment adjustment (percent)
Small (2-15)	2017	150,043	57.82	0.16	73.61	0.47
	2018	121,450	79.99	0.74	97.18	1.55
	2019	129,282	78.23	0.31	89.95	1.11
Solo (1)	2017	61,151	33.84	0.09	10.00	0.02
	2018	33,617	57.11	0.15	74.00	0.46
	2019	32,537	64.59	0.00	72.48	0.00
Geographic location						
Rural	2017	335,593	79.22	0.77	92.95	1.50
	2018	116,223	85.99	1.02	99.45	1.66
	2019	120,156	85.47	0.80	92.71	1.29
Non-rural	2017	721,548	72.50	0.41	88.20	1.25
	2018	768,990	87.09	1.07	99.63	1.66
	2019	827,869	85.56	0.81	92.21	1.26
Health professional shortage area[a]	2017	429,154	78.08	0.71	91.74	1.44
	2018	187,472	85.78	1.01	98.80	1.62
	2019	215,123	84.80	0.76	91.73	1.23
Non-health professional shortage area	2017	627,987	72.28	0.40	88.43	1.26
	2018	697,741	87.26	1.08	99.83	1.67
	2019	732,902	85.77	0.82	92.35	1.27
Method of participation[b]						
Individual	2017	128,165	48.61	0.13	46.55	0.13
	2018	66,713	52.47	0.14	57.72	0.16
	2019	60,681	60.31	0.00	59.92	0.00
Group	2017	601,420	71.53	0.36	89.75	1.33
	2018	469,421	83.07	0.88	95.32	1.46
	2019	477,707	82.59	0.61	87.02	0.91
MIPS APM[c]	2017	329,855	90.48	1.37	92.63	1.48
	2018	353,466	98.74	1.62	100.00	1.68
	2019	416,201	92.76	1.30	95.75	1.50
Received a complex patient bonus						
No	2017	—	—	—	—	—
	2018	6,616	98.01	1.59	100	1.68

Demographic	Year	Score count (N)	Mean: Final score	Mean: Associated payment adjustment (percent)	Median: Final score	Median: Associated payment adjustment (percent)
	2019	8,164	93.37	1.34	95.43	1.48
Yes	2017	—	—	—	—	—
	2018	882,988	86.92	1.07	99.57	1.66
	2019	946,500	85.54	0.81	92.29	1.27

Legend: — = not applicable.

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-22-104667

Notes: Score counts within demographic categories may not sum to the overall score count due to missing demographic information for some scores. The complex patient bonus was introduced beginning in 2018. The associated payment adjustment represents the payment adjustment associated with that score or the closest actual score that appeared in the data for that year. The provider's final score for a performance year is used to determine the payment adjustment that is applied to the provider's Medicare Part B payments made 2 years later (i.e., the payment year).

[a]Health professional shortage areas are geographic areas, population groups, or health care facilities that have been designated by the Health Resources and Services Administration as having a shortage of primary, dental, or mental health care providers.

[b]Virtual groups were introduced as a method of participation in 2018 but are not reported here because of small numbers of final scores. In 2018, four final scores and payment adjustments were reported for virtual groups; in 2019, 75 final scores and payment adjustments were reported for virtual groups.

[c]A Merit-based Incentive Payment System (MIPS) alternative payment model (APM) is a payment approach that gives added incentive payments to provide high-quality, cost-efficient care to a specific clinical condition, care episode, or population. Individual providers, groups, or combinations of these may form an APM entity, which participates in a MIPS APM under an agreement with CMS.

Table 4: Mean and Median Final Scores and Associated Payment Adjustments for Selected Specialties and Overall, by Year, Performance Years 2017 through 2019

Specialty	Year	Score count (N)	Mean: Final score	Mean: Associated payment adjustment (percent)	Median: Final score	Median: Associated payment adjustment (percent)
Overall[a]	2017	1,059,440	74.65	0.52	89.71	1.33
	2018	889,604	87.00	1.07	99.63	1.66
	2019	954,664	85.61	0.81	92.30	1.27
Anesthesiology	2017	43,686	73.89	0.48	86.48	1.15
	2018	36,756	78.41	0.67	83.48	0.90
	2019	34,628	82.90	0.63	85.74	0.82
Cardiology	2017	29,206	77.99	0.70	92.20	1.46
	2018	23,261	90.35	1.23	100.00	1.68
	2019	22,720	87.23	0.92	93.76	1.37

			Mean		Median	
Specialty	Year	Score count (N)	Final score	Associated payment adjustment (percent)	Final score	Associated payment adjustment (percent)
Certified Registered Nurse Anesthetist	2017	55,093	77.20	0.66	89.90	1.34
	2018	50,374	80.00	0.74	88.46	1.14
	2019	46,936	83.70	0.68	88.29	0.99
Dermatology	2017	12,721	65.52	0.18	86.64	1.16
	2018	10,595	78.66	0.68	97.08	1.54
	2019	10,779	80.28	0.45	89.84	1.10
Diagnostic radiology	2017	49,883	79.42	0.78	92.56	1.48
	2018	42,005	91.17	1.27	100.00	1.68
	2019	44,677	89.38	1.07	95.04	1.45
Emergency medicine	2017	72,265	66.01	0.19	76.00	0.60
	2018	59,958	80.93	0.78	96.94	1.54
	2019	60,224	89.39	1.07	94.33	1.40
Family practice	2017	91,572	75.10	0.55	90.22	1.35
	2018	70,593	89.30	1.18	100.00	1.68
	2019	66,943	86.38	0.86	92.92	1.31
Gastroenterology	2017	15,575	77.61	0.68	91.04	1.40
	2018	12,589	89.15	1.17	99.16	1.64
	2019	13,008	85.46	0.80	91.23	1.19
General surgery	2017	23,480	75.61	0.58	90.67	1.38
	2018	18,559	89.52	1.19	99.96	1.68
	2019	18,386	86.93	0.90	92.35	1.27
Internal medicine	2017	119,548	71.87	0.38	89.42	1.31
	2018	86,429	85.51	1.00	100.00	1.68
	2019	83,781	81.80	0.55	91.91	1.24
Neurology	2017	17,498	76.74	0.64	92.53	1.48
	2018	13,919	87.91	1.11	99.44	1.66
	2019	14,394	85.47	0.80	91.69	1.23
Nurse practitioner	2017	112,049	77.58	0.68	91.08	1.40
	2018	102,432	88.77	1.15	99.73	1.67
	2019	111,243	86.58	0.88	92.35	1.27
Obstetrics/Gynecology	2017	26,637	82.57	0.95	93.30	1.52
	2018	21,579	93.67	1.38	100.00	1.68
	2019	22,318	90.15	1.12	93.30	1.33

