

Perspectives of Physicians in Small Rural Practices on the Medicare Quality Payment Program

Peter Mendel, Christine Buttorff, Peggy G. Chen, Katharine Sieck,
Patrick Orr, Nabeel Shariq Qureshi, Peter S. Hussey



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Preface

The Centers for Medicare & Medicaid Services recently launched its Quality Payment Program (QPP), which considerably changes the way physicians are paid under Medicare. There has been significant concern about the ability of small and rural medical practices to successfully participate in the program. The objectives of this research effort were to collect feedback through interviews with physicians in small rural practices on the initial implementation of the QPP to understand the program's initial rollout and flexibility provisions for small and rural practices and to inform future federal rulemaking for the QPP.

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RAND Health Care Communications

1776 Main Street

P.O. Box 2138

Santa Monica, CA 90407-2138

(310) 393-0411, ext. 7775

RAND_Health-Care@rand.org

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Summary

Background

The Centers for Medicare & Medicaid Services (CMS) recently launched its Quality Payment Program (QPP), which considerably changes the way physicians are paid under Medicare. There has been significant concern about the ability of small rural practices to successfully participate in the program. There is therefore a need for early feedback on the initial implementation of the QPP among these practices.

Methods

This report presents results of interviews conducted with physicians in small rural practices from September 7 to 27, 2017. Physicians were recruited using a combination of stratified random sampling and referrals from CMS technical assistance contractors. We sought to obtain variation by geographic region and include members of four groups reflecting different combinations of physician specialty (primary versus specialty care), Merit-Based Incentive Payment System eligibility, and knowledge of the QPP. A total of 20 small rural practices were interviewed. Interviews were conducted by telephone, using a semistructured format lasting approximately an hour.

Results

Although this research is based on a small sample, our findings suggest that small rural practices are struggling to participate in the QPP. Even those who were relatively knowledgeable about the QPP and who had been preparing for months to participate—either on their own or with a CMS support contractor—reported frustration with a lack of clarity of program details, requirements that appeared to be determined late and were subject to change, and the amount of effort needed to participate.

Interview participants suggested several changes to the QPP and Medicare policy to improve the ability of small rural practices to participate in the program. These changes included clarifying and specifying program requirements, reducing the frequency of program policy changes, delaying program implementation for small practices, avoiding penalizing small practices that serve vulnerable populations, developing less obtrusive methods for assessing the quality of care of small practices, providing additional information technology support for small rural practices, and enabling greater engagement of rural physicians by policymakers.

Conclusion

The qualitative findings from this study could help in interpreting the first-year QPP participation results and performance scores and inform future policy changes and evaluation questions for the QPP.

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Abbreviations

APM	alternative payment model
ASPE	Office of the Assistant Secretary for Planning and Evaluation
CAH	Critical Access Hospital
CMS	Centers for Medicare & Medicaid Services
EHR	electronic health record
GMCF	Georgia Medical Care Foundation
HHS	U.S. Department of Health and Human Services
HSAG	Health Services Advisory Group
IPA	independent physician association
IT	information technology
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MIPS	Merit-Based Incentive Payment System
NPI	National Provider Identifier
NRHI	Network for Regional Healthcare Improvement
PQRS	Physician Quality Reporting System
QIN-QIO	Quality Innovation Network–Quality Improvement Organizations
QPP	Quality Payment Program
TCPI	Transforming Clinical Practice Initiative
TIN	tax identification number

1. Introduction

Research Purpose and Goals

The objective of this research effort was to collect feedback from physicians in small rural practices on the initial implementation of the Medicare Quality Payment Program (QPP) to understand the program’s rollout and flexibility provisions for small and rural practices and inform future federal rulemaking for the QPP.

The impetus for this study arose from early concern among policymakers and the physician community that small, rural, less-resourced practices with less experience in prior quality reporting programs could be less prepared to participate in this new payment program for ambulatory practices and clinicians.¹ To determine whether these concerns were warranted, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) in the U.S. Department of Health and Human Services (HHS) tasked the RAND Corporation with conducting a limited set of interviews with physicians in small rural practices. The goals of these interviews were to

1. explore physicians’ understanding of the new QPP
2. obtain physician feedback on initial program implementation
3. solicit input on potential future policies relevant to small rural practices.

Background

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) created the QPP, which includes two paths for Medicare payments to clinicians: the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). MIPS provides financial incentives for eligible clinicians based on performance on quality, cost, clinical practice improvement activities; and use of electronic health records (EHRs). APMs are delivery and payment models that include performance-based financial risk to shift from volume- to value-based care and payment. APM-track participants have the opportunity to earn a bonus and be exempt from MIPS. In future years, qualified participants in APMs will also earn higher Medicare payment rate updates. More details on the design of the QPP are available from the Centers for Medicare & Medicaid Services (CMS).²

In MACRA, Congress recognized concerns that small and rural practices might not have the patient volume, knowledge, and resources to meet the burdens of quality reporting and participation in the QPP. The statute called for CMS to establish flexible policies in a three-year

¹ See, for example, Ron Shinkman, “Physician Frustration and Fear of MACRA,” *NEJM Catalyst*, August 4, 2016; or the CMS fact sheet for small practices: CMS, “Medicare Access and CHIP Reauthorization Act of 2015: Flexibilities and Support for Small Practices,” fact sheet, undated(a).

² CMS, “Quality Payment Program,” homepage, undated(b).

transition period, set volume thresholds for MIPS eligibility, provide targeted technical assistance to small and rural practices, and allow small practices to participate in the QPP through virtual groups that aggregate reporting volumes across providers.

In an initial set of regulations governing implementation of MIPS, HHS implemented the following first-year policies for the 2017 performance period³ and also proposed several changes for 2018⁴ that attempted to address concerns about the burden for small and rural practices:

- **Requirements applying to the 2017 performance period**
 - Low-volume exclusions: For performance year 2017, clinicians with less than \$30,000 in annual Medicare-allowed charges or fewer than 100 unique Medicare patients were exempt from MIPS requirements.
- **Proposed changes for the 2018 performance period (as of fall 2017)**
 - Low-volume exclusions: HHS proposed increasing the thresholds to \$90,000 and 200 patients.
 - Virtual groups: HHS proposed allowing small practices (with ten or fewer MIPS-eligible clinicians) to form “virtual groups” for reporting MIPS performance measures. In larger practices where a portion of the group participates in an APM, the portion not in an APM also could be allowed to join a virtual group. Virtual groups seek to address the issue of small or insufficient numbers for reliable reporting of quality measures, or to meet low-volume eligibility thresholds. Virtual groups also could help pool resources among small practices to support efforts to participate in MIPS.
 - Performance bonus scores: Also proposed was a provision for practices to earn bonus points toward their MIPS performance scores if they have higher-complexity patient panels and for small practice sizes.
- **Applicable to both performance periods**
 - Technical assistance is available to small practices (with 15 or fewer clinicians), practices in rural locations (as defined by the Federal Office of Rural Health Policy), and practices in medically underserved/health professional shortage areas through CMS contractors. Priority is given to practices in rural areas and medically underserved areas. There are 11 TA organizations tasked specifically with serving small, underserved, rural practices. An additional 14 organizations support the QPP for larger practices (with more than 15 clinicians) under the Quality Innovation Network–Quality Improvement Organizations (QIN-QIO) contract with CMS. In addition, CMS operates the Transforming Clinical Practice Initiative (TCPI), which aims to position practices for APM participation. Practices enrolled in the TCPI’s practice transformation network will receive QPP support as part of the initiative. CMS also has indicated that it will implement a “no wrong door” policy so that practices can seek QPP help from any organization they contact.

³ CMS, Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physicians-Focused Payment Models, final rule, November 4, 2016.

⁴ CMS, CY2018 Updates to the Quality Payment Program, proposed rule, June 30, 2017.

- MIPS Transition period: Clinicians have a “pick your pace” option during transition years, with options ranging from minimal to full reporting of performance information. For example, a floor score of three out of ten possible quality points is awarded for reporting a measure that does not meet the minimum number of cases, time, or data completeness requirements.
- Group participation: Clinicians can participate in MIPS either as individuals or as groups (if they share a tax identification number [TIN]).
- Flexibility in MIPS scoring: Clinicians can choose among performance measures to report. Small practices (with fewer than 15 clinicians) and those in a rural or health professional shortage area are required to submit fewer practice improvement activities for full participation (i.e., two medium-priority activities instead of four, or one high-priority activity instead of two). CMS also accounts for the availability of applicable measures for different specialties in determining the weighting of performance scores.
- Multiple reporting mechanisms: Practices have options for the mechanism used to report performance data, including registries, EHRs, claims-appended codes, CMS Web Interface (for groups only), attestation of completion of specific practice improvement activities, and approved Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey vendors (in conjunction with another reporting mechanism and for groups only). Performance benchmarks are based on the reporting mechanism selected.

Relevance for Current and Future Changes to QPP Policies

The research questions in this study reflect the first-year QPP policies, which were applicable to reporting and performance in 2017 for payment in 2019, and interest at the time in potential policies for 2018. QPP policies—such as updated low-volume thresholds for MIPS eligibility, small practice bonus points, implementation of virtual group policies, and revised EHR standards—have been updated and finalized for the 2018 performance period (affecting 2020 payment) and the 2019 performance period (affecting 2021 payment). The qualitative findings from this study might help in interpreting the first-year QPP participation results and performance scores as they become available to inform future research on the ability of small and rural practices to participate in the QPP. Furthermore, Congress subsequently extended the MIPS transition period by three years to 2021 (i.e., payment year 2023) under the Bipartisan Budget Act of 2018.⁵ This could extend the period in which flexibility policies are relevant to small and rural practices.

⁵ Pub. L. 115-123, Bipartisan Budget Act of 2018, February 9, 2018.

2. Methods

Overview and Research Questions

RAND researchers conducted interviews with physicians from small rural practices. The study addressed the following research questions, which were developed by ASPE in conjunction with the RAND study team:

1. What are the views, expectations, interest, and understanding regarding QPP program participation among small rural practices?
 - a. *Sources of information on the QPP and participation:* What are the main sources of information on the QPP (i.e., medical society, peers, news, CMS) used by these groups? What is the level of QPP awareness among small rural practices?
 - b. *MIPS and APM participation interest among small practices:* What key aspects motivate small rural practices' interest in participating in either MIPS (including virtual group) or APMs, or in not participating (i.e., incentives relative to total revenues, perceived burden, program credibility, measure validity)? What is the potential value of participating in the QPP for practices, such as accelerating ongoing quality improvement or practice transformation efforts?
 - c. *MIPS eligibility and participation choices:* What are key considerations for clinicians in small rural practices in deciding whether to participate in MIPS or join an APM; in deciding whether to participate as an individual clinician or as part of a group practice or virtual group for MIPS? What are the barriers and challenges to QPP participation (i.e., MIPS quality reporting, certified EHR technology, improvement activities, lack of available APMs or APM financial risk requirements)?
 - d. *Feedback on MIPS policies and policy flexibilities:* How do small rural practices perceive transition-year policy flexibilities? Do these policies address initial and/or ongoing barriers to participation? How do providers view proposed bonus points for medical or social complexity, or small and rural providers? Are they sufficient for providers to continue to see high-risk patients or practice as a small or rural practice?
 - e. *Virtual groups:* What do small rural practices know and understand about proposed virtual group policies? Do these proposed policies address participation and reporting issues for small practices? What are the challenges and opportunities for virtual groups? What is their potential interest and what are their considerations in whether to join one? Who would they be interested in joining with, and what types of support/facilitation do they need or want? How do small practices perceive allowing large groups to subdivide to form virtual groups? What subcomponents of large groups might be interested in being able to form a virtual group (i.e., subspecialists in multispecialty practice)?
2. What feedback do small rural practices have on the initial rollout of the QPP by CMS, such as the QPP website, individual National Provider Identifier (NPI) lookup tool, outreach information, letters sent by CMS, CMS-provided technical assistance, and the (phase 2) QPP/MIPS data-submission process?

- a. What aspects are helpful or could be improved?
- b. What are the other non-CMS sources of information on QPP (i.e., medical society, peers, news) used by these groups? Were these other sources more helpful, trusted, or useful and in what ways?
- c. How do these findings inform HHS implementation strategies (such as working with medical specialty societies, large health systems, regional extension centers, or others) to engage and support small and rural practices in QPP participation?

Sample Frame

RAND researchers developed a sample frame of potential interview participants based on characteristics relevant to this study. All of the interviewees were located in rural areas, based on applying the definition of the Federal Office of Rural Health Policy to each practice zip code. Nonphysician clinicians who are eligible for MACRA (physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists) were excluded from these interviews.

We aimed to conduct up to nine interviews in each of four groups of physicians in rural practices:

- Group 1: eligible and knowledgeable, primary care
- Group 2: eligible and knowledgeable, specialty care
- Group 3: eligible and not knowledgeable, primary and specialty care
- Group 4: not eligible, varied knowledge, primary and specialty care.

We used data from Medicare Physician Compare and the CMS MIPS participation web-based lookup tool to identify the sample frame (for detailed methods, see Appendix A). Eligible physicians were identified as meeting criteria for individual eligibility for MIPS via the CMS MIPS participation web-based lookup tool.

We drew a random sample of physicians for recruitment from our compiled sample frame for three of the interview groups: MIPS-eligible primary care physicians (Group 1), MIPS-eligible specialty care physicians (Group 2), and MIPS-noneligible primary and specialty care physicians (Group 4). The sampling pool of physicians for interview Group 3 was identified based on a screening question administered to eligible primary and specialty care physicians from the sampling pools for Groups 1 and 2 about knowledge of the QPP and MIPS during recruitment.

Within each interview group, we sought heterogeneity by geography and practice size. We defined categories of region and practice size and aimed to recruit no more than one respondent from each region-practice combination. We defined two groups of practice sizes: very small practices (one or two clinicians) and small practices (three to nine clinicians). Although MIPS policies define small practices as those with fewer than 15 clinicians, we did not include practices of ten to 14 clinicians given the study's particular concern about the ability of smaller practices to participate in MACRA and the relatively short time frame for data collection. We

defined the following five regions, each corresponding to the service area of one or multiple technical assistance providers for the QPP:⁶

- Region 1–“West”: Health Services Advisory Group (HSAG) technical assistance area (California, Arizona, New Mexico, and Hawaii), Network for Regional Healthcare Improvement (NRHI) technical assistance area (Oregon, Nevada, Utah, Wyoming, Montana, and Alaska); and Qualis technical assistance area (Washington and Idaho)
- Region 2–“Southeast”: Alliant Georgia Medical Care Foundation (GMCF) technical assistance area (Florida, Georgia, South Carolina, and North Carolina), and QSource technical assistance area (Tennessee and Alabama)
- Region 3–“Northern Midwest”: Altarum technical assistance area (Minnesota, Wisconsin, Illinois, Indiana, Michigan, Kentucky, and Ohio); and Telligen technical assistance area (North Dakota, South Dakota, Nebraska, and Iowa)
- Region 4–“Southern Midwest”: TMF Health Quality Institute technical assistance area (Colorado, Kansas, Missouri, Oklahoma, Arkansas, Texas, Louisiana, and Mississippi)
- Region 5–“Northeast”: Healthcentric Advisors technical assistance area (Maine, Vermont, New Hampshire, Massachusetts, Rhode Island, and Connecticut); Quality Insights technical assistance area (New Jersey, Delaware, Pennsylvania, and West Virginia); and IPRO technical assistance area (New York, Maryland, Virginia).

