United States Government Accountability Office

Testimony

Before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives

For Release on Delivery
Expected at 10:00 a.m. ET
Thursday, October 19, 2023

# MEDICARE

# Performance-Based and Geographic Adjustments to Physician Payments

Statement of Leslie V. Gordon, Director, Health Care

GAO-24-107106

# GAO Highlights

Highlights of GAO-24-107106, a testimony before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives

October 19, 2023

# MEDICARE

## Performance-Based and Geographic Adjustments to Physician Payments

## Why GAO Did This Study

With Medicare enrollment and spending projected to increase, controlling program spending remains a serious long-term financial challenge. Physicians and other providers play a central role in the growth of Medicare expenditures both through the services they provide and the services they order such as diagnostic tests and referrals. In 2021, Medicare payments to approximately 1.3 million physicians and other providers were about $93 billion. This represented about 18 percent of all traditional Medicare expenditures.

For decades, Congress and CMS have worked to refine the Medicare physician fee schedule to incentivize high-quality, efficient care. For example, the Medicare Access and CHIP Reauthorization Act of 2015 authorized the Quality Payment Program.

This statement summarizes GAO's previously issued reports on (1) the Quality Payment Program and the two tracks it established to incentivize Medicare providers, and (2) geographic adjustments to physician payments.

This statement is based on GAO's October 2021 report on the MIPS, its November 2021 report on the Advanced APMs, and its February 2022 report on geographic adjustments to physician payments. Details on the objectives, scope, and methodology of this work can be found in each issued report.

View GAO-24-107106. For more information, contact Leslie V. Gordon at (202) 512-7114 or gordonlv@gao.gov.

## What GAO Found

To implement the Quality Payment Program in 2017, the Centers for Medicare & Medicaid Services (CMS) established two tracks to financially incentivize Medicare providers to deliver high quality, efficient care:

--The Merit-based Incentive Payment System (MIPS) allows eligible providers to earn performance-based payment adjustments.

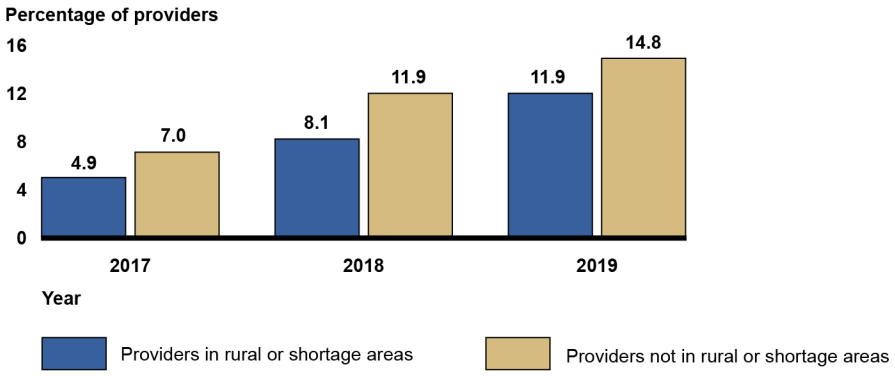
--The Advanced Alternative Payment Model (Advanced APM) encourages providers to share in the financial rewards and risk of caring for beneficiaries.

Most physicians providing Medicare services must participate in one of the two tracks.

In October 2021, GAO reported that from 2017 through 2019, at least 93 percent of providers under MIPS earned a positive adjustment while less than 5 percent qualified for a negative adjustment. The highest amount of positive adjustment was 1.88 percent.

In November 2021, GAO reported that the proportion of eligible providers who participated in Advanced APMs was lower among providers in rural or shortage areas compared to other areas in each year from 2017 through 2019. (See figure.) Most providers who participated were eligible to earn the 5 percent incentive payment, regardless of their practice area.