Specialty	Year	Score count (N)	Mean: Final score	Mean: Associated payment adjustment (percent)	Median: Final score	Median: Associated payment adjustment (percent)
Ophthalmology	2017	20,451	75.47	0.57	92.94	1.50
	2018	17,064	86.66	1.05	100.00	1.68
	2019	17,173	83.99	0.70	92.00	1.25
Optometry	2017	15,659	61.60	0.17	75.00	0.54
	2018	9,010	83.77	0.92	100.00	1.68
	2019	10,795	77.36	0.25	87.80	0.96
Orthopedic surgery	2017	25,238	71.55	0.36	86.96	1.18
	2018	20,119	83.88	0.92	96.61	1.52
	2019	19,965	80.10	0.44	88.65	1.02
Pathology	2017	13,409	72.51	0.41	89.46	1.31
	2018	10,823	86.04	1.02	99.16	1.64
	2019	12,137	83.70	0.68	89.45	1.07
Physician assistant	2017	82,762	78.13	0.71	91.06	1.40
	2018	73,778	89.10	1.17	100.00	1.68
	2019	79,842	88.10	0.98	93.05	1.32
Podiatry	2017	15,432	48.11	0.13	52.26	0.14
	2018	10,650	65.34	0.18	83.97	0.93
	2019	10,934	67.61	0.00	75.63	0.13
Psychiatry	2017	20,808	66.17	0.19	86.74	1.17
	2018	14,908	85.13	0.98	99.31	1.65
	2019	14,704	84.21	0.72	92.03	1.25

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-22-104667

Notes: We report on the specialties with among the largest numbers of MIPS-eligible providers overall or among small practices in each performance year. Specialties are based on the Medicare provider specialty code associated with the record or, if unavailable, the type of service for which the provider submitted most of their Medicare Physician Fee Schedule Part B claims. The associated payment adjustment represents the payment adjustment associated with that score or the closest actual score that appeared in the data for that year. The provider's final score for a performance year is used to determine the payment adjustment that is applied to the provider's Medicare Part B payments made 2 years later (i.e., the payment year). Providers who participate as part of a group, virtual group, or Merit-based Incentive Payment System (MIPS) alternative payment model (APM) entity all receive the same scores since performance is aggregated across the group, virtual group, or MIPS APM entity. As such, scores may not be based solely on individual performance.

[a]"Overall" reflects statistics among all final scores for each performance year, including those for specialties not shown in this table.

Table 5: Payment Adjustment Types by Practice Size, Geographic Location, Method of Participation, Complex Patient Bonus, and Overall, by Year, Performance Years 2017 through 2019

Demographic	Year	Score count (N)	Scores with a negative adjustment (percent)	Scores with a neutral adjustment (percent)	Scores with a positive adjustment, but no exceptional performance bonus (percent)	Scores with a positive adjustment, including an exceptional performance bonus (percent)
Overall	2017	1,059,440	4.84	2.01	21.16	71.99
	2018	889,604	2.00	0.45	13.35	84.20
	2019	954,664	0.29	4.37	11.50	83.83
Practice size						
Large (>99)	2017	568,847	0.52	0.13	13.07	86.27
	2018	481,114	0.18	0.07	8.53	91.22
	2019	534,776	0.13	1.59	6.91	91.36
Medium (16-99)	2017	279,399	3.18	1.37	32.52	62.93
	2018	253,423	0.74	0.16	19.75	79.35
	2019	258,069	0.59	3.48	15.51	80.42
Small (2-15)	2017	150,043	13.24	5.81	28.28	52.66
	2018	121,450	5.62	1.25	17.55	75.59
	2019	129,282	0.40	9.64	21.66	68.30
Solo (1)	2017	61,151	31.93	13.03	27.07	27.97
	2018	33,617	24.49	5.19	18.91	51.41
	2019	32,537	0.10	36.19	14.87	48.83
Geographic location						
Rural	2017	335,593	3.01	0.74	20.12	76.12
	2018	116,223	2.15	0.61	14.32	82.91
	2019	120,156	0.48	4.89	11.21	83.42
Non-rural	2017	721,548	5.70	2.60	21.66	70.03
	2018	768,990	1.99	0.43	13.27	84.31
	2019	827,869	0.27	4.33	11.62	83.78
Health professional shortage area[a]	2017	429,154	3.41	1.06	20.20	75.33
	2018	187,472	2.33	0.54	14.69	82.44
	2019	215,123	0.34	5.04	12.35	82.27
Non-health professional shortage area	2017	627,987	5.83	2.67	21.84	69.66
	2018	697,741	1.92	0.43	13.07	84.58
	2019	732,902	0.28	4.21	11.34	84.16

Demographic	Year	Score count (N)	Scores with a negative adjustment (percent)	Scores with a neutral adjustment (percent)	Scores with a positive adjustment, but no exceptional performance bonus (percent)	Scores with a positive adjustment, including an exceptional performance bonus (percent)
Method of participation[b]						
Individual	2017	128,165	1.74	15.73	44.43	38.10
	2018	66,713	24.94	5.63	25.17	44.26
	2019	60,681	0.00	43.27	15.09	41.64
Group	2017	601,420	8.15	0.19	25.57	66.09
	2018	469,421	0.24	0.05	21.42	78.29
	2019	477,707	0.55	0.62	20.13	78.70
MIPS APM[c]	2017	329,855	0.00	0.00	4.09	95.91
	2018	353,466	0.00	0.01	0.40	99.59
	2019	416,201	0.04	3.01	1.07	95.88
Received a complex patient bonus						
No	2017	—	—	—	—	—
	2018	6,616	0.00	0.00	0.89	99.11
	2019	8,164	0.28	0.24	2.01	97.46
Yes	2017	—	—	—	—	—
	2018	882,988	2.01	0.45	13.44	84.09
	2019	946,500	0.29	4.41	11.59	83.71

Legend: — = not applicable.

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-22-104667

Notes: Score counts within demographic categories may not sum to the overall score count due to missing demographic information for some scores. The complex patient bonus was introduced beginning in 2018. The provider's final score for a performance year is used to determine the payment adjustment that is applied to the provider's Medicare Part B payments made 2 years later (i.e., the payment year). Percentages within rows may not sum to 100 due to rounding.

[a]Health professional shortage areas are geographic areas, population groups, or health care facilities that have been designated by the Health Resources and Services Administration as having a shortage of primary, dental, or mental health care providers.