Because of low response rates from randomly sampled practices, we identified additional practices for the sample by requesting referrals from CMS contractors from three programs that provide MIPS technical assistance to small rural practices: Quality Payment Program Small, Rural and Underserved Support (QPP-SURS), TCPI, and QIN-QIO. Practices identified through these referrals tended to be actively engaged with CMS contractors to participate in the QPP.

Recruitment

Recruitment for the study was challenging because of the time constraints of physicians in small rural practices and the limited time frame for recruitment (recruitment and interviews were conducted between September 7 and 27, 2017). As an incentive, we offered \$150 per practice for physician participation in the interviews.

Recruitment was conducted by telephone. During the initial phone call, recruiters arranged to send the practice a fax or email explaining the study goals and interview process. Recruiters also screened for study eligibility, including confirming the rurality of the practice and the physician’s knowledge of the QPP and MIPS. Physicians were considered knowledgeable if they answered that they had a “basic” or “good” knowledge of the QPP and MIPS. Physicians were considered not knowledgeable if they answered that “this is the first time I’m hearing about QPP or MIPS” or that they “heard that there may be changes to Medicare payment, but don’t really know anything about QPP and MIPS.”⁷ We scheduled a one-hour phone interview with

⁶ CMS, undated(a).

⁷ Several physicians were reassigned between the “knowledgeable” and “not knowledgeable” groups after the interview based on their responses to interview questions.

physicians who agreed to participate and offered a wide range of times, including time slots outside of normal business hours.

Study Population

Table 2.1 summarizes the number of recruitment calls and interviews completed in each group. The table distinguishes between the total recruitment effort of both recruitment streams (random sampling and contractor referrals). The response rate was considerably higher for practices recruited through contractor referrals than through random sampling. Additional information on recruitment for both methods and by region is provided in Appendix B.

Table 2.1. Response Rates by Sampling Method and Interview Group

	Random Sampling			Contractor Referral			Overall		
	Total Practices Called	Interviews Completed	Response Rate ^b	Total Practices Called	Interviews Completed	Response Rate ^b	Total Practices Called	Interviews Completed	Response Rate ^b
Group 1	127	2	2%	14	7	50%	141	9	6%
Group 2	160	0	0%	12	3	25%	172	3	2%
Group 3 ^a	3	3	100%	2	1	50%	5	4	80%
Group 4	97	4	4%	0	0	0%	97	4	4%
Total	387	9	2%	28	11	39%	415	20	5%

NOTE: Group 1 is primary care (eligible and knowledgeable); Group 2 is specialty care (eligible and knowledgeable); Group 3 is not knowledgeable (eligible, primary and specialty care); and Group 4 is not eligible (varied knowledge, primary and specialty care).

^a Group 3 was identified by screening practices in the Group 1 and Group 2 sampling frame.

^b Response rate = interviews completed / total practices called.

Data Collection and Analysis

We developed interview protocols for each of the four groups (full interview protocols are included in Appendix C). In the interview protocols, we provided descriptions of the QPP for respondents in all interview groups and included additional background information and explanations for respondents in Group 3 (not knowledgeable) to ensure their ability to answer specific questions as needed. Each interview was conducted by a researcher with experience in qualitative research and was audio-recorded. Interviewers indicated that responses would be anonymous and confidential. They also noted that responses would be aggregated to help inform policymakers and would not be used for evaluating performance in the QPP.

After each interview, the interviewer drafted a bulleted summary of key “takeaway” points using a standardized template that covered the following six topics:

1. *Knowledge of the QPP*, including general awareness of QPP design and options, as well as QPP resources and their uses
2. *Concerns about the QPP*, especially those related to being a small rural practice

3. *Decisionmaking around the QPP*, including general approach and strategies, as well as key considerations for deciding on QPP and MIPS options
4. *Feedback on proposed changes to the QPP for small rural practices* (e.g., modifications to exclusion thresholds; bonus points for practices being small, rural, or serving medically complex patients; virtual group option)
5. *Suggested changes to QPP policy* from interview participants
6. *Other key takeaways* that did not appear to fall under the other topics.

Because of study time constraints, we conducted a rapid qualitative analysis of key themes using manual compilation and sorting of the interview takeaway notes rather than qualitative coding software. For the summary analysis presented here, the bulleted points from each interview were extracted and compiled into separate spreadsheets per topic. Each row in the spreadsheets consisted of one bullet point, along with respondent background indicators on sampling group (Group 1, 2, 3, or 4) and practice size (very small and small) for the interview from which the point was extracted.

Each topic spreadsheet was analyzed by an investigator experienced in qualitative methods who had conducted interviews for the study. Within each topic spreadsheet, analysts sorted and grouped bulleted findings from across interviews that related to common themes, then summarized each group into a single descriptive finding with more details as necessary. The indicators on respondent background were used to help distinguish differences in themes by sampling group and practice size. The initial bulleted summary results were reviewed and discussed by the entire interview team, after which the condensed summaries were revised and refined. Many of the summary results in topic 6 (other key takeaways) overlapped with results in other topics or introduced new themes, which were incorporated into the initial five topics.

In Chapter 3, we present the results of the summary analysis of key takeaway points across the interviews.

3. Results

Practice Sample

The interview sample was roughly split between very small practices (one or two clinicians) and small practices (three to nine clinicians), as shown in Table 3.1. All physicians interviewed represented small independent practices in rural settings; none were affiliated with a larger hospital or integrated health systems. Only one physician was a member of an independent physician association (IPA), and one practiced in a Federally Qualified Health Center (FQHC).

Table 3.1. Interview Sample, by Practice Size and Group

Interview Group	Very Small (One or Two Clinicians)	Small (3–9 Clinicians)	Total
Group 1 (primary care)	5	4	9
Group 2 (specialty care)	1	2	3
Group 3 (not knowledgeable)	4	0	4
Group 4 (not eligible)	1	3	4
Total	11	9	20

According to respondents, Medicare patients on average represented 35 percent of the clientele of practices in the interview sample (median: 40 percent; range: 8–80 percent). Medicaid patients represented 19 percent and private insurance patients represented 40 percent, on average. Most practices reported using an EHR system (17 out of 20); the three practices that did not use an EHR system had no plans to adopt one. Most practices described reporting quality metrics to payers; almost all of these practices reported to Medicare (including Physician Quality Reporting System [PQRS] and Medicare Advantage plans) and about half of the respondents in these practices mentioned commercial and other payers that also required quality reporting.

Capability of Small Rural Practices to Participate in the QPP

Although it is not possible to generalize the representativeness of these interview results given the small sample size and supplementation of the random sampling with support-contractor recruitment, the findings suggest that concerns about the ability of small rural practices to actively and successfully participate in the QPP are warranted, especially for the very small (one or two clinicians) independent practices serving the most rural, isolated, and vulnerable communities.

Many of the physicians we interviewed were frustrated with the QPP and some reported feeling despondent or angry. Even those who were relatively knowledgeable about the QPP and

who had been preparing for months to participate, either on their own or with a CMS support contractor, reported frustration with the lack of clarity of program details, requirements that appeared to be determined late and were subject to change, and the amount of effort needed to participate. CMS support contractors were considered helpful, but did not substantially relieve concerns about the burden of preparation. Interviewees believed that more support was provided to other physicians by being part of larger health systems or having access to consultants viewed by interviewees as prohibitively expensive.

The QPP program itself was generally viewed as intrusive and burdensome, especially to practices that do not have EHR systems. Very few interview participants thought that MIPS would improve quality of care or reduce the reporting or compliance burden for physicians. APMs were, for the most part, not considered a viable option. Many small practices were not interested in APMs; others who expressed interest in APMs felt “stuck” with MIPS. Several respondents considered the QPP to be designed to put small independent practices out of business, whether intended or not.

At the same time, many of the practitioners were highly committed to serving their rural communities and elderly patients, and did not intend to reduce the number of Medicare beneficiaries they would see in their practices. Many of the practitioners were equally committed to remaining in independent practice and were opposed to joining larger groups or health systems, some to the point of leaving the practice of medicine if that was perceived as the only option. Even those practitioners who felt that they were prepared to successfully participate in MIPS reported that colleagues in other small rural practices were struggling with understanding or complying with the program and would likely “take the hit” (i.e., the 4-percent penalty for not reporting in MIPS or participating in an Advanced APM in performance year 2017), retire, or move toward a “cash-only” practice (i.e., charging a discounted fee for services directly to patients rather than accepting insurance reimbursement). Given past experiences in these communities with early retirements after the introduction of Meaningful Use and ICD-10 requirements and the lack of new physicians willing to move to these areas, interviewees expressed concerns about who would serve rural patients if the QPP led to fewer rural independent physicians in active medical practice.

Most interview participants valued the opportunity to provide their perspectives and feedback on the QPP to federal policymakers. Some wished that they had been asked before the policy had already been launched. A few mentioned a desire for further dialogue and to see public reports that summarize the perspectives of practices like theirs and how that information is being fed back to policymakers.

Below we provide summaries of the interview results for each major “takeaway” topic: knowledge of the QPP, concerns about the QPP, decisionmaking around the QPP, perspectives on proposed changes, and suggested changes to QPP policy from interview participants.

Knowledge of the QPP

Knowledge of the QPP varied widely across the practices interviewed, even among those required to participate. Respondents with less knowledge largely had heard of the program and often had the choice between the MIPS and APM tracks, but otherwise knew very few details. Respondents described being overwhelmed, being unsure where to start, lacking time to learn about the QPP, finding it too time-consuming to figure out the QPP, and perceiving information about the QPP to be confusing or contradictory. Some erroneously believed that they were ineligible in performance year 2017. Other practices, including some in the very small (one or two clinicians) category, seemed well versed in the details of the QPP. Respondents from larger practices appeared to know more, were better prepared, and had greater administrative and information technology (IT) support to assist with QPP preparation. The few specialty practices in the sample also seemed better prepared for the QPP.

Knowledge about the QPP and payment changes was usually received through professional conferences and sources, by searching the CMS website, or by mail and other communication from CMS or private payers.

Practices had differing levels of awareness regarding the QPP support organizations and other CMS contractors that provide technical assistance to small rural practices. Several respondents were not aware of the CMS-contracted technical assistance providers for the QPP. Respondents from practices that had been engaged by a CMS contractor providing QPP support mostly found the organizations helpful in answering questions or giving tips and advice on requirements. However, even these respondents found QPP preparation to require many tasks on the part of physicians that could not be done by external technical assistance providers or office managers within the practice, such as choosing metrics and data-reporting options. A few respondents were frustrated that QPP support and technical assistance providers either lacked knowledge in certain areas (e.g., “knew nothing about claims coding”) or were unable to get answers to specific questions from CMS.

Several respondents mentioned having been contacted by private consulting services to prepare for the QPP. Others noted that they knew of other practices that used such services. However, these services were considered expensive, even by specialists in the interview sample. Respondents also reported that EHR vendors offered training on the QPP in addition to services to ensure MIPS-compliant reporting, all of which involved fees that were similarly expensive for small practices.

Concerns About the QPP

Program Burden

Respondents reported that the QPP is burdensome to small independent practices. Small independent practices have very little infrastructure to support participation in MIPS or an Advanced APM. Physicians and their staff are generally overwhelmed with daily practice

activities and compliance with current payer requirements. Smaller staffs mean fewer people to help with figuring out requirements, managing reporting, or IT support for setting up or maintaining EHR and data-collection systems. Physicians in small practices reported feeling that their peers in larger practices or those who are part of larger groups, hospitals, or health systems have more supporting infrastructure and are more insulated from the burden of the QPP. Several primary care practices considered specialists to be better able to manage the QPP given their supposed greater ability to afford consultants, although not all rural specialists in the sample agreed.

Although MIPS consolidates previous Medicare reporting systems, most respondents did not consider it to reduce burden on practices. MIPS combines reporting under one “umbrella” but does not appear to reduce the number of reporting requirements, according to respondents. Preparing for and maintaining participation in MIPS necessitates considerable additional effort and expense. In addition to the burden of reporting, respondents were concerned with related burdens, such as increased documentation requirements, paperwork, and the need to hire additional staff. Several respondents perceived the QPP to have been modeled on “docs in big cities and in hospitals” and not on the reality of small, rural, and independent practitioners, and thus is designed—whether intended or not—to “put small independent practices out of business.” A few self-described “savvy” independent practitioners, as well as those affiliated with medical groups, felt prepared to successfully participate in MIPS but reported that many small independent practitioners, especially those without EHRs, would struggle with reporting and other requirements.

Not Reflective of Practice Quality

Nearly all respondents described the QPP as being about data reporting, not quality of care or practice improvement. Despite the range of measures included in MIPS, many respondents—including those who felt prepared for MIPS and those who did not—believed that the measures generally did not reflect the quality of care they provide. A large percentage of measures appeared more dependent on patient behavior or specialist decisions than on the care provided by primary care practices (e.g., providing an educator to help diabetics keep their condition under control who many patients refuse to see; or patients receiving timely colonoscopies, which might depend on the availability and schedules of specialists). Measures often focus on fixed benchmarks rather than on incremental—but potentially clinically meaningful—patient or practice improvement (e.g., reducing a patient’s HbA1c significantly, even if not below benchmark). Measures do not reflect the time needed to sufficiently treat patients, especially those with complex medical and social needs. Finally, it was noted that MIPS lacks measures relevant to certain specialties, requiring practices to focus on unrelated measures and issues (e.g., podiatrists screening for smoking habits). Some respondents said that asking patients for information for these unrelated measures was intrusive and unnecessary to care.

EHR and IT Costs

Several respondents both with and without current EHR systems reported that EHRs in small practices contribute to burden and require more time and expense than they appear to save. In-room and post-visit documentation takes time away from patient care. EHRs have high purchase, start-up/conversion, and maintenance costs. IT support for EHRs also is expensive, and many respondents reported that more-general IT support is difficult to find in their rural area. Specific to the QPP, EHR vendors charge high module and service fees to modify systems for MIPS reporting. Respondents from small practices with paper records believed that they provide high-quality care at a low, efficient cost and had experience collating quality data. However, the QPP did not appear to have a pathway ready for manual online data reporting.