**Percentage of Medicare Providers in Rural or Shortage Areas and Providers Not Located in These Areas Who Participated in Advanced APMs, 2017 – 2019**




Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-24-107106

Medicare adjusts the amount it pays for physician services to account for differences in the costs of providing care across various geographic locations. Specifically, Medicare will pay more for a physician's service in an area where approximate costs for a physician's time, skills, and effort are higher than the national average and less in an area where costs are lower. GAO reported in 2022 that the modeling for geographic variation generally accounted for physician earnings in most localities (90 of 119 localities). However, in 14 localities, physician earnings were lower than the amount suggested by the analysis, and in 15 localities, physician earnings were higher.

Chair Guthrie, Ranking Member Eshoo, and Members of the Subcommittee:

I am pleased to be here today to discuss several issues that affect physician payments and physician experiences in traditional Medicare. With Medicare enrollment and spending projected to increase, controlling program spending remains a serious long-term financial challenge. Physicians and other providers play a central role in the growth of Medicare expenditures both through the services they provide and the services they order, including diagnostic tests, and referrals.[1] In 2021, Medicare payments to approximately 1.3 million physicians and other providers were about $93 billion, which represented about 18 percent of all traditional Medicare expenditures.[2] For decades, Congress and the Centers for Medicare & Medicaid Services (CMS) have worked to refine the physician fee schedule to account for geographic differences in providers' costs while also incentivizing high quality, efficient care.

Since 1992, when the Medicare physician fee schedule was put into place to determine payments for services provided by physicians and other providers (such as physician assistants and nurse practitioners), these payments have been adjusted to help ensure that Medicare payments reflect geographic differences in physicians' costs to operate a medical practice. These adjustments are known as geographic practice cost indices (GPCI). Each GPCI corresponds to one of the three main components of a Medicare physician payment—physician work, practice expense, and malpractice expense. One of the three indices—the physician work GPCI—adjusts the physician work component of the Medicare payment to account for geographic differences in the cost of physician labor (i.e., the time, effort, and skill that are associated with providing health care services).

[1]References to physicians and other providers in this report encompass all health care providers and clinicians who are eligible to participate in Medicare value-based payment models or paid under the physician fee schedule, such as physician assistants or nurse practitioners.

[2]Of the nearly 64 million Medicare beneficiaries in 2021, approximately 57 percent were enrolled in Medicare's traditional fee-for-service program, and the remaining 43 percent of beneficiaries received benefits through private plans in the Medicare Advantage program. See Centers for Medicare & Medicaid Services, Office of Enterprise Data and Analytics, CMS Chronic Conditions Warehouse, *Total Medicare Enrollment: Total, Original Medicare, and Medicare Advantage and Other Health Plan Enrollment,* accessed October 3, 2023, https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/cms-program-statistics-medicare-total-enrollment.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) authorized the Medicare Quality Payment Program, a payment incentive program that ties provider payments to the quality and efficiency of care, instead of paying providers based largely on the amount of services they provide.[3]

MACRA established two tracks for financially incentivizing high quality, efficient care, which CMS implemented in 2017. Certain Medicare clinicians—including most physicians—must participate in one of two tracks:

- **Merit-based Incentive Payment System (MIPS)**, in which eligible providers earn performance-based payment adjustments for the services rendered to Medicare beneficiaries;[4] or
- **an Advanced alternative payment model (Advanced APM)**, in which participating providers are encouraged to share in the financial rewards and risk of caring for beneficiaries.[5]

Over the last decade, we have examined several aspects of payments to physicians and other providers, and programs designed to incentivize high quality efficient care.[6] For example, in December 2015, we examined

[3]See Pub. L. No. 114-10, § 101, 129 Stat. 87, 89 (codified as amended at 42 U.S.C. § 1395w-4(q)).

[4]By law, certain Medicare providers, known as MIPS-eligible clinicians, are subject to MIPS. See 42 U.S.C. § 1395w-4(q)(1)(C); 42 C.F.R. § 414.1310(a) (2022) (applicability). For the purposes of this report, we refer to MIPS-eligible clinicians as "providers." In 2021 and subsequent years, eligible types of providers include physicians and other types of providers, such as physician assistants and nurse practitioners, among others. MIPS-eligible providers may be individuals or groups of these providers. See 42 C.F.R. § 414.1305 (2022) (definition of MIPS-eligible clinician).