[b]Virtual groups were introduced as a method of participation in 2018 but are not reported here because of small numbers of final scores. In 2018, four final scores and payment adjustments were reported for virtual groups; in 2019, 75 final scores and payment adjustments were reported for virtual groups.

[c]A Merit-based Incentive Payment System (MIPS) alternative payment model (APM) is a payment approach that gives added incentive payments to provide high-quality, cost-efficient care to a specific clinical condition, care episode, or population. Individual providers, groups, or combinations of these may form an APM entity, which participates in a MIPS APM under an agreement with CMS.

Table 6: Payment Adjustment Types for Selected Specialties and Overall, by Year, Performance Years 2017 through 2019

Specialty	Year	Score count (N)	Scores with a negative adjustment (percent)	Scores with a neutral adjustment (percent)	Scores with a positive adjustment, but no exceptional performance bonus (percent)	Scores with a positive adjustment, including an exceptional performance bonus (percent)
Overall[a]	2017	1,059,440	4.84	2.01	21.16	71.99
	2018	889,604	2.00	0.45	13.35	84.20
	2019	954,664	0.29	4.37	11.50	83.83
Anesthesiology	2017	43,686	4.19	1.22	27.79	66.80
	2018	36,756	0.79	0.16	28.78	70.27
	2019	34,628	0.19	1.51	19.80	78.49
Cardiology	2017	29,206	5.58	2.43	13.68	78.32
	2018	23,261	2.88	0.74	6.39	89.99
	2019	22,720	0.11	5.11	6.51	88.27
Certified Registered Nurse Anesthetist	2017	55,093	2.06	0.87	24.95	72.12
	2018	50,374	0.24	0.04	28.01	71.71
	2019	46,936	0.37	1.01	19.94	78.68
Dermatology	2017	12,721	11.43	7.40	17.37	63.80
	2018	10,595	7.57	1.76	15.72	74.94
	2019	10,779	0.09	11.01	14.31	74.58
Diagnostic radiology	2017	49,883	2.81	0.95	19.03	77.21
	2018	42,005	1.15	0.30	8.54	90.01
	2019	44,677	0.12	1.78	9.14	88.96
Emergency medicine	2017	72,265	2.36	0.74	43.16	53.74
	2018	59,958	0.95	0.21	25.69	73.15
	2019	60,224	0.43	1.40	8.80	89.36
Family practice	2017	91,572	5.30	2.19	19.20	73.32
	2018	70,593	1.94	0.44	10.41	87.21
	2019	66,943	0.30	4.79	9.02	85.89
Gastroenterology	2017	15,575	5.53	2.59	13.50	78.38
	2018	12,589	3.23	0.74	6.12	89.91
	2019	13,008	0.04	4.94	8.58	86.45
General surgery	2017	23,480	5.77	2.49	16.79	74.95
	2018	18,559	2.33	0.54	8.45	88.67
	2019	18,386	0.11	3.44	8.82	87.64

Specialty	Year	Score count (N)	Scores with a negative adjustment (percent)	Scores with a neutral adjustment (percent)	Scores with a positive adjustment, but no exceptional performance bonus (percent)	Scores with a positive adjustment, including an exceptional performance bonus (percent)
Internal medicine	2017	119,548	5.77	2.38	21.31	70.55
	2018	86,429	2.95	0.63	14.90	81.51
	2019	83,781	0.26	10.79	10.94	78.01
Neurology	2017	17,498	7.09	2.90	12.36	77.65
	2018	13,919	4.11	0.95	7.45	87.49
	2019	14,394	0.13	5.60	8.82	85.45
Nurse practitioner	2017	112,049	2.87	0.92	20.67	75.54
	2018	102,432	0.75	0.15	12.37	86.73
	2019	111,243	0.46	2.30	12.07	85.17
Obstetrics/Gynecology	2017	26,637	2.53	0.78	13.56	83.13
	2018	21,579	0.63	0.14	5.43	93.79
	2019	22,318	0.10	0.78	4.85	94.27
Ophthalmology	2017	20,451	5.88	3.09	16.85	74.18
	2018	17,064	3.57	1.00	11.65	83.78
	2019	17,173	0.11	6.36	13.55	79.98
Optometry	2017	15,659	10.25	3.31	32.56	53.89
	2018	9,010	3.12	1.17	15.97	79.74
	2019	10,795	0.21	5.98	26.24	67.56
Orthopedic surgery	2017	25,238	7.32	3.34	19.07	70.27
	2018	20,119	4.00	0.64	12.44	82.93
	2019	19,965	0.62	9.22	16.61	73.55
Pathology	2017	13,409	3.39	1.03	29.70	65.88
	2018	10,823	1.23	0.39	16.31	82.08
	2019	12,137	0.21	2.29	18.00	79.49
Physician assistant	2017	82,762	2.07	0.72	22.16	75.05
	2018	73,778	0.34	0.11	12.78	86.77
	2019	79,842	0.62	1.15	10.79	87.45
Podiatry	2017	15,432	20.79	11.00	26.04	42.16
	2018	10,650	15.59	2.65	22.04	59.73
	2019	10,934	0.27	24.57	24.63	50.53

Specialty	Year	Score count (N)	Scores with a negative adjustment (percent)	Scores with a neutral adjustment (percent)	Scores with a positive adjustment, but no exceptional performance bonus (percent)	Scores with a positive adjustment, including an exceptional performance bonus (percent)
Psychiatry	2017	20,808	10.45	3.89	21.85	63.81
	2018	14,908	4.49	0.85	11.64	83.02
	2019	14,704	0.10	6.36	10.79	82.75

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-22-104667

Notes: We report on the specialties with among the largest numbers of MIPS-eligible providers overall or among small practices in each performance year. Specialties are based on the Medicare provider specialty code associated with the record or, if unavailable, the type of service for which the provider submitted most of their Medicare Physician Fee Schedule Part B claims. The provider's final score for a performance year is used to determine the payment adjustment that is applied to the provider's Medicare Part B payments made 2 years later (i.e., the payment year). Providers who participate as part of a group, virtual group, or Merit-based Incentive Payment System (MIPS) alternative payment model (APM) entity all receive the same scores since performance is aggregated across the group, virtual group, or MIPS APM entity. As such, scores may not be based solely on individual performance. Percentages within rows may not sum to 100 due to rounding.

[a]"Overall" reflects statistics among all scores for each performance year, including those for specialties not shown in this table.