Penalty Disadvantage

Respondents expressed concern that small independent practices are at greater risk of being penalized under the QPP than larger practices or those affiliated with a larger hospital or health system. Many respondents reported believing that participating in the QPP represents a great deal of effort for dwindling reimbursement and little prospect of improving care or receiving additional payment. Several respondents from practices that had made an effort to prepare for MIPS were concerned that they will “jump through the hoops” to participate and still be penalized. Similarly, practices do not want to be penalized for inabilities or deficiencies in reporting rather than for providing poor quality of care. Respondents from very small practices feared having difficulty competing with more-resourced practices on certain measures, especially measures that are likely to be reported by many practices (e.g., screening for falls, preventive procedures).

Lack of Clarity and Certainty

Respondents reported a lack of clarity and certainty in QPP requirements. Even practices that were knowledgeable of the QPP or engaged with QPP support providers reported frustration with requirements either being set late or shifting, key details of QPP implementation not being revealed, and the inability of CMS or QPP support providers to answer questions that are important for practices in order to prepare for participation. For example, one respondent noted that, because requirements and guidance were released late in 2017, the respondent’s EHR was not ready to collect the required data and there was no system in place to transmit the data. Another physician noted that, although he was required to submit data in 2017, the registry in which he was supposed to manually submit data was not expected to be ready until 2018. Similarly, he believed that he submitted some data via claims coding but has not been able to verify whether CMS has received them. Other respondents appreciated changes made to increase flexibility and options within MIPS but were concerned that not enough lead time had been given for participants to take changes into account, adding to perceptions that CMS is “changing rules after the game has started.” A few respondents requested information be conveyed in clearer, “simple English,” rather than “legalese” or technical language. Several respondents

reported spending a great deal of time—from several months to a year—attempting to prepare for the QPP but still feeling far from being able to participate.

Decisionmaking Around the QPP

QPP Participation and Track

The interviewees were split among practices planning to participate in the QPP, those expecting not to participate, and those still trying to decide. All respondents in our sample who were planning to participate in the QPP expected to do so through MIPS. Providers in larger practices, those affiliated with medical groups, and those in specialty practice appeared more likely to report participating at some level compared with primary care providers in very small practices (one or two clinicians). The major factor discussed by respondents in deciding to participate was whether the cost (in time and money) was expected to be more than the 4-percent penalty for not participating. Even respondents who planned to participate in the QPP predicted that it would be more cost-effective for many other small rural practices to not participate, especially if those practices did not have an EHR or experience reporting quality data.

The Advanced APM track was not considered to be a viable option by any respondent in this sample, or one that most respondents were interested in. Many respondents, including those that expressed interest in APMs, noted that there were no APMs in their areas to join, or that the nearest APMs (typically accountable care organizations) were too far away from their patient populations. APMs were generally viewed as requiring too much financial risk for small practices operating on thin margins, imposing too much overhead cost and additional administrative burden, and being too intrusive to the care that practices provide to patients. Several practices had previously participated in an accountable care organization but eventually pulled out because of issues with data submission and performance scoring, interference with patient care (e.g., attempting to provide disease management or other services to patients without coordinating with the practice), and confusing or inappropriate communication with patients. One practice currently participates in an accountable care organization, but it includes very few of their patients (only about 30 individuals). Another practice that had considered the Advanced APM track eventually decided that the 5-percent bonus probably would not be worth the investment.

MIPS Performance Categories

Respondents discussed issues in complying with each of the four performance categories used by the MIPS track to calculate incentive payments: quality measures, care improvement activities, advancing care information, and cost measures.

Quality measures: Practices expecting to participate in MIPS planned to select measures that were the easiest to collect and/or metrics in which they were confident their practice could do well. For most of these practices, selected metrics were ones they were used to reporting for PQRS. Few respondents considered the selected metrics to be particularly reflective of the

overall quality of care their practices provide. Respondents from practices expected to participate in MIPS were planning to report data for either the one-year or 90-day options, rather than the “test report” option (of as little as one measure for any period), which, although avoiding a downward payment adjustment, would not offer the opportunity for a bonus. These respondents were from practices with EHR systems and had experience with quality reporting, so they preferred to try for a bonus as long as they were making the effort to participate in MIPS.

Care improvement activities: Most respondents were not concerned with attesting to improvement activities because it was considered an exercise in documenting activities their practices were already planned to undertake. Respondents from two very small practices were concerned that some of the activities that would fulfill the improvement activities category were activities for which they did not have the staff to continue (e.g., expanded clinic hours), while another respondent reported feeling that some approved activities were “tone deaf” to daily practice concerns (e.g., automated systems for patients to schedule their own appointments would not prevent the scheduling of two talkative patients back to back).

Advancing care information: Most practices that currently have certified EHR systems were not concerned with the requirements under MIPS. However, most respondents believed that practices that do not have EHRs or experience with previous CMS incentive programs (e.g., Meaningful Use) will find it nearly impossible to adopt systems and certify to the requirements in time to comply with MIPS this year. Some respondents in our sample who do not currently have an EHR system were highly resistant to the notion of adopting one. Other respondents believed that many practitioners who have not adopted EHR systems by now would tend not to be amenable to new IT support or incentives even if made available.

Cost measures: Several respondents were very concerned about the cost measures, even though they were to be weighted at zero in the performance score for 2017. They were worried because they have little control over patients’ use of medical care at other facilities and the prices other providers charge. There were concerns that practices would not receive the cost data with enough time to know how it will affect their cost performance. There was also uncertainty with regard to how CMS will weight or use the cost performance measures in the future.

Avoiding QPP Eligibility

Nearly half of the respondents stated that they would consider ceasing to accept insurance (transitioning to either a “cash-only” or a concierge model of practice) or leaving active medical practice (e.g., retiring, forensics consulting, or working in a nonmedical field), rather than joining larger systems to relieve reporting burdens under the QPP or other payor requirements. Those who would remain in practice, even if not accepting insurance, also stated an intention to not decrease the number of Medicare-eligible elderly patients they currently see. Respondents in the sample tended to be strongly committed to their rural communities and elderly patients and did not foresee reducing the number of Medicare beneficiaries they see because of the QPP, even though they recognize that other practices have done so.

In particular, several respondents noted that reducing Medicare patients was not an option given the demographics of their communities—“if you’re not seeing Medicare patients, you’re not in practice.” One physician noted that while many small rural practices will continue to serve Medicare beneficiaries, the quality metrics under the QPP could incentivize providers to refuse patients they considered noncompliant, many of whom represent the most complex and needy cases.

Many physicians in the sample were equally committed to independent practice and were not interested in joining larger groups or systems. Most of these respondents were concerned that larger groups or systems entail pressures to see more patients and make other practice modifications at the expense of care quality. Other respondents were concerned about the costs and overhead of affiliating with larger systems.

More than one-quarter of the interviewees reported that they or other physicians they know in small rural practices would retire early or leave active medical practice if QPP reporting and requirements became too onerous. Respondents noted that few younger physicians are moving to rural communities and those who did would find it difficult to set up an independent practice. Some respondents also thought that larger groups and systems would be unlikely to want to serve the most remote communities, greatly impeding access to care for elderly patients in those areas.

One-fifth of respondents discussed interest in moving to either a “cash-only” practice (i.e., charging a discounted fee for services directly to patients rather than accepting insurance reimbursement) or the possibility of becoming a concierge practice (i.e., charging a retainer fee to serve as the exclusive physician to a smaller panel of patients) if the QPP and other requirements become too burdensome. “Cash-only” practice was perceived as a more sustainable model for continuing to serve rural patients by reducing the practice overhead imposed by insurers while allowing for sliding-fee schedules for lower-income clients. Of the two practices that discussed the possibility of becoming a concierge medical practice, only one respondent believed that there were enough affluent patients in the area to make the concierge model feasible.

Feedback on Proposed Changes to the QPP

Respondents provided feedback on proposed changes to the QPP with regard to exclusion thresholds, bonus-point adjustments, and virtual groups.

Exclusion Thresholds

Many practices welcomed raising the thresholds to exclude more small practices. However, a few respondents were concerned that many small practices would still be included under both the current and proposed thresholds because the thresholds are based on a practice’s proportion of patients or revenues from Medicare—as opposed to its size and rural location. Respondents noted that these practices are the most burdened by QPP requirements and least able to absorb any penalties. These respondents typically did not believe that they had enough information to

determine how high the thresholds should be set, although one respondent estimated that somewhere in the range of 500 Medicare patients would be a more reasonable threshold for exclusion. Other respondents were similarly concerned that raising the thresholds could create disincentives for certain practices to see Medicare beneficiaries or unduly disadvantage practices that bear the brunt of serving vulnerable populations.

Bonus-Point Adjustments

Practices also generally welcomed adding bonus points to MIPS performance scores for practices that are small, serve complex patients at high risk, and are located in rural areas. Bonus points for being a small practice and serving complex patients were considered to be more helpful or appropriate than those for simply being rural.

Small practices: Bonus points for being a small practice were considered particularly helpful because smaller practices have less infrastructure for navigating and complying with the QPP and are less able to absorb payment reductions.

Serving complex, high-risk patients: Added bonus points for serving a high proportion of such patients also was considered helpful because current MIPS measures were viewed as not sufficiently taking into account the added time and resources that complex patients require or adequately adjusting for these patients' poorer outcomes. Respondents observed that many small rural practices manage such patients with relatively few resources.

Rural practices: Several respondents noted difficulties specific to rural practices for which bonus points would help adjust, such as transportation challenges for patients, poor internet connections for practices (even in areas that do not currently qualify for an internet hardship exemption under MIPS), and certain conditions of rural life (e.g., hypertension common at high elevations).

Other respondents cautioned about the use of rurality for adjusting bonus points, noting the challenge of defining truly rural practices serving poor, underserved, isolated communities (who are most at risk), and questioning whether practices affiliated with larger groups, hospitals, or health systems need the adjustment simply for being located in a rural area. Many respondents also had difficulty assessing, or were skeptical of, the effects of the bonus-point adjustments without greater clarity on the structure of the performance scoring system and the expected degree to which these adjustments would account for practice conditions and change performance outcomes.

Virtual Groups

Most respondents were not interested in a virtual group option. Virtual groups were perceived to entail an additional burden (e.g., requiring at least one practice to take the initiative to organize) that respondents were not willing to accept. Others were concerned about combining their performance with other practices that might not be as high-performing as their own, or with finding enough local practices with which they would be comfortable forming a virtual group.

A few practices did express interest or see value in the virtual group option. The leader of one high-performing small practice thought it was an interesting option to “band together” and had several local practices of similar size and philosophy in mind; he would not be interested in grouping with “just anyone.” Respondents from one of the small practices (three to nine clinicians) believed that it could be a useful option for smaller practices, although not for their own. Respondents from a third practice thought that the virtual group option sounded similar to a primary care consortium of small practices being organized in their area by a large regional health system specifically to achieve “strength in numbers” for reporting (with no other care coordination or risk-sharing involved).

It is not clear from these results that the small practices that could most benefit from a virtual group arrangement would be most likely to pursue the option or feel sufficiently capable of forming a virtual group without substantial external initiative or support.

Suggested Changes to QPP Policy

Interview participants suggested the following changes to QPP and Medicare policy to improve the ability of small rural practices to participate in the program:

- **Increase clarity** by providing guidance in less “bureaucratic” and “legalese” language. Provide more-specific instructions on what practices need to do to comply with and implement the QPP and MIPS, perhaps even through a “MIPS for Dummies” guide. Several respondents mentioned difficulty answering questions about the effects of the QPP on their practices because they did not have a clear understanding of key requirements.
- **Hold steady, provide greater certainty.** The periodic rule-changing without sufficient lead time was considered difficult for many practices, even if the changes are well-intentioned by CMS. For example, one respondent noted that changes were being discussed in fall 2017 that would go into effect four months later.
- **Delay implementation for small practices.** Because many small practices were not ready or aware of the need to report for MIPS by early October 2017 and because of the perceived lack of clarity and late or shifting requirements on CMS’s part, it was suggested that Medicare delay implementation of all or some requirements for small practices.
- **Avoid penalizing small practices that serve vulnerable populations** and that are least able to absorb payment reductions. The main concern for several respondents was the effect of QPP burden on small practices in ways that would reduce access and service to vulnerable elderly rural populations. Other respondents reported feeling that it is appropriate to reward practices that take on the expense of EHRs, infrastructure, and other burdens of complying with the QPP, but did not want to punish practices that find it difficult to comply and face the threat of closing.
- **Instead of adding bonus points, consider adjusting the penalty** that small rural practices serving complex patients might receive. This would ensure that the impact on practices would be adjusted for these factors, and practices might be more amenable to taking what would be considered a “partial hit.”

- **Consider less obtrusive models for assessing the quality of small practices.** One respondent suggested that such methods as observational site visits, similar to teacher in-classroom assessments, might be less burdensome and more accurately capture quality in small practices.
- **Provide additional IT support for small rural practices,** including those that currently have EHR systems. Although many small independent practices without EHRs might not be interested in adopting these systems, the systems themselves are beyond the resources and capacity of many small practices that would consider adoption. Complying with the QPP requires significant expense and effort on the part of small practices that already have certified EHR systems, as well as the need for more-reliable local IT infrastructure (including internet connections, the ability of other providers to interface electronically, and local computer support and repair services).
- **Simplify requirements and reduce burden.** Several respondents made a general plea to simplify requirements and reduce burden, especially for small independent practices.
- **Increase engagement of rural physicians** by soliciting rural practice input earlier in policy development and directing dialogue and observation (e.g., site visits) with practitioners to better understand the realities of small, independent rural practices.

4. Limitations of This Research

This research effort was subject to several limitations. Response rates to recruitment calls were relatively low, particularly among the randomly sampled practices. Given the short time frame for this project, there was limited time for follow-up efforts and other methods to increase response rates. Response rates were higher for practices referred by technical assistance providers. This likely led to two different types of bias. First, respondents recruited without referral were less likely to be knowledgeable about and engaged with MACRA, the QPP, or Medicare policy in general. Second, respondents recruited through referral were more likely to be engaged in preparation for the QPP. In addition, generalizability of the study findings is limited by the small sample size.

Because of time and resource constraints, our sample was limited to a maximum of nine respondents in each group. We did not follow typical qualitative methodological approaches of recruiting until achieving thematic saturation given the short time frame. Although the sample frame was constructed to ensure heterogeneity in geographic location and practice size, the sample is not generalizable to a national population of small rural physician practices. The sample also excluded certain groups eligible for the QPP, including nonphysician practitioners. Their experiences might differ from those included in this study's sample.