[5]Pub. L. No. 114-10, § 101(c)(2)(D), 129 Stat. 87, 114. An APM is a payment approach that gives added incentive payments to providers to provide high-quality and cost-efficient care. See 42 C.F.R. § 414.1305 (2022) (definition of APM). An Advanced APM is an APM that CMS determines meets the criteria set forth in regulation pertaining to use of certified electronic health record technology, quality measures, and financial risk. See 42 C.F.R. § 414.1415 (2022) (advanced APM criteria). According to CMS, there were nine Advanced APMs in 2019.

[6]See GAO, *Medicare Physician Payment Rates: Better Data and Greater Transparency Could Improve Accuracy.* GAO-15-434 (Washington, D.C.: May 21, 2015). GAO, *Medicare: Increasing Hospital-Physician Consolidation Highlights Need for Payment Reform.* GAO-16-189 (Washington D.C.: Dec. 18, 2015). GAO, *Medicare Value-Based Payment Models: Participation Challenges and Available Assistance for Small and Rural Practices,* GAO-17-55 (Washington, D.C.: Dec. 9, 2016). GAO *Medicare: Voluntary and Mandatory Episode-Based Payment Models and Their Participants.* GAO-19-156. (Washington, D.C.: Dec. 21, 2018).

hospital-physician consolidation and found that Medicare pays a higher rate for certain services, such as evaluation and management office visits, when these visits are performed in a hospital outpatient setting rather than a physician office.[7] We recommended that Congress consider directing the Secretary of HHS to equalize payments between settings. The Bipartisan Budget Act of 2015 partially addressed this as it limits certain providers from billing at higher hospital outpatient department payment rates. To fully implement our recommendation and reduce Medicare spending by billions of dollars, Medicare payment rates for evaluation and management services should be equalized for all hospital outpatient departments. In December 2016, we reported that small and rural physician practices may be less equipped to manage any administrative, technological, or financial challenges associated with participating in payment models such as those in the Quality Payment Program.[8]

In 2023, we updated Congress on the significant risks to the federal budget and the health care sector overall due to the overall Medicare program's size, complexity, and susceptibility to mismanagement and improper payments, which were an estimated $46.8 billion in fiscal year 2022.[9] Although CMS has generally reduced improper payments over the last decade, the agency needs to continue to develop its action plan, monitor improper payments, and demonstrate progress. In March 2019, we recommended that CMS take steps to routinely assess how variations in the documentation requirements between Medicare and Medicaid may affect estimates of improper payment rates, including for physician services.[10] As of January 2023, the agency is reviewing and assessing how to best implement this recommendation.

My statement today summarizes three previously issued reports—our 2022 report on geographic adjustments to physician payments and two

[7]GAO-16-189

[8]GAO-17-55.

[9]GAO, *High-Risk Series: Efforts Made to Achieve Progress Need to Be Maintained and Expanded to Fully Address All Areas,* GAO-23-106203 (Washington, D.C.: Apr. 20, 2023). Improper payments refer to those made either in an incorrect amount or that should not have been made at all.

[10]See GAO, *Medicare and Medicaid: CMS Should Assess Documentation Necessary to Identify Improper Payments*. GAO-19-277 (Washington, D.C.: Mar. 27, 2019).

2021 reports on physicians' and other providers' participation in, and experiences under MIPS and in APMs, including Advanced APMs.[11]

Detailed information on the objectives, scope, and methodology of this work can be found in each issued report. We conducted the work on which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

# Background

## Medicare Physician Payments

Under traditional Medicare, CMS determines payment amounts for physicians' services based on the underlying relative values that CMS assigns to about 10,000 services included in the physician fee schedule. For each of these services, there are three relative value units that correspond to the three components of physician payment for each of these services.[12] In addition, CMS uses the GPCIs to adjust each of the three relative value units to account for variations in physicians' costs of providing care in different geographic areas, called payment localities. The GPCIs are numerical factors expressed as the ratio of an area's cost to the national average.[13] To calculate the Medicare payment amount for a service in a particular geographic area, each of the three relative value units for a service is adjusted by the appropriate GPCI and then converted into a dollar amount.