Appendix II: Selected Quality and Cost Scores, Final Scores, and Payment Adjustments, Performance Years 2017 through 2019

Under the Merit-based Incentive Payment System (MIPS), MIPS-eligible providers are scored on the quality and cost of their care provided to patients during the year, among other things, and those scores are subsequently used to compute a final score and payment adjustment.[1] Quality and cost scores may range from 0 to 100. From 2017 through 2019, positive payment adjustments may have included an exceptional performance bonus based on the provider's final score. Providers' mean and median quality scores were generally similar across demographics we examined, with few exceptions (see tables 7 and 8). For example, median quality scores for providers in solo practices were generally lower than those in small, medium, and large practices in each year.[2] Similarly, median quality scores for providers participating as individuals were lower than those for providers participating as part of a group or MIPS alternative payment model (APM) entity in each year.[3] Tables 9 and 10 show mean and median final scores and associated payment adjustments within ranges of quality and cost performance category scores. Mean and median final scores and payment adjustments increased with higher performance category scores. For example, cost scores of 25 or lower (but not zero) were associated with median final scores of about 37 to 85, depending on the year, whereas cost scores of 100 were associated with median final scores of about 91 to 95.[4]

[1]Final scores are calculated for each eligible Tax Identification Number (TIN) and National Provider Identifier (NPI) combination. The provider's final score for a performance year is used to determine the payment adjustment that is applied to the provider's Medicare Part B payments made 2 years later (i.e., the payment year). A single provider (as identified through the NPI) who participated in MIPS under multiple employers (as identified through the TIN) during a performance year may receive multiple final scores and payment adjustments. Payment adjustments earned under a TIN and NPI combination in the performance year are applied to the Medicare Part B payments made to the same TIN and NPI combination in the payment year. In this report, we use the term "year" to refer to a "performance year," unless otherwise specified as a "payment year."

[2]Quality scores are computed based on selected measures submitted by the provider and are not necessarily indicative of the provider's overall quality of care.

[3]About 26 to 38 percent of providers participating as individuals were solo practitioners, depending on the year. Similar tables are not provided for cost scores due to systematic differences in providers being exempt from having cost used to compute their final scores, such as MIPS APM participants.

[4]Cost scores reported here do not include cases for which cost was not used to compute the final score, such as due to receiving an exemption. There were no cases for which cost was used to compute the final score and the cost score was 0.

Table 7: Mean and Median Quality Performance Category Scores by Practice Size, Geographic Location, Method of Participation, Complex Patient Bonus, and Overall, by Year, Performance Years 2017 through 2019

Demographic	Year	Score count (N)	Mean quality score	Median quality score
Overall	2017	1,039,375	73.96	90.30
	2018	880,979	82.64	99.20
	2019	900,246	89.95	100.00
Practice size				
Large (>99)	2017	563,806	83.87	94.70
	2018	478,002	88.45	100.00
	2019	519,123	92.31	100.00
Medium (16-99)	2017	274,649	68.06	84.40
	2018	251,798	78.78	93.70
	2019	244,635	87.15	99.36
Small (2-15)	2017	144,314	60.46	79.30
	2018	119,423	74.83	93.40
	2019	116,039	86.07	100.00
Solo (1)	2017	56,606	38.34	15.00
	2018	31,756	55.21	71.10
	2019	20,449	85.55	100.00
Geographic location				
Rural	2017	332,531	77.06	93.50
	2018	115,137	81.67	97.60
	2019	113,218	90.37	100.00
Non-rural	2017	704,548	72.45	89.00
	2018	761,496	82.71	99.20
	2019	780,832	89.82	100.00
Health professional shortage area[a]	2017	424,192	76.42	92.30
	2018	185,851	81.38	97.60
	2019	201,729	89.53	100.00
Non-health professional shortage area	2017	612,887	72.21	89.40
	2018	690,782	82.89	99.30
	2019	692,321	89.99	100.00
Method of participation[b]				
Individual	2017	114,599	54.06	58.30
	2018	62,898	49.04	53.90
	2019	33,952	81.22	87.82

Demographic	Year	Score count (N)	Mean quality score	Median quality score
Group	2017	601,053	67.74	87.10
	2018	465,350	76.17	92.40
	2019	473,185	82.77	89.36
MIPS APM[c]	2017	323,723	92.56	94.70
	2018	352,727	97.18	100.00
	2019	393,034	99.36	100.00
Received a complex patient bonus				
No	2017	—	—	—
	2018	6,571	96.41	100.00
	2019	7,644	99.26	100.00
Yes	2017	—	—	—
	2018	874,408	82.54	99.20
	2019	892,602	89.87	100.00

Legend: — = not applicable.

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-22-104667

Notes: Results omit cases for which the quality performance category was not used to compute the final score, such as due to receiving a reporting exemption. Score counts within demographic categories may not sum to the overall score count due to missing demographic information for some scores. The complex patient bonus was introduced beginning in 2018. The provider's final score for a performance year is used to determine the payment adjustment that is applied to the provider's Medicare Part B payments made 2 years later (i.e., the payment year).

[a]Health professional shortage areas are geographic areas, population groups, or health care facilities that have been designated by the Health Resources and Services Administration as having a shortage of primary, dental, or mental health care providers.

[b]Virtual groups were introduced as a method of participation in 2018 but are not reported here because of small numbers of final scores. In 2018, four final scores and payment adjustments were reported for virtual groups; in 2019, 75 final scores and payment adjustments were reported for virtual groups.

[c]A Merit-based Incentive Payment System (MIPS) alternative payment model (APM) is a payment approach that gives added incentive payments to provide high-quality, cost-efficient care to a specific clinical condition, care episode, or population. Individual providers, groups, or combinations of these may form an APM entity, which participates in a MIPS APM under an agreement with CMS.