Another limitation related to sampling is that zip codes are not always homogeneous with regard to rurality and some small practices might fall under the TIN of a larger organization, limiting our ability to accurately identify small rural practices. We were able to verify the size and location of practices individually during the screening process, which partially mitigated this limitation. However, this might be more of an issue for studies with larger samples.

Given the multiple payers and systems for which medical practices must report quality data, it is also possible that respondents could confuse the requirements of the QPP with those of other insurer programs and health plans. To avoid this confusion, we asked physicians about reporting programs and requirements for other payers. Many respondents shared their thoughts about quality reporting in general, which also have been noted in the results.

5. Recommendations for Follow-Up Research

This research provides important information about the perspectives of small rural practices on the QPP but was subject to several important limitations, as noted earlier. In the following sections, we provide several recommendations for potential future follow-up research, which we have grouped into two categories: topics and recruitment methods.

Extensions to the Sample and Topics

This research effort included a limited number of interviews and limited time for analysis of interview data. Future follow-up research could address these limitations by

- interviewing more than nine individuals per group (sample size should be determined by achievement of thematic saturation, which would be expected to occur in the range of 15–20 interviews per group)
- analyzing interview transcripts using rigorous qualitative research methods supported by qualitative analysis software.

The results of this study also suggested several research directions that would be candidates for future follow-up research. Possible research directions include

- expansion of the sample frame to include a broader range of small practices. The results of this study indicate that rural status is identified as less of a barrier to QPP engagement than status as a small independent practice. The sample frame could be expanded to add other types of respondents, including
 - small practices in urban and suburban locations
 - MIPS-eligible clinicians other than physicians (e.g., nurse practitioners)
 - small practices affiliated with health systems for contrast with small independent practices
 - practices at the higher end of the “small practice” range (ten–15 clinicians and possibly larger). This would provide a contrast with the range of small and very small practices (one to nine clinicians) included in this study.
- interviews with QPP technical assistance providers. The results of this study indicate that in some cases, physicians’ perspectives of available support might differ from CMS’s goals. Interviews with technical assistance providers could provide useful insights that complement physicians’ perspectives on technical assistance, particularly if they are conducted by an independent evaluator on a confidential basis and conducted with assistance providers rather than managers.
- analysis of the potential unintended consequences of the QPP related to small rural practices. Several respondents indicated that they would retire, move to cash-only practices, or stop seeing Medicare patients to avoid the QPP. Analyses could be conducted to quantify the actual and potential effects of these responses on Medicare beneficiaries’ access to care.

- site visits with selected small rural practices to supplement telephone interviews to provide richer information on how practices are responding to the QPP and the practice setting.

Recruitment Methods

Future follow-up research could include additional recruitment of the sample identified for this study. The limited time frame of this study required a short window for recruitment and scheduling of interviews. This study provided a useful pilot of recruitment procedures for physicians in small rural practices, but we identified the following important barriers to recruitment:

- Physicians in targeted practices are extremely busy and are focused on patient care. Specialists were particularly likely to report not having time to participate.
- Interviews often needed to be scheduled outside of clinic hours and frequently needed to be rescheduled because of urgent changes in physician schedules.
- Physicians in small rural practices frequently use faxes as a primary method of communication; the sample frame data sources we used did not include fax numbers or email addresses.
- Practice phone numbers in the publicly available data sources used to construct the sample frame were sometimes out of service or incorrect.
- Physicians—particularly specialists—often practice in multiple locations, so it can be difficult to locate them during recruitment.
- Physicians often rely on practice managers for participation in such programs as the QPP and recommended that we interview them (we offered to include practice managers on calls, but required that the physician also be present).

These lessons could be addressed in recruitment procedures for future follow-up research. It is challenging to make direct contact with a physician in any practice, particularly when the purpose of the contact is not related to the direct care of specific patients. Personal outreach can help, so in future follow-up research, it might be useful to consider recruiting through local chapters of professional societies, which could either suggest practices or provide a letter of support. A letter of support from the research sponsor (ASPE/CMS in the case of this study) sent to practices in the initial recruitment letter could help to legitimize the request. A recommended recruitment approach would be to send an official letter and fax if possible; time the first phone call so that it occurs right after receipt of the letter; allow for sufficient time for follow-up; and provide flexible hours for scheduling interviews, planning for a high rate of cancellations and rescheduling requests because of schedule conflicts.

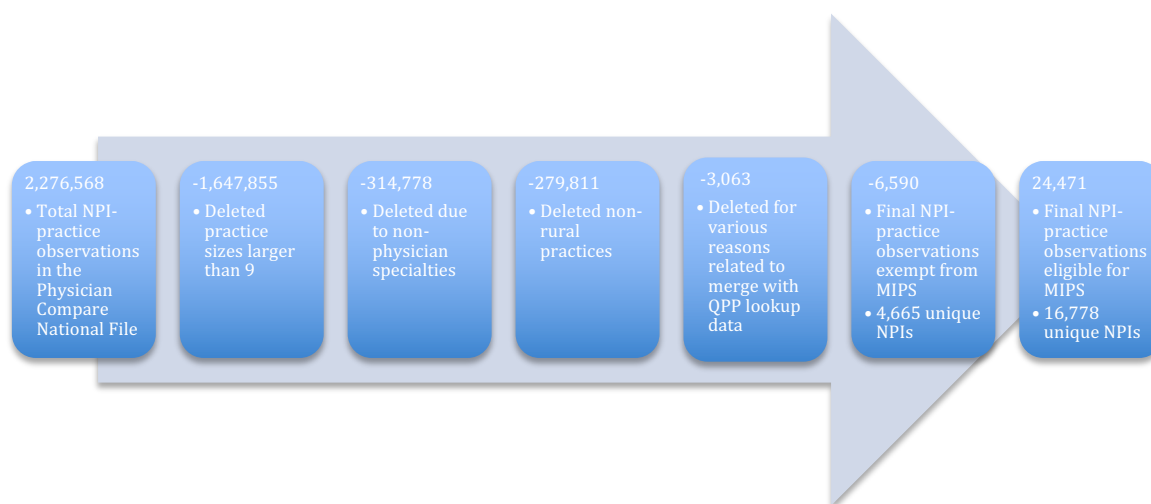
6. Conclusion

Despite the small sample size and limitations with regard to the representativeness of results, the findings of this research suggest that concerns about the ability of small rural practices to actively and successfully participate in the QPP are warranted, especially for the very small (one or two clinicians) independent practices serving the most rural, isolated, and vulnerable communities. Particular implications of the findings are the need to (1) verify whether these concerns are more widely shared among small rural and small nonrural practices and nonphysician MIPS-eligible clinicians (per the recommended extensions for future research); (2) evaluate the extent to which accommodations and changes in policies implemented since this study was conducted have addressed these concerns; and (3) examine the utility and feasibility of other policy and implementation solutions suggested by the respondents to this study.

Appendix A. Sample Frame Methods

In this appendix, we describe our methods for sampling small rural physician practices. The final sampling frame included 16,778 physicians eligible for MIPS (sampling Groups 1–3) and 4,665 exempt from MIPS (sampling Group 4), which we show in Figure A.1.

Figure A.1. Summary of Steps in the Creation of the Sampling Frame File



We started with the sample of clinicians from the Physician Compare National Downloadable File for 2015.⁸ The unit of observation is the professional/enrollment record/Group Practice/address; clinicians with multiple Medicare enrollment records and/or single enrollments linking to multiple practice location addresses are listed on multiple lines. In some cases, this reflects multiple practices, but in other cases it may reflect multiple address records for a single practice.

Second, we dropped 1,647,855 NPI-practice observations with more than nine clinicians in the practice. Missing practice size is assumed to represent one (solo practice). See Table A.1 for the distribution of practice sizes among the excluded practices.

⁸ CMS, “Physician Compare National Downloadable File” (filename “Physician_Compare_National_Downloadable_File.csv”), data set, 2015 (downloaded August 2, 2017).

Table A.1. Distribution of Practice Sizes (Number of Clinicians) Among Excluded NPI-Practice Observations

Percentiles	Number of Clinicians
1%	10
5%	14
10%	19
25%	49
50%	201
75%	792
90%	1,831
95%	2,290
99%	7,364

Third, we dropped 314,778 observations with primary specialty indicating a nonphysician. Although several clinician types, such as physician assistants, certified registered nurse anesthetists, nurse practitioners, and clinical nurse specialists are MACRA-eligible clinician types, we only sampled and interviewed physicians for this project. See Table A.2 for the specialties excluded from the sample frame.

Table A.2. Specialties Excluded from Sample Frame

Primary Specialty	Frequency of NPI-Practice Observations	Percentage
Anesthesiology assistant	10	0.00
Audiologist	6,517	2.07
Cardiac electrophysiology	617	0.20
Certified nurse midwife	623	0.20
Certified registered nurse anesthetist	3,501	1.11
Chiropractic	57,983	18.42
Clinical nurse specialist	1,361	0.43
Clinical psychologist	32,063	10.19
Clinical social worker	36,394	11.56
Dentist	33	0.01
Nurse practitioner	36,519	11.60
Occupational therapy	3,685	1.17
Optometry	39,985	12.70
Osteopathic manipulative medicine	510	0.16
Physical medicine and rehabilitation	6,333	2.01
Physical therapy	43,494	13.82
Physician assistant	20,488	6.51
Podiatry	21,376	6.79
Registered dietitian or nutrition professional	1,797	0.57
Speech language pathologist	1,363	0.43
Undefined nonphysician type (specify)	6	0.00
Undefined physician type (specify)	120	0.04
Total	314,778	100.00

Fourth, we used Federal Office of Rural Health Policy (FORHP) data on rural zip codes to identify NPI-practice observations with addresses not in rural zip codes.⁹ We dropped 279,811 NPI-practice observations with addresses not in a rural zip code (see Table A.3).

Table A.3. FORHP Rural Status of NPI-Practice Observations

FORHP Rural Zip Code Designation	Frequency of NPI-Practice Observations	Percentage
Nonrural	279,811	89.13
Rural	34,122	10.87
Total	313,933	100.00

Next, we assigned each practice zip code to the county containing the plurality of resident addresses using data from the U.S. Department of Housing and Urban Development.¹⁰ Zip codes might span several counties; this file identifies all counties that include part of each zip code, along with the ratio of residential addresses in the zip code (county section to the total number of residential addresses in the entire zip code).

We then merged characteristics needed for balancing the sample during the recruitment process, but did not cut any observations. We used a list of Critical Access Hospitals (CAHs) to identify NPI-practice observations with: (1) a CAH in the same county and (2) a CAH in the same zip code. The CAH location data are for 1,341 CAHs identified as of July 2017 from the Flex Monitoring Team based on “CMS reports, augmented by information provided by state Flex Coordinators and data collected by the NC Rural Health Research Program on hospital closures.”¹¹ Note that because zip codes were assigned to unique counties and because counties vary widely in size, some practices that are indicated as in the same county as a CAH may be far away and vice versa. More-accurate measurement would require geocoding practices and CAHs.

We assigned a sampling region to each NPI practice based on the practice address (state). Assignments are as follows:

- Region 1—“West”: HSAG technical assistance area (California, Arizona, New Mexico, and Hawaii); NRHI technical assistance area (Oregon, Nevada, Utah, Wyoming, Montana, and Alaska); and Qualis technical assistance area (Washington and Idaho)
- Region 2—“Southeast”: Alliant GMCF technical assistance area (Florida, Georgia, South Carolina, and North Carolina), and QSource technical assistance area (Tennessee and Alabama)
- Region 3—“Northern Midwest”: Altarum technical assistance area (Minnesota, Wisconsin, Illinois, Indiana, Michigan, Kentucky, Ohio); Telligen technical assistance area (North Dakota, South Dakota, Nebraska, Iowa)

⁹ Health Resources and Services Administration, “Federal Office of Rural Health Policy (FORHP) Data Files” (file name: “forhp_eligible_zips.xlsx”), data set, December 2018 (downloaded August 11, 2017).

¹⁰ U.S. Department of Housing and Urban Development, “HUD USPS Zip Code Crosswalk Files” (file named “ZIP_COUNTY_062017.xlsx”), data set, 2017 (downloaded August 10, 2017).

¹¹ Flex Monitoring Team, “Critical Access Hospital Locations” (file named “CAH_List_07_12_17.xlsx”) data set, 2018 (downloaded August 10, 2017).

- Region 4—“Southern Midwest”: TMF technical assistance area (Colorado, Kansas, Missouri, Oklahoma, Arkansas, Texas, Louisiana, and Mississippi)
- Region 5—“Northeast”: Healthcentric Advisors technical assistance area (Maine, Vermont, New Hampshire, Massachusetts, Rhode Island, and Connecticut); Quality Insights technical assistance area (New Jersey, Delaware, Pennsylvania, and West Virginia); and IPRO technical assistance area (New York, Maryland, and Virginia).

The resulting file has 34,129 unique NPI-practice observations (23,738 unique NPIs). From this list, we generated a list of unique NPIs from this sample. We “web-scraped” a file of QPP participation status for each NPI using the CMS QPP participation tool.¹² We then merged web-scraped data with Physician Compare data by NPI:

1. We dropped 50 NPI-practice observations where the web participation lookup tool did not return any results.
2. We dropped 422 observations with practice details excluded from web lookup results because of provider type.
3. We dropped six NPI-practice observations where the web participation lookup tool returned a different NPI than the input NPI because of unknown errors.
4. We dropped 330 NPI-practice observations (215 unique NPIs) with “provider type” returned from the web participation lookup tool not equal to “Doctor of Medicine” or “Doctor of Osteopathy.” See Table A.4 for excluded physician types.

Table A.4. Specialty and Web Lookup Provider Type of Excluded Physicians

Primary Specialty (from Physician Compare)	Provider Type (from QPP Participation Lookup)—Number of NPIs						Total
	Doctor of Dental Medicine	Doctor of Optometry	Not Applicable	Nurse Practitioner	Physical Therapist	Physician Assistant	
Allergy/immunology	1	0	0	0	0	0	1
Family practice	0	1	0	1	1	2	5
General practice	0	0	0	1	0	1	2
Maxillofacial surgery	86	0	0	0	0	0	86
Neurology	2	0	0	0	0	0	2
Neuropsychiatry	4	0	0	0	0	0	4
Neurosurgery	1	0	0	0	0	0	1
Ophthalmology	0	10	4	0	0	0	14
Oral surgery	88	0	0	0	0	0	88
Otolaryngology	4	0	0	0	0	0	4
Plastic and reconstructive surgery	1	0	0	0	0	0	1
Psychiatry	7	0	0	0	0	0	7
Total	194	11	4	2	1	3	215

We dropped 2,253 NPI-practice observations without status as a small practice for any affiliated practice according to the QPP web participation lookup tool. Table A.5 shows that these 2,253 observations have a distribution of values from one to nine for group practice member count from Physician Compare. This indicates a discrepancy between practice size

¹² CMS, “Quality Payment Program: QPP Participation Status,” webpage, undated(c).

measures in Physician Compare and the QPP web participation lookup tool that cannot be easily reconciled.