[11]See GAO, *Medicare: Information on Geographic Adjustments to Physician Payments for Physicians' Time, Skills, and Effort*, GAO-22-103876 (Washington, D.C.: Feb. 4, 2022), *Medicare: Provider Performance and Experiences under the Merit-based Incentive Payment System,* GAO-22-104667 (Washington, D.C.: Oct. 1, 2021) and *Medicare: Information on the Transition to Alternative Payment Models by Providers in Rural, Health Professional Shortage, or Underserved Areas,* GAO-22-104618 (Washington, D.C.: Nov. 17, 2021).

[12]The three components are 1) physician work—the financial value of physicians' labor (i.e, the time, effort, and skill that are associated with providing the service); 2) practice expense—the costs incurred by physicians in employing office staff, renting office space, and buying supplies and equipment; and 3) malpractice expense—the premiums paid by physicians for professional liability insurance.

[13]For example, in 2023, the physician work GPCI for Houston, Texas is 1.023, which means that the physician work GPCI value is 2.3 percent above the national average.

The physician work GPCI is calculated by using the wages of proxy occupations, specifically seven categories of non-physician professional occupations, such as architects, engineers, and attorneys. The physician work GPCI also has several modifications applied after it is initially calculated. One such modification is the application of a "floor" whereby any payment localities that are below the national average work GPCI value are automatically raised to the national average.[14]

## Quality Payment Program

In addition to the payment adjustments made by the GPCIs, payments to physicians and other providers may also be adjusted based on their participation and performance in the Quality Payment Program.[15] Certain Medicare providers, including most physicians, are required to participate in one of the two Quality Payment Program tracks. There are exceptions to participating, such as an exclusion for providers that serve a low volume of Medicare beneficiaries.[16]

Under the MIPS track, Medicare providers submit performance data to CMS each year. Providers' performance is generally measured in four categories—quality, cost, improvement activities, and promoting interoperability—which are used to compute an overall performance score. That overall score is then measured against the performance threshold for the year, and providers participating in MIPS may be subject to a positive, neutral (i.e., no change), or negative payment adjustment that is applied to their Medicare Part B payments made 2 years later. Under statutory budget neutrality requirements, positive adjustments resulting in increased payments to providers must be offset by negative adjustments resulting in lower payments to other providers participating in the MIPS program.[17] In 2020, about 934,000 were eligible to participate in MIPS.[18]

[14]The application of the work floor was established in 2003 and currently expires at the end of 2023. See Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 412, 117 Stat. 2066, 2274 (2003) (codified, as amended, at 42 U.S.C. § 1395w-4(e)(1)(E)); Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, Div. CC, Title I, § 101, 134 Stat. 1182, 2940 (2020).

[15]By law, certain Medicare providers, known as MIPS-eligible clinicians, are subject to MIPS. See 42 U.S.C. § 1395w-4(q)(1)(C); 42 C.F.R. § 414.1310(a) (2022) (applicability). For the purposes of this statement, we refer to MIPS-eligible clinicians as "providers."

[16]See 42 U.S.C. § 1395w-4(q)(1)(C).

[17]42 U.S.C. § 1395w-4(q)(6)(F).

[18]Providers receive a score whether or not they submitted performance data, with about 838,000 submitting performance data to MIPS.

Under the Advanced APMs, participating providers are encouraged to share in both the financial rewards and risk of caring for Medicare beneficiaries. An Advanced APM is an APM that CMS determines has met the criteria set forth in regulation pertaining to use of certified electronic health record technology, quality measures, and financial risk.[19] Only providers who participate in an Advanced APM and achieve certain payment or patient count thresholds receive an incentive payment.[20] About 235,000 providers were eligible to receive an incentive payment for their performance in 2020.