Table 8: Mean and Median Quality Performance Category Scores for Selected Specialties and Overall, by Year, Performance Years 2017 through 2019

Specialty	Year	Score count (N)	Mean quality score	Median quality score
Overall[a]	2017	1,039,375	73.96	90.30
	2018	880,979	82.64	99.20
	2019	900,246	89.95	100.00
Anesthesiology	2017	43,187	73.82	87.10
	2018	36,621	71.64	77.10
	2019	33,830	81.42	83.63
Cardiology	2017	28,663	77.71	92.50
	2018	22,967	87.23	99.60
	2019	21,154	93.41	100.00
Certified Registered Nurse Anesthetist	2017	54,599	76.78	90.30
	2018	50,132	73.60	80.90
	2019	46,373	82.87	89.19
Dermatology	2017	12,319	67.37	88.30
	2018	10,386	75.34	93.30
	2019	9,540	88.10	100.00
Diagnostic radiology	2017	49,363	78.90	92.60
	2018	41,817	88.22	100.00
	2019	43,732	90.91	100.00
Emergency medicine	2017	71,764	62.90	74.90
	2018	59,357	73.73	92.90
	2019	59,283	89.03	97.04
Family practice	2017	90,363	75.02	91.90
	2018	69,684	86.06	100.00
	2019	62,760	92.71	100.00
Gastroenterology	2017	15,288	77.18	91.00
	2018	12,386	84.95	98.20
	2019	12,278	91.18	100.00
General surgery	2017	23,035	74.39	90.80
	2018	18,373	85.42	99.30
	2019	17,585	91.85	100.00
Internal medicine	2017	117,507	71.93	90.30
	2018	85,283	81.55	99.80
	2019	73,777	90.51	100.00
Neurology	2017	17,113	75.98	91.90

Specialty	Year	Score count (N)	Mean quality score	Median quality score
	2018	13,725	84.20	99.20
	2019	13,458	91.91	100.00
Nurse practitioner	2017	110,108	76.16	91.70
	2018	101,830	84.07	99.50
	2019	107,477	90.14	100.00
Obstetrics/Gynecology	2017	26,411	81.76	93.90
	2018	21,413	90.57	100.00
	2019	21,921	94.76	100.00
Ophthalmology	2017	20,131	77.90	96.20
	2018	16,887	84.69	100.00
	2019	16,047	90.63	100.00
Optometry	2017	15,382	64.22	82.20
	2018	8,901	80.63	100.00
	2019	10,130	84.56	95.31
Orthopedic surgery	2017	24,747	69.71	86.50
	2018	19,896	78.42	93.60
	2019	15,607	88.65	100.00
Pathology	2017	13,267	70.43	88.50
	2018	10,703	81.44	99.30
	2019	11,822	84.74	92.11
Physician assistant	2017	81,934	76.06	90.80
	2018	73,274	84.33	99.90
	2019	77,797	90.63	100.00
Podiatry	2017	14,782	48.95	53.10
	2018	10,343	59.77	77.30
	2019	8,076	79.75	92.03
Psychiatry	2017	20,252	65.74	86.50
	2018	14,743	80.91	97.80
	2019	13,666	89.83	100.00

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-22-104667

Notes: Results omit cases for which the quality performance category was not used to compute the final score, such as due to receiving a reporting exemption. The provider's final score for a performance year is used to determine the payment adjustment that is applied to the provider's Medicare Part B payments made 2 years later (i.e., the payment year). We report on the specialties with among the largest numbers of MIPS-eligible providers overall or among small practices in each performance year. Specialties are based on the Medicare provider specialty code associated with the record or, if unavailable, the type of service for which the provider submitted most of their Medicare Physician Fee Schedule Part B claims. Providers who participate as part of a group, virtual group, or Merit-based Incentive Payment System (MIPS) alternative payment model (APM) entity all receive the same scores since performance is aggregated across the group, virtual group, or MIPS APM entity. As such, scores may not be based solely on individual performance.

[a]"Overall" reflects statistics among all quality scores for each performance year, including those for specialties not shown in this table.

Table 9: Mean and Median Final Scores and Associated Payment Adjustments within Quality and Cost Score Ranges and Overall, by Year, Performance Years 2017 through 2019

			Mean		Median	
	Year	Score count (N)	Final score	Associated payment adjustment (percent)	Final score	Associated payment adjustment (percent)
Overall	2017	1,059,440	74.65	0.52	89.71	1.33
	2018	889,604	87.00	1.07	99.63	1.66
	2019	954,664	85.61	0.81	92.30	1.27
Quality Score						
0	2017	123,403	13.04	0.03	7.50	0.01
	2018	60,630	21.24	0.02	22.99	0.03
	2019	8,634	36.82	0.00	38.05	0.00
> 0 and <= 25	2017	42,418	13.91	0.03	11.33	0.02
	2018	19,106	35.39	0.07	35.98	0.08
	2019	4,077	39.29	0.00	36.61	0.00
> 25 and <= 50	2017	52,325	43.73	0.12	45.40	0.12
	2018	34,970	54.95	0.15	55.11	0.15
	2019	29,426	51.40	0.00	52.01	0.00
> 50 and <= 75	2017	91,249	68.01	0.19	70.58	0.31
	2018	85,299	75.37	0.52	76.90	0.59
	2019	95,323	71.62	0.00	74.22	0.00
> 75 and < 100	2017	481,959	90.13	1.35	92.27	1.46
	2018	278,372	95.48	1.47	97.60	1.57
	2019	270,010	87.90	0.97	88.38	1.00
100	2017	248,021	97.98	1.77	100.00	1.88
	2018	402,602	99.38	1.65	100.00	1.68
	2019	492,776	95.15	1.46	95.89	1.51
Cost Score						
> 0 and <= 25	2018	24	45.62	0.10	37.16	0.08
	2019	18	79.93	0.76	84.83	0.76
> 25 and <= 50	2018	41,276	72.30	0.38	81.07	0.79
	2019	12,880	71.51	0.00	77.93	0.29
> 50 and <= 75	2018	132,117	88.35	1.13	97.08	1.54
	2019	227,748	82.36	0.59	86.21	0.85

	Year	Score count (N)	Mean: Final score	Mean: Associated payment adjustment (percent)	Median: Final score	Median: Associated payment adjustment (percent)
> 75 and < 100	2018	126,002	89.30	1.18	99.88	1.68
	2019	133,511	85.65	0.81	89.66	1.09
100	2018	65,450	78.66	0.68	90.84	1.25
	2019	18,128	90.04	1.11	95.09	1.46

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-22-104667

Notes: For 2017, cost scores were not available because they did not contribute toward the final score. The provider's final score for a performance year is used to determine the payment adjustment that is applied to the provider's Medicare Part B payments made 2 years later (i.e., the payment year). The associated payment adjustment represents the payment adjustment associated with that score or the closest actual score that appeared in the data for that year. Results other than "overall" omit cases for which the performance category (quality or cost) was not used to compute the final score, such as due to receiving an exemption. There were no cases for which cost was used to compute the final score and the cost score was 0.