Table A.5. Group Practice Member Count (per Physician Compare) for Observations That Have No Small Practice Status for Any Practice in the QPP Web Lookup Tool

Group Practice Member Count from Physician Compare	Frequency of NPI-TIN Observations	Percentage
1	191	8.48
2	137	6.08
3	195	8.66
4	219	9.72
5	237	10.52
6	245	10.87
7	280	12.43
8	337	14.96
9	412	18.29
Total	2,253	100.00

We identified 6,590 NPI-practice observations associated with 4,665 NPIs that were exempt from MIPS and included in the sampling frame for Group 4. Table A.6 reports the prevalence of Physician Compare quality measure reporting and EHR usage by MIPS eligibility status.

Table A.6. MIPS Eligibility Status, Physician Compare Quality Reporting, and EHR Usage

MIPS Eligibility Status	Number of NPIs	Reported Quality Measures	Used EHRs
Exempt from MIPS	4,665 (22%)	31.6%	8.6%
Included in MIPS	16,778 (78%)	57.4%	29.7%
Total	21,443 (100%)	51.8%	25.1%

NOTE: MIPS eligibility status reflects eligibility across all associated TINs. EHR use reflects successful participation in the EHR Incentive Program.

The resulting sample frame data file for Groups 1–3 contained 24,471 NPI-practice observations eligible for MIPS (16,778 unique NPIs). Of these, 7,154 (43 percent) were primary care and 9,624 (57 percent) were specialists.

Appendix B. Recruitment Detail

Random Sample

Table B.1. Random Sampling Recruitment Detail, by Interview Group

	Total Random Sampling Frame	Total Practices Randomly Selected	Total Practices Called	Nonresponse			Declined (Before Screening)	Screened	Not Eligible for Interview ^c	Declined (After Screening)	Completed	Response Rate ^d
				Non- Working Number	Voicemail Messages Only	Follow-Up in Progress ^b						
Group 1	7,151	383	127	19	30	22	53	3	0	1	2	2%
Group 2	9,627	567	160	46	53	37	24	0	0	0	0	0%
Group 3 ^a	—	—	3	—	—	—	—	3	0	0	3	100%
Group 4	4,665	464	97	5	58	17	13	4	0	0	4	4%
Total	21,443	1,414	387	70 (18%)	141 (37%)	76 (20%)	90 (23%)	10	0	1	9	2%

^a Group 3 was identified from screening practices in the Group 1 and Group 2 sampling frame.

^b "Follow-Up in Progress" denotes that contact was made with a practice but the decision to accept or decline participation was not yet made (e.g., message left with receptionist, told to call back, email or fax).

^c Practice size was determined to be too large (more than nine clinicians).

^d Response Rate = Completed / Total Practices Called.

Table B.2. Random Sampling Recruitment Detail, by Interview Region

	Total Random Sampling Frame	Total Practices Randomly Selected	Total Practices Called	Nonresponse		Follow-Up in Progress ^a	Declined (Before Screening)	Screened	Not Eligible for Interview ^b	Declined (After Screening)	Completed	Response Rate ^c
				Non-Working Number	Voicemail Messages Only							
Region 1	3,314	284	154	39	58	24	28	6	0	0	6	4%
Region 2	4,863	274	73	7	26	9	30	2	0	0	2	3%
Region 3	4,511	289	61	4	18	22	15	2	0	1	1	2%
Region 4	5,440	282	16	0	6	3	7	0	0	0	0	0%
Region 5	3,315	285	81	20	33	18	10	0	0	0	0	0%
Total	21,443	1,414	387	70 (18%)	141 (37%)	76 (20%)	90 (23%)	10	0	1	9	2%

^a "Follow-Up in Progress" denotes that contact was made with a practice but the decision to accept or decline participation was not yet made (e.g., message left with receptionist; told to call back, email, or fax).

^b Practice size was determined to be too large (more than nine clinicians).

^c Response Rate = Completed / Total Practices Called.

Contractor Referral

Table B.3. Contractor Referral Recruitment Detail, by Interview Group

	Total Contractor Referrals Provided	Total Contractor Referrals Called	Nonresponse		Follow-Up in Progress ^b	Declined (Before Screening)	Screened	Not Eligible for Interview ^c	Declined (After Screening)	Completed	Response Rate ^d
			Non-Working Number	Voicemail Messages Only							
Group 1	14	14	0	4	3	0	7	0	0	7	50%
Group 2	12	12	0	8	0	0	4	0	1	3	25%
Group 3 ^a	2	2	—	—	—	1	1	0	0	1	50%
Group 4	0	0	—	—	—	—	—	—	—	0	0%
Total	28	28	0 (0%)	12 (43%)	3 (11%)	1 (4%)	12	0	1	11	39%

^a Group 3 was identified from screening practices in the Group 1 and Group 2 sampling frame.

^b "Follow-Up in Progress" denotes that contact was made with a practice but the decision to accept or decline participation was not yet made (e.g., message left with receptionist; told to call back, email, or fax).

^c Practice size was determined to be too large (more than nine clinicians).

^d Response Rate = Completed / Total Contractor Referrals Called.

Table B.4. Contractor Referral Recruitment Detail, by Interview Region

	Total Contractor Referrals Provided	Total Contractor Referrals Called	Nonresponse		Follow-Up in Progress ^a	Declined (Before Screening)	Screened	Not Eligible for Interview ^b	Declined (After Screening)	Completed	Response Rate ^c
			Non-Working Number	Voicemail Messages Only							
Region 1	8	8	0	2	1	0	5	0	1	4	50%
Region 2	0	0	—	—	—	—	—	—	—	0	0%
Region 3	8	8	0	2	0	1	5	0	0	5	63%
Region 4	12	12	0	8	2	0	2	0	0	2	17%
Region 5	0	0	—	—	—	—	—	—	—	0	0%
Total	28	28	0 (0%)	12 (43%)	3 (11%)	1 (4%)	12	0	1	11	39%

^a "Follow-Up in Progress" denotes that contact was made with a practice but the decision to accept or decline participation was not yet made (e.g., message left with receptionist; told to call back, email, or fax).

^b Practice size was determined to be too large (more than nine clinicians).

^c Response Rate = Completed / Total Contractor Referrals Called.

Appendix C. Interview Protocols

MACRA QPP: Small Rural Practices

Interview Guide

GROUP 1: Eligible with Knowledge of QPP, Primary Care

INTRODUCTION & CONSENT (~5 mins)

Description of Project and Funder

Hi, my name is [*interviewer name*] from the RAND Corporation, a nonprofit research institute. I'm joined on the line by my colleague [*notetaker name*] who will be taking notes. As was mentioned when we first contacted your practice, the U.S. Department of Health and Human Services wants to make sure that the perspectives of small and rural practices are taken into account as it rolls out the new reimbursement system for Medicare called the Quality Payment Program (or QPP).

We at RAND have been contracted by the Department's Office of the Assistant Secretary for Planning and Evaluation to conduct independent interviews regarding small and rural practices' views of this new payment system, barriers to participating, and thoughts on future improvements to the policy. Results of this study are intended to inform the implementation of and possible adjustments to the Quality Payment Program.

Why You Were Selected to Participate

We are speaking with physicians in small rural practices around the country, and we randomly identified you as a physician in such a practice. We expect the interview to last about an hour.

Risks and Benefits

- We do not anticipate any risks associated with your participation in our study.
- We are offering \$150 for participating in the interview.
- You may also value the opportunity to provide input to Medicare on payment policy for small and rural practices.

Use of the Collected Data

- We will use the information you share with us anonymously in a report to the Department of Health and Human Services on the implementation challenges and possible changes to the Quality Payment Program for small and rural practices.
- No specific quotations will be attributed to you or your practice, and no one outside the RAND research team will be told that you have participated in this interview.
- We would like to audio-record the interview to ensure that we capture all of your comments accurately. At the end of the study, we will delete all audio files.
- We will also destroy all information we have that identifies you at the end of the study.

Respondent Rights

- Your participation is entirely voluntary, and you can feel free to decline to discuss any topic at any time.

Point of Contact

- If you have any questions about this study, please contact the interview director for this study, Peter Mendel.
- If you have any questions or concerns regarding your rights as a human subject in a research study, you can contact RAND's Human Subjects Protection Committee
- Contact information for both Dr. Mendel and RAND's Human Subjects Protection Committee are provided in the background information we sent you for the interview. Do you recall receiving that information?

[This information would have been emailed—or, if they preferred not to use email, faxed to them. If not, let them know you'll resend the information after the interview, and confirm the email address or fax number to which they'd like it sent.]

- Do you consent to be interviewed?
 - *If no, stop the interview*
- Do you consent to audio recording of the interview?
 - *If no, let them know that you'll take notes during the interview instead.*

INTERVIEW QUESTIONS

PRACTICE SETTING & EXPERIENCE (~7 mins)

I'd first like to get a basic understanding of your practice.

1. The information I have says that your practice has [X#] clinician(s) and is located in [City, State].
 - a. Is that correct?
2. Is the practice affiliated with any larger organization, hospital, health system, network, or group? If so, please describe what kinds of affiliations these are and your practice's role in them.

Probe: IPA, other network membership, hospital, or health system ownership or other affiliation; ACOs [Accountable Care Organizations]; informal affiliations with other providers or systems?
3. Roughly how many total patients does the practice serve? What's your payer mix in terms of
 - a. rough proportion Medicare?
 - b. Medicaid?
 - c. privately insured?
 - d. uninsured?
4. Does the practice participate in any value-based reimbursement arrangements with payers, such as accountable care organizations (ACOs), shared savings, bundled payments, quality bonus programs, etc.?
 - a. If so, please describe the arrangements and what type of public or private payer they're with.
5. Does your practice currently report quality measures for any payer, such as Medicare, Medicaid in your state, or commercial insurers?
 - a. If yes, what types of quality measures do you report, and to whom?
6. Has your practice been involved in any type of quality-improvement activities or practice-change initiatives now or in the past (e.g., improvement collaboratives or demonstrations, patient-centered medical home, practice transformation)?
 - a. If so, what were they, and how long ago?
7. Does the practice use an electronic medical or health record?
 - a. If yes, for how long?
 - b. If not, does the practice have any plans to get one? Why or why not?

GENERAL UNDERSTANDING OF QPP/MIPS (~13 mins)

As you may know, CMS—the Centers for Medicare and Medicaid Services—has started implementing a new Medicare reimbursement system for physicians called the Quality Payment Program (or QPP).

8. First, we'd like to know what you have heard about the Quality Payment Program.

[Note: Use question to get a qualitative sense of respondent's general understanding of the QPP.

OK not to prompt much if they don't have much to say.]

9. What is your overall impression of the QPP and its approach to changing Medicare physician reimbursement?
10. How prepared do you feel for the QPP and its changes to Medicare physician payment?
11. Do you know whether you are included in the Quality Payment Program?
 - a. If yes, how did you determine whether you were included in the QPP?
Probe: Clinician Participation Letter sent to the practice? MIPS Participation Look-up Tool on qpp.cms.gov? Asked the TA Service Center?
 - b. If you do not know, how do you think you can find out?
12. Where have you received any information or assistance about the QPP? What kinds of information or support have they provided? How helpful have they been?
 - a. What about information or support from medical societies or associations? Which ones?
 - b. Other clinicians, word of mouth?
 - c. CMS? Which CMS resources? How helpful have they been?
 - d. Are there other kinds of support you're considering to use in the future to help get ready for the QPP (e.g., hire a consultant, EHR vendor)?
13. What other sources do you rely on for information about payment changes for Medicare?
14. How have you changed or do you plan to change your practice in response to the QPP or MIPS? (e.g., adding staff, looking into EHRs).
 - a. Is there anything you would like to change about your practice in response to the QPP or MIPS, but cannot implement because of some limitations? What limitations?

PERSPECTIVES ON KEY QPP/MIPS OPTIONS AND CHOICES (~20 mins)

Now I'd like to ask you about specific options and choices in the QPP.

MIPS versus APM

As you may know, under the QPP, many physicians will be required to participate in one of two quality-based payment tracks.

The first track is called the Merit-Based Incentive Payment System (or MIPS). MIPS replaces three existing physician reporting programs: the Physician Quality Reporting System (PQRS); the Physician Value-Based Modifier (VM) Program; and the Meaningful Use program that incentivized the use of electronic medical records.

The second track requires that a physician participate in an approved Advanced Alternative Payment Model (APM). Advanced APMs are CMS payment programs that tie payment to performance and involve a sufficient level of shared upside and downside financial risk, like CPC+ or Medicare accountable care organizations at financial risk for shared savings and losses.

As you may also know, one of the first decisions physicians have to make in the QPP is whether to participate through the Merit-Based Incentive Payment System (or MIPS) track **or** through the Advanced APM track.

Under MIPS, you can choose your level of participation (called “Pick Your Pace”) and can receive a payment adjustment of up to 4 percent in 2019, depending on how much you choose to report and your performance in 2017. If you don’t send in any 2017 data under the MIPS option, and you don’t participate through the Advanced APM track, then your Medicare payments will be reduced by 4 percent in 2019.

To qualify for the Advanced APM track, you must have a sufficient number of patients in an approved Advanced Alternative Payment Model. Physicians in the Advanced APM track will receive an automatic 5-percent incentive payment in 2019.

15. Have you thought about whether you would participate in the QPP through MIPS or the Advanced APM track? Which track, and why?
 - a. What are or would be the major factors in that decision? What additional information would you need?
 - b. How do you think being a small or rural practice affects that decision?

[If, in Q15, respondent indicated being in an Advanced APM: SKIP TO Q18]

[If, in Q15, respondent indicated being in an APM]: You previously indicated that your practice participates in an APM, [name of APM(s)]. [SKIP TO Q16.b]

16. Do you have any interest in participating in a Medicare APM? Why or why not?
 - a. Do you know of an APM in your area that you would consider joining?
 - b. *[If interested or already in an APM]* Are you interested in participating in an Advanced APM? What kind?
 - c. What might make it more difficult for *small* or *rural* practices to participate in an APM, especially in an Advanced APM? What might make it easier (e.g., a small amount at financial risk, lower proportion of Medicare payments through the Advanced APM, or allow a wider range of payers)?
 - d. How much would the QPP’s 5-percent automatic bonus payment be an incentive to joining an Advanced APM versus choosing the MIPS path? Why?
17. After 2026, physicians in the Advanced APM track will receive a higher annual Medicare Physician Fee update than those not in the Advanced APM track (0.75 percent versus 0.25 percent).
 - a. How might that factor into your decisionmaking of which track to participate in?
18. To what extent do you think the QPP will affect the number of Medicare patients you’ll accept to see? Why?