## Physician Work GPCI Generally Accounted for Geographic Variation; Modifications Could Decrease Overall Physician Payments

In February 2022, we reported that the work GPCI as implemented generally accounted for geographic variation in physician earnings in the majority of payment localities (90 of 119 localities) based on our analysis of IRS data on physician earnings and other data from 2012 to 2018.[21] In 14 localities, the work GPCI value as implemented was below the level needed to reflect geographic variation in physician earnings. In the other 15 localities, the work GPCI value as implemented was above the level needed to reflect geographic variation in physician earnings.

### Modifying the Geographic Adjustment Could Decrease Physician Payments Overall

In February 2022, we also assessed and reported on the effects of hypothetical modifications to the work GPCI, including removing the work GPCI floor, and their effects on the amount and distribution of physician payments under traditional Medicare.[22] Under the modification that removes the work GPCI floor, overall payments would decrease by $438.7 million, about 0.7 percent of all physician payments under

[19]See 42 U.S.C. § 1395l(z)(3)(D) and 42 C.F.R. § 414.1415 (2022).

[20]See 42 C.F.R § 414.1450 (2022) (APM incentive payment). For performance years 2017-2022, the incentive payment is 5 percent of their estimated aggregate Medicare Part B payments and in 2023 it is 3.5 percent. Under current law, these incentive payments will expire at the end of performance year 2023, resulting in final incentive payments in 2025.

[21]A work GPCI value is said to generally reflect geographic variation in physician earnings when the locality-specific dummy variable was not significant at the 5 percent level in the results of the model used for our February 2022 report. In addition, we use the term 'work GPCI as implemented' to refer to the 2018 work GPCI values as they were applied to Medicare payments, meaning that the work GPCI values had the floor and other adjustments applied. Additional details about our models, including the factors that we controlled for and the specific tests we used are detailed in appendix I of GAO-22-103876.

[22]GAO-22-103876

traditional Medicare in 2018.[23] Although the magnitude of payment changes across the localities varied, most of the payment localities affected would see less than 2 percent decreases in payments if the work GPCI floor was removed.

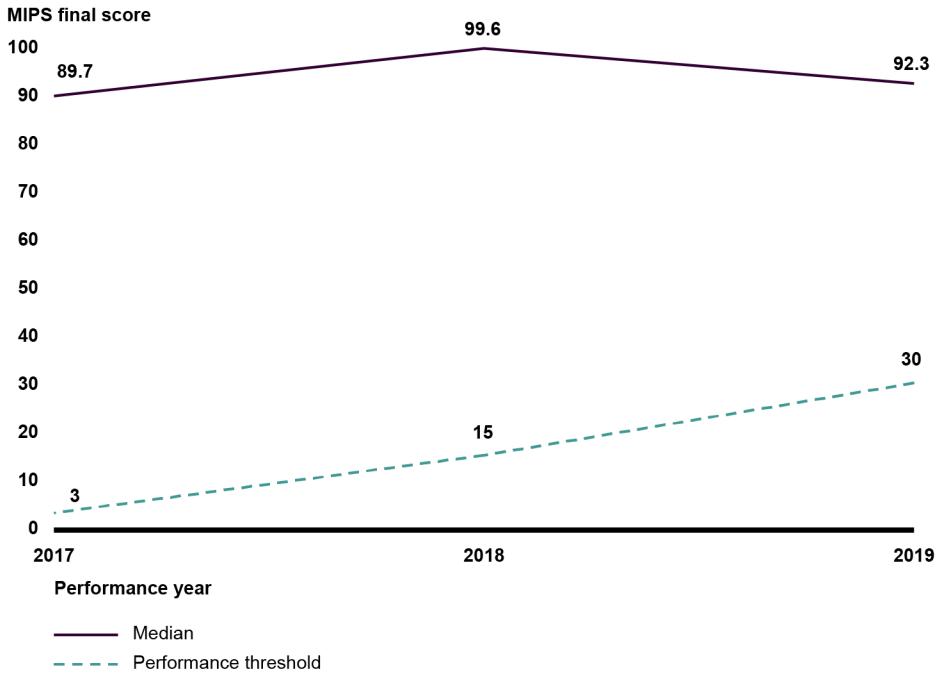
## Over 90 Percent of Providers under MIPS Earned a Small Positive Adjustment, but Provider Groups Identified Several Program Challenges