Table 10: Payment Adjustment Types within Quality and Cost Score Ranges and Overall, by Year, Performance Years 2017 through 2019

	Year	Score count (N)	Scores with a negative adjustment (percent)	Scores with a neutral adjustment (percent)	Scores with a positive adjustment, but no exceptional performance bonus (percent)	Scores with a positive adjustment, including an exceptional performance bonus (percent)
Overall	2017	1,059,440	4.84	2.01	21.16	71.99
	2018	889,604	2.00	0.45	13.35	84.20
	2019	954,664	0.29	4.37	11.50	83.83
Quality Score						
0	2017	123,403	41.52	0.00	58.48	0.00
	2018	60,630	27.13	0.03	72.84	0.00
	2019	8,634	25.85	0.00	74.15	0.00
> 0 and <= 25	2017	42,418	0.05	18.21	81.74	0.00
	2018	19,106	7.00	0.01	92.98	0.01
	2019	4,077	8.00	0.00	92.00	0.00
> 25 and <= 50	2017	52,325	0.00	0.00	99.97	0.03
	2018	34,970	0.00	0.00	85.45	14.55
	2019	29,426	0.17	0.00	99.63	0.20
> 50 and <= 75	2017	91,249	0.00	0.00	47.64	52.36
	2018	85,299	0.00	0.00	25.49	74.51

	Year	Score count (N)	Scores with a negative adjustment (percent)	Scores with a neutral adjustment (percent)	Scores with a positive adjustment, but no exceptional performance bonus (percent)	Scores with a positive adjustment, including an exceptional performance bonus (percent)
	2019	95,323	0.00	0.00	53.62	46.38
> 75 and < 100	2017	481,959	0.00	0.00	3.96	96.04
	2018	278,372	0.00	0.00	1.35	98.65
	2019	270,010	0.00	0.00	4.66	95.34
100	2017	248,021	0.00	0.00	0.87	99.13
	2018	402,602	0.00	0.00	0.20	99.80
	2019	492,776	0.00	0.00	0.71	99.29
Cost Score						
> 0 and <= 25	2018	24	4.17	0.00	75.00	20.83
	2019	18	0.00	0.00	16.67	83.33
> 25 and <= 50	2018	41,276	0.65	0.00	34.65	64.70
	2019	12,880	1.59	0.00	46.12	52.29
> 50 and <= 75	2018	132,117	0.13	0.00	11.19	88.68
	2019	227,748	0.27	0.00	18.87	80.86
> 75 and < 100	2018	126,002	0.02	0.00	13.03	86.95
	2019	133,511	0.58	0.00	15.97	83.44
100	2018	65,450	0.14	0.03	31.06	68.77
	2019	18,128	0.02	0.00	10.73	89.25

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-22-104667

Notes: For 2017, cost scores were not available because they did not contribute toward the final score. The provider's final score for a performance year is used to determine the payment adjustment that is applied to the provider's Medicare Part B payments made 2 years later (i.e., the payment year). Payment adjustments are based on final scores. Percentages within rows may not sum to 100 due to rounding. Results other than "overall" omit cases for which the performance category (quality or cost) was not used to compute the final score, such as due to receiving an exception. There were no cases for which cost was used to compute the final score and the cost score was 0.

Appendix III: Payment Adjustments under the Projected 2022 Performance Threshold Using 2019 Data

The Centers for Medicare & Medicaid Services (CMS) has projected the performance threshold for Merit-based Incentive Payment System (MIPS) final scores in performance year 2022 to be 74.01.[1] Using data from performance year 2019, we estimated how distributions of payment adjustments would have changed if CMS's projected performance threshold for 2022 had been in effect that year. To do this, we first identified CMS's projected performance threshold for 2022 that was published in the 2020 proposed rule. We then identified final scores that were set equal to the performance threshold in 2019 (e.g., due to a reporting exception) and set those final scores as equal to CMS's projected 2022 performance threshold. We then examined scores that fell below the projected 2022 performance threshold (which would have earned a negative adjustment), those equal to the performance threshold (which would have earned a neutral adjustment), and those above the performance threshold (which would have earned a positive adjustment) and compared those against the actual distributions for the year. This analysis assumed no changes other than to the performance threshold and was not intended to account for how future performance may be affected by other changes to the MIPS program.

Under the actual 2019 performance threshold of 30 points, about 95 percent of MIPS-eligible providers earned a positive adjustment.[2] If CMS's projected performance threshold of 74.01 for 2022 had been in effect, about 84 percent of scores would have earned a positive adjustment.

Across all practice sizes, geographic locations, and methods of participation, fewer scores would have earned positive adjustments under

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[1]See 84 Fed. Reg. 40,482, 40,802 (Aug. 14, 2019). CMS subsequently proposed a performance threshold of 75 points for performance year 2022. See 86 Fed. Reg. 39,104, 39,590 (proposed July 23, 2021) (proposing to amend 42 C.F.R. § 414.1405). Final scores are calculated for each eligible Tax Identification Number (TIN) and National Provider Identifier (NPI) combination. The provider's final score for a performance year is used to determine the payment adjustment that is applied to the provider's Medicare Part B payments made 2 years later (i.e., the payment year). A single provider (as identified through the NPI) who participated in MIPS under multiple employers (as identified through the TIN) during a performance year may receive multiple final scores and payment adjustments. Payment adjustments earned under a TIN and NPI combination in the performance year are applied to the Medicare Part B payments made to the same TIN and NPI combination in the payment year. In this report, we use the term "year" to refer to a "performance year," unless otherwise specified as a "payment year."

[2]Final scores are earned by unique Tax Identification Number (TIN) and National Provider Identifier (NPI) combinations; therefore, a unique provider (NPI) who is eligible to participate through multiple employers (TINs) may receive multiple final scores.

the projected threshold, but the size of the difference would have varied. For example, about 98 percent of large practices earned a positive adjustment in 2019, whereas about 92 percent would have earned a positive adjustment under the projected threshold (see table 11). However, while about 90 percent of small practices earned a positive adjustment in 2019, about 69 percent would have earned a positive adjustment under the projected threshold. Under the projected threshold, only 1 percent fewer MIPS alternative payment model (APM) scores would have earned a positive adjustment, whereas 14 percent fewer individuals and 19 percent fewer groups would have earned a positive adjustment. Rural, non-rural, health professional shortage areas, and non-health professional shortage areas would have seen similar decreases of about 11 to 12 percent each.