19. Have you considered taking the maximum MIPS payment reduction (i.e., 4 percent in 2019) rather than participate in either the MIPS or APM path of the QPP? If yes, why?
- Are you considering any strategies that would help you avoid having to participate or be eligible for the QPP? If so, what are they?
Probe: Sell practice, become an employee of a larger health system, reduce the amount of Medicare patients you see.
 - [Ask only if respondent does NOT plan on participating in QPP this first year:]* How large would the maximum MIPS payment reduction have to be for you to decide to participate?
Probe: 5 percent, 9 percent?

MIPS Options

I'd now like to get your perspectives on the different options that the MIPS path offers for levels of participation in this first reporting year, and for selecting metrics to report.

Individual versus Group

Physicians in the MIPS path also can choose whether to participate as an individual physician (using data reported for your NPI number) or as part of a group (using data reported for the group's Tax Identification Number or TIN).

20. Have you thought about whether you would participate in MIPS as an individual physician or as part of a group?
- What are or would be the major factors in that decision?
 - What additional information would you or your practice need?
 - How do you think being a *small* or *rural* practice affects that decision?

Metrics to Report

MIPS incentive payments will be calculated based on measures in four performance categories:

- ***Quality***—based on six quality measures that you select
- ***Improvement Activities***—based on attestation that you have completed up to two activities for a minimum of 90 days (for large practices and those in nonrural areas, this is higher)
 - These are activities that relate to such practice improvements as offering extended hours, conducting population health management activities, or integrating behavioral and physical health care.
- ***Advancing Care Information***—use of Certified Electronic Health Record Technology (CEHRT) to the 2015 and/or 2014 editions
- ***Costs***—cost measures calculated by CMS based on claims data (no submission needed), but won't be used as part of incentive calculations until 2018.

21. Which of these categories might *small* or *rural* practices have particular difficulty with? Why?
- What information would help you decide what to report? What help or resources have you consulted, if any?

[Only ask if it is clear that the respondent has given thought to reporting under MIPS]

Under MIPS reporting for 2017, physicians are given the choice—called “Pick Your Pace”—of whether to “test”-report data (which can be as little as one measure in any category for any period of time) to avoid any downward payment adjustment in 2019 or to report data on multiple measures for either at least 90 days or a whole year and be eligible to receive the maximum positive adjustment in 2019.

22. Have you decided or started to consider which measures to report and for what time period?
 - a. If so, are you planning to report measures in all categories? Which ones and why those?
23. *[If not covered above]* For the first performance category in particular—Quality—have you decided or started to consider which measures to report?
 - a. If so, how many quality measures are you planning to report, and for what time period?
 - b. How have you gone about deciding on the specific quality measures and time periods?
24. How does being a *small* or *rural* practice affect which categories, quality measures, and time periods to report?

MIPS Design Goals

[If, in Q5, respondent indicated that they did NOT previously report quality data to Medicare: SKIP Q25]

Streamlining. One of the concerns with previous Medicare reporting requirements was that there were too many reporting systems that physicians had to use. One of the overarching goals of MIPS was to streamline three previous physician reporting systems (namely, the Physician Quality Reporting System or PQRS; the Medicare EHR Incentive or Meaningful Use; and the Value-Based Modifier program) into one combined program through MIPS and the centralized QPP website.

25. If you’ve previously reported quality in PQRS or participated in Meaningful Use, how much do you think MIPS streamlines these previous CMS reporting programs? Do you think it will lower or increase burden from the previous programs? Why?

Flexibility. A concern in designing MIPS has been whether it will be flexible enough to allow small and rural practices to participate. So it includes such options as

- offering the different “Pick Your Pace” levels of reporting
- allowing physicians to choose the six quality measures most meaningful to their own practice and providing options to report as an individual or group
- different methods for submitting data

Small practices also have fewer improvement activities to report and aren’t assessed on readmissions, while practices with insufficient internet can apply for hardship exceptions to the EHR category.

26. Based on what you know of the program, what do you think would make it easier for small rural practices to participate in MIPS?

- a. Does it seem like there is too much flexibility in MIPS? Would you prefer a program with fewer options to accommodate different practices, but that is easier to understand?

PERSPECTIVES ON QPP/MIPS CHANGES FOR SMALL & RURAL PRACTICES (~10 mins)

We're almost to the end of the interview. Now I'd like to ask you about a few changes to QPP that CMS is considering to better accommodate small and rural practices.

Virtual Groups

One change that CMS is considering to the MIPS track is to allow solo or small practices with fewer than ten clinicians each to join together in what they call "virtual groups." It is hoped that virtual groups could help solo and small practitioners overcome barriers to participating related to reporting quality data, such as having adequate EHR systems or having enough cases for quality or cost measures.

27. Have you heard anything about the proposed virtual group option? If so, what?
 - a. How attractive would joining a virtual group be to you, and why?
 - b. What are the potential challenges with virtual groups from your perspective?
Probe: no practices with similar enough specialties to join with, having payments dependent on the quality of other physicians, concerns joining with potential competitors.

28. If you were to join a virtual group, what kinds of other solo or small practices would you want to join with (kinds of specialty, geographic distance, similar or better performance, etc.)?
 - a. What types of support or assistance would you need to form a virtual group, and who would you look to for that support?

Other Proposed Changes

CMS is considering other changes to the MIPS track. I'm going to read three:

- raising the thresholds for low-volume exclusion of small practices (from \$30,000 or 100 beneficiaries in 2017 to \$90,000 or 200 beneficiaries in 2018)
- adding bonus points to a practice's MIPS performance score for being a small practice and for serving patients with high medical complexity or social risk
- CMS also would like feedback on whether to add bonus points for being a *rural* practice.

29. Which of these changes do you think would be most helpful for small rural practices? Why?
 - a. Do all three seem helpful? Any that don't?
 - b. What others might you suggest?

SUMMARY THOUGHTS (~5 mins)

I have just a couple of wrap-up questions.

30. In general, what do you see as the main challenges that *small* or *rural* practices face with the Quality Payment Program? Which are the most important to address?

31. What changes to QPP would you suggest that would help *small* or *rural* primary care practices to participate in the program? What other changes to the program might you suggest?

MACRA QPP: Small Rural Practices
Interview Guide
GROUP 2: Eligible with Knowledge of QPP, Specialty Care

INTRODUCTION & CONSENT (~5 mins)

Description of Project and Funder

Hi, my name is [*interviewer name*] from the RAND Corporation, a nonprofit research institute. I'm joined on the line by my colleague [*notetaker name*] who will be taking notes. As was mentioned when we first contacted your practice, the U.S. Department of Health and Human Services wants to make sure that the perspectives of small and rural practices are taken into account as it rolls out the new reimbursement system for Medicare called the Quality Payment Program (or QPP).

We at RAND have been contracted by the Department's Office of the Assistant Secretary for Planning and Evaluation to conduct independent interviews regarding small and rural practices' views of this new payment system, barriers to participating, and thoughts on future improvements to the policy. Results of this study are intended to inform the implementation of and possible adjustments to the Quality Payment Program.

Why You Were Selected to Participate

We are speaking with physicians in small rural practices around the country, and we randomly identified you as a physician in such a practice. We expect the interview to last about an hour.

Risks and Benefits

- We do not anticipate any risks associated with your participation in our study.
- We are offering \$150 for participating in the interview.
- You may also value the opportunity to provide input to Medicare on payment policy for small and rural practices.

Use of the Collected Data

- We will use the information you share with us anonymously in a report to the Department of Health and Human Services on the implementation challenges and possible changes to the Quality Payment Program for small and rural practices.
- No specific quotations will be attributed to you or your practice, and no one outside the RAND research team will be told that you have participated in this interview.
- We would like to audio-record the interview to ensure that we capture all of your comments accurately. At the end of the study, we will delete all audio files.
- We will also destroy all information we have that identifies you at the end of the study.

Respondent Rights

- Your participation is entirely voluntary, and you can feel free to decline to discuss any topic at any time.

Point of Contact

- If you have any questions about this study, please contact the interview director for this study, Peter Mendel.
- If you have any questions or concerns regarding your rights as a human subject in a research study, you can contact RAND's Human Subjects Protection Committee

- Contact information for both Dr. Mendel and RAND's Human Subjects Protection Committee are provided in the background information we sent you for the interview. Do you recall receiving that information?

[This information would have been emailed—or, if they preferred not to use email, faxed to them. If not, let them know you'll resend the information after the interview, and confirm the email address or fax number to which they'd like it sent.]

- Do you consent to be interviewed?
 - *If no, stop the interview*
- Do you consent to audio recording of the interview?
 - *If no, let them know that you'll take notes during the interview instead.*

INTERVIEW QUESTIONS

PRACTICE SETTING & EXPERIENCE (~7 mins)

I'd first like to get a basic understanding of your practice.

1. The information I have says that your practice has [X#] clinician(s) and is located in [City, State].
 - a. Is that correct?
2. Is the practice affiliated with any larger organization, hospital, health system, network, or group? If so, please describe what kinds of affiliations these are and your practice's role in them.

Probe: IPA, other network membership, hospital, or health system ownership or other affiliation; ACOs; informal affiliations with other providers or systems?
3. Roughly how many total patients does the practice serve? What's your payer mix in terms of
 - a. rough proportion Medicare?
 - b. Medicaid?
 - c. privately insured?
 - d. uninsured?
4. Does the practice participate in any value-based reimbursement arrangements with payers, such as accountable care organizations (ACOs), shared savings, bundled payments, quality bonus programs, etc.?
 - a. If so, please describe the arrangements and what type of public or private payer they're with.
5. Does your practice currently report quality measures for any payer, such as Medicare, Medicaid in your state, or commercial insurers?
 - a. If yes, what types of quality measures do you report, and to whom?
6. Has your practice been involved in any type of quality improvement activities or practice change initiatives now or in the past (e.g., improvement collaboratives or demonstrations, patient-centered medical home, practice transformation)?
 - a. If so, what were they, and how long ago?
7. Does the practice use an electronic medical or health record?
 - a. If yes, for how long?
 - b. If not, does the practice have any plans to get one? Why or why not?

GENERAL UNDERSTANDING OF QPP/MIPS (~13 mins)

As you may know, CMS—the Centers for Medicare and Medicaid Services—has started implementing a new Medicare reimbursement system for physicians called the Quality Payment Program (or QPP).

8. First, we'd like to know what you have heard about the Quality Payment Program.

[Note: Use question to get a qualitative sense of respondent's general understanding of the QPP. OK not to prompt much if they don't have much to say.]

9. What is your overall impression of the QPP and its approach to changing Medicare physician reimbursement?
10. How prepared do you feel for the QPP and its changes to Medicare physician payment?
11. Do you know whether you are included in the Quality Payment Program?
 - a. If yes, how did you determine whether you were included in the QPP?
Probe: Clinician Participation Letter sent to the practice? MIPS Participation Look-up Tool on qpp.cms.gov? Asked the TA Service Center?
 - b. If you do not know, how do you think you can find out?
12. Where have you received any information or assistance about the QPP? What kinds of information or support have they provided? How helpful have they been?
 - a. What about information or support from medical societies or associations? Which ones?
 - b. Other clinicians, word of mouth?
 - c. CMS? Which CMS resources? How helpful have they been?
 - d. Are there other kinds of support you're considering to use in the future to help get ready for QPP (e.g., hire a consultant, EHR vendor)?
13. What other sources do you rely on for information about payment changes for Medicare?
14. How have you changed or do you plan to change your practice in response to QPP or MIPS (e.g., adding staff, looking into EHRs)?
 - a. Is there anything you would like to change about your practice in response to QPP or MIPS, but cannot implement because of some limitations? What limitations?

PERSPECTIVES ON KEY QPP/MIPS OPTIONS AND CHOICES (~20 mins)

Now I'd like to ask you about specific options and choices in the QPP program.

MIPS versus APM

As you may know, under the QPP, many physicians will be required to participate in one of two quality-based payment tracks.

The first track is called the Merit-Based Incentive Payment System (or MIPS). MIPS replaces three existing physician reporting programs: the Physician Quality Reporting System (PQRS); the Physician Value-based Modifier (VM) Program; and the Meaningful Use program that incentivized the use of electronic medical records.

The second track requires that a physician participate in an approved Advanced Alternative Payment Model (APM). Advanced APMs are CMS payment programs that tie payment to performance and involve a sufficient level of shared upside and downside financial risk, like CPC+ or Medicare accountable care organizations at financial risk for shared savings and losses.

As you may also know, one of the first decisions physicians have to make in the QPP is whether to participate through the Merit-Based Incentive Payment System (MIPS) track *or* through the Advanced APM track.

Under MIPS, you can choose your level of participation (called “Pick Your Pace”) and can receive a payment adjustment of up to 4 percent in 2019 depending on how much you choose to report and your performance in 2017. If you don’t send in any 2017 data under the MIPS option, and you don’t participate through the Advanced APM track, then your Medicare payments will be reduced by 4 percent in 2019.

To qualify for the Advanced APM track, you must have a sufficient number of patients in an approved Advanced Alternative Payment Model. Physicians in the Advanced APM track will receive an automatic 5-percent incentive payment in 2019.

15. Have you thought about whether you would participate in the QPP through MIPS or the Advanced APM track? Which track, and why?
 - a. What are or would be the major factors in that decision? What additional information would you need?
 - b. How do you think being a *small* or *rural* practice affects that decision?

[If, in Q15, respondent indicated being in an Advanced APM: SKIP TO Q18]

[If, in Q15, respondent indicated being in an APM]: You previously indicated that your practice participates in an APM, [name of APM(s)]. SKIP TO Q16.b

16. Do you have any interest in participating in a Medicare APM? Why or why not?
 - a. Do you know of an APM in your area that you would consider joining?
 - b. *[If interested or already in an APM]* Are you interested in participating in an Advanced APM? What kind?
 - c. What might make it more difficult for *small* or *rural* practices to participate in an APM, especially in an Advanced APM? What might make it easier (a small amount at financial risk, lower proportion of Medicare payments through the Advanced APM, or allow a wider range of payers)?
 - d. How much would the QPP’s 5-percent automatic bonus payment be an incentive to joining an Advanced APM versus choosing the MIPS path? Why?
17. After 2026, physicians in the Advanced APM track will receive a higher annual Medicare Physician Fee update than those not in the Advanced APM track (0.75 percent versus 0.25 percent).
 - a. How might that factor into your decisionmaking of which track to participate in?
18. Are there certain types of value-based payment models that you think are better suited to small, rural *specialty* practices (e.g., bundled or episode-based payment models, medical homes, accountable care organizations, other)?
 - a. Are you interested in those models? Why, what’s better about those models?
19. To what extent do you think that the QPP will affect the number of Medicare patients you’ll accept to see? Why?