In October 2021, we reported that at least 93 percent of providers qualified for a positive payment adjustment, and less than 5 percent of providers qualified for a negative payment adjustment in any year from 2017 through 2019 (see fig. 1).[24] Since relatively few providers earned negative adjustments in 2017, 2018, and 2019, relatively few funds were available to spread out over a large number of providers who earned positive adjustments. Positive payment adjustments ranged up to 1.88 percent, depending on the year.

[23]The work GPCI is subject to a budget neutrality adjustment to ensure that total physician payments do not increase as a result of the updated GPCIs. In theory, this should keep overall Medicare physician payments the same, as localities with increases are offset by decreases in equal amounts in other localities. However, the total Medicare physician payments may increase or decrease because the budget neutrality adjustment is applied before some adjustments, like the work GPCI floor.

[24]GAO-22-104667.

**Figure 1: Median Merit-based Incentive Payment System (MIPS) Performance Scores Relative to Performance Threshold, 2017 through 2019**




Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-24-107106

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

The provider's performance score is used to determine the payment adjustment that is applied to the provider's Medicare Part B payments made 2 years later.

## Provider Groups Identified MIPS Design Strengths and Challenges

In October 2021, we also reported that stakeholders from 11 provider groups we interviewed identified some strengths of the MIPS program and some challenges for participating providers.[25] According to some stakeholder groups, two aspects of the program reportedly reduced participation burden:

- **Performance category exemption.** Three stakeholder groups said exemptions that allow providers to not report measures for one or

[25]GAO-22-104667.

more performance categories in a given year helped to reduce reporting burdens for certain participating providers.[26]

- **Low-volume threshold exemption.** Two stakeholder groups said the low-volume threshold—the minimum Medicare Part B patient, billing, and service volume requirements for participation in MIPS—reduced participation burden for smaller practices by exempting them from participation.

We also reported that stakeholders from the 11 provider groups we interviewed discussed several challenges for providers participating in the MIPS program:

- **Performance feedback was not timely or meaningful.** Ten stakeholder groups said the feedback providers received from CMS about their performance was not timely and left providers with insufficient time to make changes to improve their performance for the current year. Stakeholders also said that CMS could provide more meaningful feedback by, for example, providing comparative data on how providers are performing compared to other providers of similar specialty or practice size.
- **Some measure reporting may not improve quality of care.** Eight stakeholder groups questioned whether the MIPS program helped to meaningfully improve quality of care or patient health outcomes. For example, some stakeholders said that because providers can choose which quality measures they want to report, they may report those on which they are performing well or that are easy to achieve instead of those where they may need improvement or that are clinically relevant. Stakeholders also said some of the specialty-specific measures assessed providers' performance on infrequent activities or events instead of those that were clinically common. For example, one measure related to emergency medicine called for providers to report information on the percentage of adult patients who were prescribed antibiotics to treat sinus infections. However, one stakeholder group said emergency physicians were not regularly treating patients with sinus infections.
- **Low return on investment for MIPS participation.** Eight stakeholder groups said providers had a low return on investment for

[26]In the preamble to its 2016 final rule, CMS acknowledged that the exception was beneficial for certain providers who lack the ability to (1) affect their practices' health information technology decisions or (2) have the face-to-face patient interactions required for many of the measures in the promoting interoperability category. See 81 Fed. Reg. 77,008, 77,238-29 (Nov. 4, 2016).