Table 11: Payment Adjustment Types by Practice Size, Geographic Location, Method of Participation, Complex Patient Bonus, and Overall, by Actual and Alternative Performance Threshold, Performance Year 2019

Demographic	Performance Threshold	Score count (N)	Scores with a negative adjustment (percent)	Scores with a neutral adjustment (percent)	Scores with a positive adjustment (percent)
Overall	Actual	954,664	0.29	4.37	95.34
	Alternative	954,664	11.16	4.37	84.47
Practice size					
Large (>99)	Actual	534,776	0.13	1.59	98.27
	Alternative	534,776	6.53	1.59	91.88
Medium (16-99)	Actual	258,069	0.59	3.48	95.93
	Alternative	258,069	15.20	3.48	81.32
Small (2-15)	Actual	129,282	0.40	9.64	89.96
	Alternative	129,282	21.37	9.64	68.99
Solo (1)	Actual	32,537	0.10	36.19	63.71
	Alternative	32,537	14.53	36.19	49.28
Geographic location					
Rural	Actual	120,156	0.48	4.89	94.63
	Alternative	120,156	11.26	4.89	83.85
Non-rural	Actual	827,869	0.27	4.33	95.40
	Alternative	827,869	11.21	4.33	84.46
Health professional shortage area[a]	Actual	215,123	0.34	5.04	94.62
	Alternative	215,123	12.10	5.04	82.86
Non-health professional shortage area	Actual	732,902	0.28	4.21	95.51

Demographic	Performance Threshold	Score count (N)	Scores with a negative adjustment (percent)	Scores with a neutral adjustment (percent)	Scores with a positive adjustment (percent)
	Alternative	732,902	10.96	4.21	84.82
Method of participation[b]					
Individual	Actual	60,681	0.00	43.27	56.73
	Alternative	60,681	14.36	43.27	42.38
Group	Actual	477,707	0.55	0.62	98.83
	Alternative	477,707	19.55	0.62	79.83
MIPS APM[c]	Actual	416,201	0.04	3.01	96.95
	Alternative	416,201	1.05	3.01	95.95
Received a complex patient bonus					
No	Actual	8,164	0.28	0.24	99.47
	Alternative	8,164	2.23	0.24	97.53
Yes	Actual	946,500	0.29	4.41	95.30
	Alternative	946,500	11.23	4.41	84.36

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-22-104667

Notes: Score counts within demographic categories may not sum to the overall score count due to missing demographic information for some scores. Payment adjustments are based on final scores. The provider's final score for a performance year is used to determine the payment adjustment that is applied to the provider's Medicare Part B payments made 2 years later (i.e., the payment year). For performance year 2019, the actual performance threshold a final score needed to meet to receive a neutral payment adjustment was 30. Scores above the performance threshold receive a positive adjustment, whereas those below the threshold receive a negative adjustment. The alternative performance threshold is 74.01, which CMS previously projected may be the performance threshold in performance year 2022.

[a]Health professional shortage areas are geographic areas, population groups, or health care facilities that have been designated by the Health Resources and Services Administration as having a shortage of primary, dental, or mental health care providers.

[b]Virtual groups were introduced as a method of participation in 2018 but are not reported here because of small numbers of final scores. In 2018, four final scores and payment adjustments were reported for virtual groups; in 2019, 75 final scores and payment adjustments were reported for virtual groups.

[c]A Merit-based Incentive Payment System (MIPS) alternative payment model (APM) is a payment approach that gives added incentive payments to provide high-quality, cost-efficient care to a specific clinical condition, care episode, or population. Individual providers, groups, or combinations of these may form an APM entity, which participates in a MIPS APM under an agreement with CMS.

All of the specialties whose scores we examined would have seen a decrease in the percentage of scores earning a positive adjustment, though some would have had larger shifts than others. For example, in 2019, about 94 percent of optometry scores earned a positive adjustment, but under the projected 2022 performance threshold, about 68 percent would have earned such an adjustment (see table 12). In contrast, about 99 percent of obstetrics/gynecology scores earned a positive adjustment

in 2019; under the projected 2022 performance threshold, about 94 percent would have continued to earn a positive adjustment.

Table 12: Payment Adjustment Types for Selected Specialties and Overall, by Actual and Alternative Performance Threshold, Performance Year 2019

Specialty	Performance Threshold	Score count (N)	Scores with a negative adjustment (percent)	Scores with a neutral adjustment (percent)	Scores with a positive adjustment (percent)
Overall[a]	Actual	954,664	0.29	4.37	95.34
	Alternative	954,664	11.16	4.37	84.47
Anesthesiology	Actual	34,628	0.19	1.51	98.30
	Alternative	34,628	17.70	1.51	80.79
Cardiology	Actual	22,720	0.11	5.11	94.78
	Alternative	22,720	6.37	5.11	88.52
Certified Registered Nurse Anesthetist	Actual	46,936	0.37	1.01	98.62
	Alternative	46,936	19.25	1.01	79.74
Dermatology	Actual	10,779	0.09	11.01	88.90
	Alternative	10,779	14.10	11.01	74.89
Diagnostic radiology	Actual	44,677	0.12	1.78	98.10
	Alternative	44,677	8.64	1.78	89.57
Emergency medicine	Actual	60,224	0.43	1.40	98.17
	Alternative	60,224	8.55	1.40	90.04
Family practice	Actual	66,943	0.30	4.79	94.91
	Alternative	66,943	8.82	4.79	86.39
Gastroenterology	Actual	13,008	0.04	4.94	95.03
	Alternative	13,008	7.64	4.94	87.42
General surgery	Actual	18,386	0.11	3.44	96.45
	Alternative	18,386	8.56	3.44	88.01
Internal medicine	Actual	83,781	0.26	10.79	88.95
	Alternative	83,781	10.62	10.79	78.59
Neurology	Actual	14,394	0.13	5.60	94.27
	Alternative	14,394	8.36	5.60	86.04
Nurse practitioner	Actual	111,243	0.46	2.30	97.24
	Alternative	111,243	11.68	2.30	86.01
Obstetrics/Gynecology	Actual	22,318	0.10	0.78	99.12
	Alternative	22,318	4.76	0.78	94.46
Ophthalmology	Actual	17,173	0.11	6.36	93.53

Specialty	Performance Threshold	Score count (N)	Scores with a negative adjustment (percent)	Scores with a neutral adjustment (percent)	Scores with a positive adjustment (percent)
	Alternative	17,173	13.13	6.36	80.51
Optometry	Actual	10,795	0.21	5.98	93.80
	Alternative	10,795	25.67	5.98	68.35
Orthopedic surgery	Actual	19,965	0.62	9.22	90.17
	Alternative	19,965	16.53	9.22	74.25
Pathology	Actual	12,137	0.21	2.29	97.50
	Alternative	12,137	17.33	2.29	80.38
Physician assistant	Actual	79,842	0.62	1.15	98.23
	Alternative	79,842	10.86	1.15	87.99
Podiatry	Actual	10,934	0.27	24.57	75.16
	Alternative	10,934	24.14	24.57	51.29
Psychiatry	Actual	14,704	0.10	6.36	93.54
	Alternative	14,704	10.58	6.36	83.07