20. Have you considered taking the maximum MIPS payment reduction (i.e., 4 percent in 2019) rather than participate in either the MIPS or APM path of the QPP? If yes, why?
- Are you considering any strategies that would help you avoid having to participate or be eligible for the QPP? If so, what are they?
Probe: Sell practice, become an employee of a larger health system, reduce the amount of Medicare patients you see.
 - [Ask only if the respondent does NOT plan on participating in the QPP in this first year:]
How large would the maximum MIPS payment reduction have to be for you to decide to participate?
Probe: 5 percent, 9 percent?

MIPS Options

I'd now like to get your perspectives on the different options that the MIPS path offers for the level of participation in this first reporting year and for selecting metrics to report.

Individual versus Group

Physicians in the MIPS path also can choose whether to participate as an individual physician (using data reported for your NPI number) or as part of a group (using data reported for the group's Tax Identification Number or TIN).

21. Have you thought about whether you would participate in MIPS as an individual physician or as part of a group?
- What are or would be the major factors in that decision?
 - What additional information would you or your practice need?
 - How do you think being a *small* or *rural* practice affects that decision?

Metrics to Report

MIPS incentive payments will be calculated based on measures in four performance categories:

- ***Quality***—based on six quality measures that you select
 - ***Improvement Activities***—based on the attestation that you have completed up to two activities for a minimum of 90 days (for large practices and those in non-rural areas, this is higher)
 - These are activities that relate to such practice improvements as offering extended hours, conducting population health management activities, or integrating behavioral and physical health care.
 - ***Advancing Care Information***—use of Certified Electronic Health Record Technology (CEHRT) to the 2015 and/or 2014 editions
 - ***Costs***—cost measures calculated by CMS based on claims data (no submission needed), but won't be used as part of incentive calculations until 2018.
22. Which of these categories might *small* or *rural* practices have particular difficulty with? Why?
- What information would help you decide what to report? What help or resources have you consulted, if any?

[Only ask if it is clear that the respondent has given thought to reporting under MIPS]

Under MIPS reporting for 2017, physicians are given the choice—called “Pick Your Pace”—of whether to “test”-report data (which can be as little as one measure in any category for any period of time) to avoid any downward payment adjustment in 2019, or to report data on multiple measures for either at least 90 days or a whole year and be eligible to receive the maximum positive adjustment in 2019.

23. Have you decided or started to consider which measures to report and for what time period?
 - a. If so, are you planning to report measures in all categories? Which ones and why those?
24. *[If not covered above]* For the first performance category in particular—Quality—have you decided or started to consider which measures to report?
 - a. If so, how many quality measures are you planning to report, and for what time period?
 - b. How have you gone about deciding on the specific quality measures and time periods?
25. Do you have any concerns that the quality measures Medicare may be using do not capture the quality of your specialty practice? Why/Why not?
 - a. What kinds of measures may be needed to better capture the quality of your specialty practice?
26. How much do you hear from your specialty society about quality measures affecting your practice?
 - a. Have you been involved, or tried to be involved, in providing input on quality measures for your specialty? In what ways?
 - b. Will you report quality measures through a specialty society registry?
27. How does being a *small* or *rural* practice affect which categories, quality measures, and time periods to report?

MIPS Design Goals

[If, in Q5, respondent indicated that they did NOT previously report quality data to Medicare: SKIP Q28]

Streamlining. One of the concerns with previous Medicare reporting requirements was that there were too many reporting systems that physicians had to use. One of the overarching goals of MIPS was to streamline the three previous physician reporting systems (namely, the Physician Quality Reporting System or PQRS; the Medicare EHR Incentive or Meaningful Use; and the Value-Based Modifier program) into one combined program through MIPS and the centralized QPP website.

28. If you’ve previously reported quality in PQRS or participated in Meaningful Use, how much do you think MIPS streamlines these previous CMS reporting programs? Do you think it will lower or increase burden from the previous programs? Why?

Flexibility. A concern in designing the MIPS has been whether it will be flexible enough to allow small and rural practices to participate. So it includes options like

- offering the different “Pick Your Pace” levels of reporting
- allowing physicians to choose the six quality measures most meaningful to their own practice and providing options to report as an individual or group
- different methods for submitting data.

Small practices also have fewer improvement activities to report and aren’t assessed on readmissions, while practices with insufficient internet can apply for hardship exceptions to the EHR category.

29. Based on what you know of the program, what do you think would make it easier for small rural practices to participate in MIPS?
- a. Does it seem like there is too much flexibility in MIPS? Would you prefer a program with fewer options to accommodate different practices, but that is easier to understand?

PERSPECTIVES ON QPP/MIPS CHANGES FOR SMALL & RURAL PRACTICES (~10 mins)

We’re almost to the end of the interview. Now I’d like to ask you about a few changes to the QPP that CMS is considering to better accommodate small and rural practices.

Virtual Groups

One change that CMS is considering for the MIPS track is to allow solo or small practices with fewer than ten clinicians each to join together in what they call “virtual groups.” It is hoped that virtual groups could help solo and small practitioners overcome barriers to participating related to reporting quality data, such as having adequate EHR systems or having enough cases for quality or cost measures.

30. Have you heard anything about the proposed virtual group option? If so, what?
- a. How attractive would joining a virtual group be to you, and why?
 - b. What are the potential challenges with virtual groups from your perspective?
Probe: no practices with similar enough specialties to join with, having payments dependent on the quality of other physicians, concerns joining with potential competitors.

31. If you were to join a virtual group, what kinds of other solo or small practices would you want to join with (kinds of specialty, geographic distance, similar or better performance etc.)?
- a. What types of support or assistance would you need to form a virtual group, and who would you look to for that support?

Other Proposed Changes

CMS is considering other changes to the MIPS track. I’m going to read three:

- raising the thresholds for low-volume exclusion of small practices (from \$30,000 or 100 beneficiaries in 2017 to \$90,000 or 200 beneficiaries in 2018)
- adding bonus points to a practice’s MIPS performance score for being a small practice and for serving patients with high medical complexity or social risk.
- CMS also would like feedback on whether to add bonus points for being a *rural* practice.

32. Which of these changes do you think would be most helpful for small rural practices? Why?
 - a. Do all three seem helpful? Any that don't?
 - b. What others might you suggest?

SUMMARY THOUGHTS (~5 mins)

I just have a few wrap-up questions.

33. In general, what do you see as the main challenges that *small* or *rural* practices face with the Quality Payment Program? Which are the most important to address?
34. What challenges, if any, do *small rural specialty* practices face with the QPP, versus specialists in other areas? Do you feel that they are being taken into account in the QPP program?
35. What changes to the QPP would you suggest that would help *small rural specialty* practices the most to participate in the program? What other changes to the program might you suggest?

MACRA QPP: Small Rural Practices
Interview Guide
GROUP 3: Eligible with No Knowledge of QPP
(Primary & Specialty Care)

INTRODUCTION & CONSENT (~5 mins)

Description of Project and Funder

Hi, my name is [*interviewer name*] from the RAND Corporation, a nonprofit research institute. I'm joined on the line by my colleague [*notetaker name*] who will be taking notes. As was mentioned when we first contacted your practice, the U.S. Department of Health and Human Services wants to make sure that the perspectives of small and rural practices are taken into account as it rolls out the new reimbursement system for Medicare called the Quality Payment Program (or QPP).

We at RAND have been contracted by the Department's Office of the Assistant Secretary for Planning and Evaluation to conduct independent interviews regarding small and rural practices' views of this new payment system, barriers to participating, and thoughts on future improvements to the policy. Results of this study are intended to inform the implementation of and possible adjustments to the Quality Payment Program.

Why You Were Selected to Participate

We are speaking with physicians in small rural practices around the country, and we randomly identified you as a physician in such a practice. We expect the interview to last about an hour.

Risks and Benefits

- We do not anticipate any risks associated with your participation in our study.
- We are offering \$150 for participating in the interview.
- You may also value the opportunity to provide input to Medicare on payment policy for small and rural practices.

Use of the Collected Data

- We will use the information you share with us anonymously in a report to the Department of Health and Human Services on the implementation challenges and possible changes to the Quality Payment Program for small and rural practices.
- No specific quotations will be attributed to you or your practice, and no one outside the RAND research team will be told that you have participated in this interview.
- We would like to audio-record the interview to ensure that we capture all of your comments accurately. At the end of the study, we will delete all audio files.
- We will also destroy all information we have that identifies you at the end of the study.

Respondent Rights

- Your participation is entirely voluntary, and you can feel free to decline to discuss any topic at any time.

Point of Contact

- If you have any questions about this study, please contact the interview director for this study, Peter Mendel.

- If you have any questions or concerns regarding your rights as a human subject in a research study, you can contact RAND's Human Subjects Protection Committee
- Contact information for both Dr. Mendel and RAND's Human Subjects Protection Committee are provided in the background information we sent you for the interview. Do you recall receiving that information?

[This information would have been emailed—or, if they preferred not to use email, faxed to them. If not, let them know you'll resend the information after the interview, and confirm the email address or fax number to which they'd like it sent.]

- Do you consent to be interviewed?
 - *If no, stop the interview*
- Do you consent to audio recording of the interview?
 - *If no, let them know that you'll take notes during the interview instead.*

INTERVIEW QUESTIONS

PRACTICE SETTING & EXPERIENCE (~10 mins)

I'd first like to get a basic understanding of your practice.

1. The information I have says that your practice has [X#] clinician(s) and is located in [City, State].
 - a. Is that correct?
2. Is the practice affiliated with any larger organization, hospital, health system, network, or group? If so, please describe what kinds of affiliations these are and your practice's role in them.

Probe: IPA, other network membership, hospital, or health system ownership or other affiliation; ACOs; informal affiliations with other providers or systems?
3. Roughly how many total patients does the practice serve? What's your payer mix in terms of
 - a. rough proportion Medicare? Medicare Advantage?
 - b. Medicaid?
 - c. privately insured?
 - d. uninsured?
4. Does the practice participate in any value-based reimbursement arrangements with payers, such as accountable care organizations (ACOs), shared savings, bundled payments, quality bonus programs, etc.?
 - a. If so, please describe the arrangements and what type of public or private payer they're with.
5. Does your practice currently report quality measures for any payer, such as Medicare, Medicaid in your state, or commercial insurers?
 - a. If yes, what types of quality measures do you report, and to whom?
6. Has your practice been involved in any type of quality improvement activities or practice change initiatives now or in the past (e.g., improvement collaboratives or demonstrations, patient-centered medical home, practice transformation)?
 - a. If so, what were they, and how long ago?
7. Does the practice use an electronic medical or health record?
 - a. If yes, for how long?
 - b. If not, does the practice have any plans to get one? Why or why not?

GENERAL UNDERSTANDING OF QPP/MIPS (~20 mins)

As you may know, CMS—the Centers for Medicare and Medicaid Services—has started implementing a new Medicare reimbursement system for physicians called the Quality Payment Program (or QPP).

8. What have *you* heard about the Quality Payment Program?

[Note: Use this question to get a qualitative sense of respondent's general understanding of QPP. OK not to prompt much if they don't have much to say.]

9. What is your overall impression of the QPP and its approach to changing Medicare physician payment?
10. When we first called you, you indicated that you hadn't heard much about the QPP. Have you been wanting to learn more about the QPP?
 - a. *[If so]* What in particular have you been wanting to know?
11. Do you know whether you are included in the Quality Payment Program?
 - a. *[If yes]* How did you determine whether you were included in the QPP?
Probe: Clinician Participation Letter sent to the practice? MIPS Participation Look-up Tool on qpp.cms.gov? Asked the TA Service Center?
 - b. If you do not know, how do you think you can find out?
12. How do you usually get information about payment changes for Medicare?
 - a. Who in your practice usually receives or follows this type of information?
13. How prepared do you feel for the QPP and its changes to Medicare physician payment?
14. Do you expect that you will try to participate in the QPP this year? Why or why not?
15. Where have you received any information or assistance about the QPP? What kinds of information or support have they provided? How helpful have they been?
 - a. What about information or support from medical societies or associations? Which ones?
 - b. Other clinicians, word of mouth?
 - c. CMS? Which CMS resources? How helpful have they been?
 - d. Are there other kinds of support you're considering to use in the future to help get ready for the QPP (e.g., hire a consultant, EHR vendor)?
16. Have you changed or do you plan to change anything about your practice because of the introduction of the QPP?
 - a. What changes? Why?

PERSPECTIVES ON KEY QPP/MIPS OPTIONS AND CHOICES (~15 mins)

Now I'd like to ask what you think about a few specific options and choices about the QPP.

INTEREST IN MIPS versus APMs

One of the first decisions physicians have to make in the QPP is whether to participate through the program's Merit-Based Incentive Payment System (or MIPS) track **or** through the Advanced Alternative Payment Model (APM) track.

The MIPS track consolidates three current Medicare physician reporting programs and puts in place a system of incentives for quality and cost performance. Under MIPS, a physician can receive a payment adjustment of up to 4 percent in 2019 depending on how much they choose to report and

their performance in 2017. Clinicians become eligible for MIPS if they meet a volume threshold in 2017 of at least 100 Medicare beneficiaries or \$30,000 in Medicare Part B payments.

If an eligible clinician does not submit any 2017 data under the MIPS track, and they don't participate through the Advanced APM track, then their Medicare payments will be reduced by 4 percent in 2019.

To qualify for the Advanced APM track, a physician must have a sufficient number of their patients in an Advanced APM. Advanced APMs are Medicare payment programs that tie payment to performance and involve a sufficient level of shared upside and downside financial risk, like CPC+ or Next Generation ACOs. A physician participating in the Advanced APM track will receive an automatic 5-percent incentive payment in 2019.

17. Have you thought about whether you would participate in the QPP through MIPS or the Advanced APM track? Which track, and why?
 - a. What are or would be the major factors in that decision? What additional information would you need?
 - b. How do you think being a *small* or *rural* practice affects that decision?

[If, in Q17, respondent indicated being in an Advanced APM: SKIP TO Q20]

[If, in Q17, respondent indicated being in an APM]: You previously indicated that your practice participates in an APM, [name of APM(s)]. SKIP TO Q18.b]

18. Do you have any interest in participating in a Medicare APM? Why or why not?
 - a. Do you know of an APM in your area that you would consider joining?
 - b. *[If interested or already in an APM]* Are you interested in participating in an Advanced APM?
 - c. What might make it more difficult for *small* or *rural* practices to participate in an APM, especially in an Advanced APM? What might make it easier (a small amount at financial risk, lower proportion of Medicare payments through the Advanced APM, or allow a wider range of payers)?
 - d. How much would the QPP's 5-percent automatic bonus payment be an incentive to joining an Advanced APM versus choosing the MIPS path? Why?