their participation in MIPS—that is, they receive low positive payment adjustments relative to the high financial or administrative costs incurred. Specifically, some stakeholders said the small positive payment adjustments did not cover the providers' financial or administrative costs. For example, stakeholders said providers may incur costs associated with investments in technological resources or with hiring or training staff to keep abreast of the complex annual changes to the program and to report necessary data to CMS. As a result, some stakeholders said some providers may opt not to report data at all and take a negative adjustment or rely on participation exemptions to qualify for a neutral adjustment.[27]

In October 2021, we reported that CMS planned to address some of these challenges, in part, by implementing the MIPS Value Pathways. MIPS Value Pathways, which began in 2023, allow providers the option of reporting on a group of activities and measures from the MIPS performance categories that are relevant to a specific specialty, medical condition, or episode of care. According to CMS, MIPS Value Pathways would provide more clinically meaningful feedback and comparative performance data for providers who report on the same MIPS Value Pathways; and standardize performance measurement across specific specialties, medical conditions, or episodes of care. CMS finalized its initial plans for the MIPS Value Pathways reporting option in the calendar year 2023 Medicare Physician Fee Schedule final rule.[28]

## Providers in Rural or Shortage Areas Participated in Advanced APMs at Lower Rates than Others

In November 2021, we reported that the proportion of eligible providers who participated in Advanced APMs was lower in rural or health professional shortage areas compared to other areas in each of 2017 through 2019.[29] For example, about 12 percent of eligible providers in rural or shortage areas participated in an Advanced APM in 2019, compared to about 15 percent of eligible providers in other areas that year. (See fig. 2.) Most providers who participated in an Advanced APM were eligible to earn the 5 percent incentive payment, regardless of whether they were in a rural or shortage area in each of 2017 through 2019. Based on their performance in 2017, about 88 percent of eligible providers in rural or shortage areas received the incentive payment,

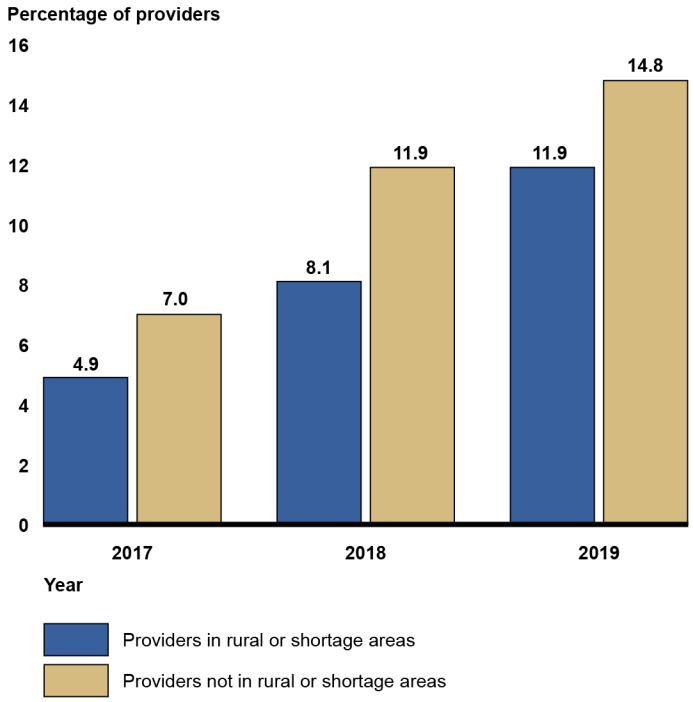
[27]For example, certain providers who applied for an "extreme and uncontrollable circumstances" exception in 2021 qualified for a neutral payment adjustment based on their performance for that year.

[28]87 Fed. Reg. 69,404 (Nov. 18, 2022).

[29]GAO-22-104618.

increasing to about 92 percent in 2018. Percentages were similar for providers not located in rural or shortage areas.