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-22-104667

Notes: We report on the specialties with among the largest numbers of MIPS-eligible providers overall or among small practices in each performance year. Specialties are based on the Medicare provider specialty code associated with the record or, if unavailable, the type of service for which the provider submitted most of their Medicare Physician Fee Schedule Part B claims. Payment adjustments reflected are based on final scores. The provider’s final score for a performance year is used to determine the payment adjustment that is applied to the provider’s Medicare Part B payments made 2 years later (i.e., the payment year). Providers who participate as part of a group, virtual group, or Merit-based Incentive Payment System (MIPS) alternative payment model (APM) entity all receive the same scores since performance is aggregated across the group, virtual group, or MIPS APM entity. As such, scores may not be based solely on individual performance. Percentages within rows may not sum to 100 due to rounding.

For performance year 2019, the actual performance threshold a final score needed to meet to receive a neutral payment adjustment was 30. Scores above the performance threshold receive a positive adjustment, whereas those below the threshold receive a negative adjustment. The alternative performance threshold is 74.01, which CMS previously projected may be the performance threshold in performance year 2022.

[a]”Overall” reflects statistics among all scores for each performance year, including those for specialties not shown in this table.

Appendix IV: The Centers for Medicare & Medicaid Services' Merit-based Incentive Payment System Technical Assistance for Providers in Small Practices

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) directed the Secretary of Health and Human Services to contract with external organizations to offer technical assistance to Merit-based Incentive Payment System (MIPS)-eligible providers in small practices and authorized the department to use $100 million for this purpose.[1] This assistance is intended to help providers improve their scores in performance categories or to help them transition to Advanced alternative payment models (Advanced APM).[2] By law, priority for technical assistance must be given to providers in small practices who are located in rural, health professional shortage, or medically underserved areas or have low final performance scores.[3]

The Centers for Medicare & Medicaid Services (CMS) has made MIPS technical assistance available to providers, in part, through the Small, Underserved, and Rural Support (SURS) program.[4] The SURS program provides program- and practice-level technical assistance to small practices of 15 or fewer providers. For example, according to CMS, SURS technical assistance can provide support in understanding the general requirements of MIPS; advice on identifying appropriate measures to report; help submitting data; and develop strategies for implementing certified electronic health record technology, among other things.[5] SURS technical assistance is provided through 11 external contractors which are assigned different sets of states to support. CMS

[1]Pub. L. No. 114-10, § 101(c), 129 Stat. 87, 110 (codified as amended at 42 U.S.C. § 1395w-4(q)(11)).

[2]An APM is a payment approach that gives added incentive payments to providers to provide high-quality and cost-efficient care. See 42 C.F.R. § 414.1305 (2020) (definition of APM). An Advanced APM is an APM that CMS determines meets the criteria set forth in regulation pertaining to use of certified electronic health record technology, quality measures, and financial risk. See 42 C.F.R. § 414.1415 (2020) (advanced APM criteria).

[3]Health professional shortage areas are geographic areas, population groups, or health care facilities that have been designated by the Health Resources and Services Administration as having a shortage of primary, dental, or mental health care providers. Medically underserved areas are areas designated by the Health Resources and Services Administration as having too few primary care providers, high infant mortality, high poverty, or a high elderly population.

[4]According to agency officials, in addition to SURS, CMS also provided technical assistance to medium and large practices at the onset of the MIPS program. Officials noted that CMS discontinued the support as these providers adjusted to the program.

[5]Centers for Medicare & Medicaid Services, "Small, Underserved, and Rural Practices," accessed July 22, 2021, https://qpp.cms.gov/resources/small-underserved-rural-practices.

officials said that the SURS technical assistance program is funded with the amounts made available under MACRA through February 15, 2022, after which time it is expected to end.[6]

To describe what is known about the effectiveness of CMS's MIPS technical assistance in helping providers improve their final scores, we interviewed officials from a non-generalizable sample of 11 provider stakeholder groups about their experiences with the technical assistance. We also interviewed CMS officials about any formal evaluations that have been conducted on its effectiveness; interviewed or reviewed written responses from officials with each of the 11 SURS technical assistance contractors about their activities; and reviewed summary client interaction statistics provided by both CMS and the SURS contractors.[7]

Our review found that little is known about the effectiveness of CMS's MIPS technical assistance in helping providers improve their final scores. CMS officials said contractors for the SURS program reported providing assistance to about 185,000 providers in 2017.[8] By 2020, the number of providers served decreased to about 99,000. MACRA does not require CMS or its contractors to evaluate the effectiveness of the technical assistance, and officials with CMS and its contractors said no formal evaluation has been conducted. However, contractors for the SURS program reported positive provider satisfaction ratings ranging from about 98.0 to 99.4 percent based on feedback provided by about 13 to 18 percent of the providers assisted each year from 2017 through 2020. Stakeholders we spoke with provided little feedback on the SURS program. Only one of the stakeholder groups we spoke with was able to

[6]Technical assistance is also available for providers through the Quality Payment Program (QPP) Service Center. The QPP Service Center provides technical support to providers participating in MIPS or Advanced APMs. According to CMS officials, the QPP Service Center's call agents may answer questions directly or refer the inquiry to a SURS technical assistance contractor. Officials said the QPP Service Center will continue to be available to provide technical support after the funding for the SURS program has been expended.

[7]The 11 SURS technical assistance contractors were Alliant GMCF, Altarum, Comagine Health, Healthcentric Advisors, Health Services Advisory Group, IPRO, Network for Regional Healthcare Improvement, QSource, Quality Insights, Telligen, and TMF Health Quality Institute.

[8]Contractors for the SURS technical assistance program reported providing a variety of technical assistance efforts. For example, contractors said they conducted annual outreach to MIPS-eligible solo and small practices in their areas and developed online educational resources. Contractors added they provided one-on-one assistance through various means, such as through phone calls, video conferences, and remote desktop sessions.

provide any feedback. That stakeholder group said that while some providers found the technical assistance to be helpful, others experienced problems with timeliness or utility of responses.

Appendix V: GAO Contact and Staff Acknowledgments

GAO Contact

Jessica Farb at (202) 512-7114 or farbj@gao.gov

Staff Acknowledgments

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