19. After 2026, physicians in the Advanced APM track will receive a higher annual Medicare Physician Fee update than those who are not in the Advanced APM track (0.75 percent versus 0.25 percent).
 - a. How might that factor into your decisionmaking of which track to participate in?

20. To what extent do you think the QPP will affect the number of Medicare patients you'll accept to see? Why?

21. Are you or would you consider any strategies to avoid having to participate or be eligible for the QPP? If so, what would they be?

Probes: Sell practice, become an employee of a larger health system, reduce the number of Medicare patients you see?

[Ask only if the respondent does NOT plan on participating in the QPP in this first year:]

- a. How large would the maximum MIPS payment reduction have to be for you to decide to participate?

Probe: 5 percent, 9 percent??

MIPS Options

Now I'd like to ask what you think about the data reporting requirements under the MIPS track.

MIPS incentive payments will be calculated based on measures in three performance categories that physicians report, and one that CMS calculates:

- ***Quality***—based on six quality measures that the physician selects
- ***Improvement Activities***—physicians in small rural practices attest to implementing at least two practice improvements for a minimum of 90 days
- ***Advancing Care Information***—use of Certified Electronic Health Record Technology (CEHRT) to the 2015 and/or 2014 editions
- ***Costs***—cost measures calculated by CMS based on claims data (no submission needed).

22. Which of these categories might *small* or *rural* practices have particular difficulty with? Why?

- a. What information would help you decide what to report? Where might you go for help to decide what to report?

MIPS Design Goals

[If, in Q5, respondent indicated that they did NOT previously report quality data to Medicare: SKIP Q23]

Streamlining. One of the concerns with previous Medicare reporting requirements was that there were too many reporting systems that physicians had to use. One of the overarching goals of MIPS was to streamline three previous physician reporting systems (namely, the Physician Quality Reporting System, or PQRS; the Medicare EHR Incentive or Meaningful Use; and the Value-Based Modifier program) into one combined program through MIPS and the centralized QPP website.

23. If you've previously reported quality in PQRS or participated in Meaningful Use, how much do you think MIPS streamlines these previous CMS reporting programs? Do you think it will lower or increase burden from the previous programs? Why?

Flexibility. A concern in designing MIPS has been whether it will be flexible enough to allow small and rural practices to participate. So it includes options like

- offering different "Pick Your Pace" levels of reporting
- allowing physicians to choose the six quality measures most meaningful to their own practice, and providing options to report as an individual or group
- different methods for submitting data.

Small practices also have fewer improvement activities to report and aren't assessed on readmissions, while practices with insufficient internet can apply for hardship exceptions to the EHR category.

24. Based on what you know of the program, what do you think would make it easier for small rural practices to participate in MIPS?
- a. Does it seem like there is too much flexibility in MIPS? Would you prefer a program with fewer options to accommodate different practices, but one that is easier to understand?

Other Proposed Changes

CMS is considering other changes to the MIPS track. I'm going to read three:

- raising the thresholds for low-volume exclusion of small practices (from \$30,000 or 100 beneficiaries in 2017 to \$90,000 or 200 beneficiaries in 2018)
- adding bonus points to a practice's MIPS performance score for being a small practice and for serving patients with high medical complexity or social risk.
- CMS also would like feedback on whether to add bonus points for being a *rural* practice.

25. Which of these changes do you think would be most helpful for small rural practices? Why?
- a. Do all three seem helpful? Any that don't?
 - b. What others might you suggest?

SUMMARY THOUGHTS (~10 mins)

I just have a few wrap-up questions.

26. In general, what do you see as the main challenges that *small* or *rural* practices face with the Quality Payment Program? Which are the most important to address?
27. What information, help, or assistance do you need now from CMS that would help you and your practice participate in either MIPS or Advanced APMs?
28. Based on what I've told you today about how the QPP works, are you leaning any more or less toward participating in the QPP this year? Why?

MACRA QPP: Small Rural Practices
Interview Guide
GROUP 4: Not Eligible for QPP
(Assumed Little Knowledge of QPP, Primary & Specialty Care)

INTRODUCTION & CONSENT (~5 mins)

Description of Project and Funder

Hi, my name is [*interviewer name*] from the RAND Corporation, a nonprofit research institute. I'm joined on the line by my colleague [*notetaker name*] who will be taking notes. As was mentioned when we first contacted your practice, the U.S. Department of Health and Human Services wants to make sure that the perspectives of small and rural practices are taken into account as it rolls out the new reimbursement system for Medicare called the Quality Payment Program (or QPP).

We at RAND have been contracted by the Department's Office of the Assistant Secretary for Planning and Evaluation to conduct independent interviews regarding small and rural practices' views of this new payment system, barriers to participating, and thoughts on future improvements to the policy. Results of this study are intended to inform the implementation of and possible adjustments to the Quality Payment Program.

Why You Were Selected to Participate

We are speaking with physicians in small rural practices around the country, and we randomly identified you as a physician in such a practice. We expect the interview to last about an hour.

Risks and Benefits

- We do not anticipate any risks associated with your participation in our study.
- We are offering \$150 for participating in the interview.
- You may also value the opportunity to provide input to Medicare on payment policy for small and rural practices.

Use of the Collected Data

- We will use the information you share with us anonymously in a report to the Department of Health and Human Services on the implementation challenges and possible changes to the Quality Payment Program for small and rural practices.
- No specific quotations will be attributed to you or your practice, and no one outside the RAND research team will be told that you have participated in this interview.
- We would like to audio-record the interview to ensure that we capture all of your comments accurately. At the end of the study, we will delete all audio files.
- We will also destroy all information we have that identifies you at the end of the study.

Respondent Rights

- Your participation is entirely voluntary, and you can feel free to decline to discuss any topic at any time.

Point of Contact

- If you have any questions about this study, please contact the interview director for this study, Peter Mendel.

- If you have any questions or concerns regarding your rights as a human subject in a research study, you can contact RAND's Human Subjects Protection Committee
- Contact information for both Dr. Mendel and RAND's Human Subjects Protection Committee are provided in the background information we sent you for the interview. Do you recall receiving that information?

[This information would have been emailed—or, if they preferred not to use email, faxed to them. If not, let them know you'll resend the information after the interview, and confirm the email address or fax number to which they'd like it sent.]

- Do you consent to be interviewed?
 - *If no, stop the interview*
- Do you consent to audio recording of the interview?
 - *If no, let them know that you'll take notes during the interview instead.*

INTERVIEW QUESTIONS

PRACTICE SETTING & EXPERIENCE (~10 mins)

I'd first like to get a basic understanding of your practice.

1. The information I have says that your practice has [X#] clinician(s) and is located in [City, State].
 - a. Is that correct?
2. Is the practice affiliated with any larger organization, hospital, health system, network, or group? If so, please describe what kinds of affiliations these are and your practice's role in them.

Probe: IPA, other network membership, hospital, or health system ownership or other affiliation; ACOs; informal affiliations with other providers or systems?
3. Roughly how many total patients does the practice serve? How would you describe the practice's patient population in terms of
 - a. rough proportion Medicare? Medicare Advantage?
 - b. Medicaid?
 - c. privately insured?
 - d. uninsured?
4. On average, how far do your Medicare patients travel to get to your practice?
 - a. How far is the nearest medical practice that sees Medicare patients?
5. Does the practice participate in any value-based reimbursement arrangements with payers, such as accountable care organizations (ACOs), shared savings, bundled payments, quality bonus programs, etc.?
 - a. If so, please describe the arrangements and what type of public or private payer they're with.
6. Does your practice currently report quality measures for any payer, such as Medicare, Medicaid in your state, or commercial insurers?
 - a. If yes, what types of quality measures do you report, and to whom?
7. Has your practice been involved in any type of quality improvement activities or practice change initiatives now or in the past (e.g., improvement collaboratives or demonstrations, patient-centered medical home, practice transformation)?
 - a. If so, what were they, and how long ago?
8. Does the practice use an electronic medical or health record?
 - a. If yes, for how long?
 - b. If not, does the practice have any plans to get one? Why or why not?

GENERAL UNDERSTANDING OF QPP (~7 mins)

As you may know, CMS—the Centers for Medicare and Medicaid Services—has started implementing a new Medicare reimbursement system for physicians called the Quality Payment Program (or QPP).

9. First, we'd like to know what you have heard about the Quality Payment Program.
[Note: Use this question to get a qualitative sense of respondent's general understanding of QPP. OK not to prompt much if they don't have much to say.]
10. What is your overall impression of the QPP and its approach to changing Medicare physician payment?
11. How do you usually get information about payment changes for Medicare?
12. Have you looked into whether you are included in the Quality Payment Program?
 - a. If so, how?
 - b. How easy or hard was it to find out? Did you run into any problems?

Our records indicate that you currently do not meet the thresholds to be eligible for the QPP this year. But we're very interested in your perspectives on what you might do if you become eligible in the future.

13. Although you aren't currently eligible for the QPP, have you changed or do you plan to change anything about your practice because of the introduction of the QPP?
 - a. What changes, and why?
14. Do you anticipate that you may become eligible for MIPS in the future? Why?

PERSPECTIVES ON KEY QPP/MIPS OPTIONS AND CHOICES (~18 mins)

Now I'd like to briefly describe a few aspects of the QPP program and get your thoughts on them.

Interest in MIPS versus APMs

One of the first decisions physicians in the QPP have to make is whether to participate through the program's Merit-Based Incentive Payment System (MIPS) track, or through the Advanced Alternative Payment Model (APM) track.

The MIPS track consolidates three current Medicare physician reporting programs and puts in place a system of incentives for quality and cost performance. Under MIPS, a physician can receive a payment adjustment of up to 4 percent in 2019 depending on how much they choose to report and their performance in 2017. Clinicians become eligible for MIPS if they meet a volume threshold in 2017 of at least 100 Medicare beneficiaries or \$30,000 in Medicare Part B payments.

If an eligible clinician does not submit any 2017 data under the MIPS track and they don't participate through the Advanced APM track, then their Medicare payments will be reduced by 4 percent in 2019.

To qualify for the Advanced APM track, a physician must have a sufficient number of their patients in an Advanced APM. Advanced APMs are Medicare payment programs that tie payment to performance and involve a sufficient level of shared upside and downside financial risk, like CPC+ or Next Generation ACOs. A physician participating in the Advanced APM track will receive an automatic 5-percent incentive payment in 2019.

Physicians who aren't currently eligible for MIPS but who qualify for the Advanced APM track can participate in the QPP and receive the Advanced APM 5-percent bonus payment.

[If, in Q5, respondent indicated being in an Advanced APM: SKIP TO Q18]

[If, in Q5, respondent indicated being in an APM]: You previously indicated that your practice participates in a value-based payment arrangement like an ACO, medical home, or bundled payment model. Medicare calls these Alternative Payment Models (APM), [name of APM(s)]. SKIP TO Q15.b]

15. Do you have any interest in participating in a Medicare APM? Why or why not?
 - a. Do you know of an APM in your area that you would consider joining?
 - b. *[If interested or already in an APM]* Are you interested in participating in an Advanced APM?
 - c. What might make it more difficult for *small* or *rural* practices to participate in an APM, especially in an Advanced APM, which requires downside financial risk?
 - d. What might make it easier (a small amount at financial risk, lower proportion of Medicare payments through the Advanced APM, or allow a wider range of payers)?
 - e. How much would the QPP's 5-percent automatic bonus payment be an incentive to joining an Advanced APM versus choosing the MIPS track or not participating in the QPP at all? Why?

16. If, in the future, you became eligible to participate in MIPS, what would be the major factors in whether you would participate through the MIPS or the Advanced APM track, or not participate at all in the QPP? What information would you need?
 - a. How do you think being a *small* or *rural* practice affects that decision?

17. After 2026, physicians in the Advanced APM track will receive a higher annual Medicare Physician Fee update than those who are not in the Advanced APM track (0.75 percent versus 0.25 percent).
 - a. How might that factor into your decisionmaking of which track to participate in, or whether to not participate at all in the QPP?

18. To what extent do you think the QPP will affect the number of Medicare patients you'll accept to see? Why?

MIPS Reporting Requirements

Under the MIPS track, the incentive payments will be calculated based on measures in three performance categories that physicians report and one that CMS calculates:

- ***Quality***—based on six quality measures that the physician selects
- ***Improvement Activities***—physicians in small rural practices attest to implementing at least two practice improvements for a minimum of 90 days

- **Advancing Care Information**—use of Certified Electronic Health Record Technology (CEHRT) to the 2015 and/or 2014 editions
- **Costs**—cost measures calculated by CMS based on claims data (no submission needed).

19. Which of these categories might *small rural* practices have particular difficulty with? Why?
- What information would help you decide what to report? Where might you go for help to decide what to report?

MIPS Opt-In

Medicare is also considering whether to give physicians who aren't eligible for MIPS and who don't participate in an Advanced APM the choice to opt in to the MIPS program.

20. If opting in to MIPS became available, would that be something that might be of interest to your practice? Why or why not?
- Under what circumstances would opting in to MIPS be of interest? What would make it a useful or attractive option for your practice?

One of the underlying objectives of the QPP and MIPS is to move Medicare to pay for value and link payment to some level of practice performance or improvement.

21. From what you know, does the QPP or MIPS sound like an appropriate approach for Medicare value-based payment with *small rural* practices such as yours? Why/why not?
- Are there other approaches you think are more appropriate or effective for value-based payment or improving quality and costs with *small rural* practices? Which ones, and why? How do they differ from the QPP and MIPS approach?

FUTURE MIPS ELIGIBILITY (~10 mins)

22. In the future, if your practice became eligible for MIPS, do you think you would consider any strategies to avoid having to participate in MIPS or the QPP? If so, what would they be?
- Probes:* Sell practice, become an employee of a larger health system, reduce the number of Medicare patients you see?

23. In the future, if you became eligible or decided to opt in to MIPS, how much lead time would you need to prepare to participate?
- What would be important for you to know to get started?
 - Where would you go for help or support?
 - Probes:* medical society or specialty association, CMS, EHR vendor, practice consultants, etc.?

24. Have you seen or had any experience with information or support for the QPP offered by CMS, such as the QPP website, webinars, or training videos; QPP technical assistance providers; or QIN-QIOs?
- If yes, which ones? How helpful did you find them?

SUMMARY THOUGHTS (~10 mins)

I have a few wrap-up questions.

25. In general, what concerns, if any, do you have about the Quality Payment Program?
26. Would you have any particular concerns if other practices in your area started to participate in the QPP program but you were not? If yes, what concerns?
27. What challenges or needs of *small rural* practices such as yours would be important to take into account for the QPP program?
28. What feedback might you have for Medicare on what they should do for *small rural* practices such as yours that might become eligible or decide to participate later on in the QPP?

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