**Figure 2: Percentage of Medicare Providers in Rural or Shortage Areas and Providers Not Located in These Areas Who Participated in Advanced Alternative Payment Models (APM), 2017-2019**




Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-24-107106

Notes: Advanced APMs are payment approaches designed to encourage providers to share in the financial rewards and risk of caring for Medicare beneficiaries. We included providers eligible to participate in Advanced APMs for whom CMS had information on whether they were located in a rural or shortage area based on the place of service in their Medicare Part B claims. We excluded providers for whom CMS did not provide information on their location because, according to CMS, the provider did not have Medicare Part B claims in the year.

## Reported Challenges for Providers in Rural or Shortage Areas

In November 2021, we also reported that Medicare providers in rural, shortage, or underserved areas faced a number of challenges in transitioning to APMs, including Advanced APMs.[30] We grouped these challenges into four areas: 1) financial resources and risk management;

[30]We interviewed 18 stakeholder organizations, CMS officials, and reviewed two studies identified in a literature review. The two studies were: RAND Corporation, *Perspectives of Physicians in Small Rural Practices on the Medicare Quality Payment Program* (Santa Monica, CA: 2019); and Bipartisan Policy Center, *Confronting Rural America's Health Care Crisis* (Washington, D.C.: 2020).

2) data and health information technology; 3) staff resources and capabilities; and 4) design and availability of models.[31]

**Financial resources and risk management.** Some providers may be unable to finance the upfront costs of transitioning from a fee-for-service payment system to APMs. These costs may include hiring additional staff, developing new care management strategies, and performing analysis to estimate their likely performance in an APM before joining. Additionally, providers may

- be averse to taking on financial risk or may lack resources to cover potential losses if they do not meet the performance benchmarks.[32]
- have few Medicare patients, which can make it difficult to justify the investment required to participate, or
- face difficulty meeting a financial benchmark for controlling the cost of care because they often must refer patients elsewhere for specialized care.

**Data and health information technology.** Some providers may be unable to conduct the financial modeling and data analytics needed to assess their performance in an APM. Additionally, Advanced APMs require the use of certified electronic health record technology, which can be cost-prohibitive and may require high-speed internet access that may not be available to providers in some areas.[33]

**Staff resources and capabilities.** Some practices in rural, shortage, or underserved areas may already be overburdened with administrative duties and may lack the staffing capacity to further manage the transition to, or participation in, an APM. Additionally, providers may not understand individual APMs or see their relevance and may be too busy treating patients to learn about them.

**Design and availability of models.** Providers in rural, shortage, or underserved areas may have limited options for APMs in which to participate, such as due to geographic limitations, participant limitations,

[31]The reported challenges were identified by 15 stakeholders, CMS officials, and two studies identified in our literature review.

[32]Advanced APM entities must meet or exceed one or more specified performance standards, which may include expected expenditures, or face financial penalties. See 42 C.F.R. § 414.1415(c) (2022).

[33]42 C.F.R. § 414.1415(a) (2022).

or model design. Changing rules and requirements for APMs can also be challenging for providers to keep up with due to the financial modeling and staffing challenges discussed earlier. One stakeholder said there is a mismatch between the long-term nature of health care investment and the short-term lifespan of some APMs.

In November 2021, we also reported that CMS had implemented a number of models with features such as upfront funding for providers, technical assistance, and other elements. These could help providers in rural, shortage, or underserved areas, and small practices, transition to APMs, including Advanced APMs. CMS has also offered programs and initiatives to help providers broadly, and specifically those in rural, shortage, and underserved areas, transition to APMs. See appendix I for a list of selected actions CMS has taken to address challenges of participating in APMs.

Chair Guthrie, Ranking Member Eshoo, and Members of the Subcommittee, this concludes my prepared statement. I would be pleased to respond to any questions that you may have at this time.

## GAO Contact and Staff Acknowledgments

If you or your staff members have any questions concerning this testimony, please contact me at (202) 512-7114 or GordonLV@gao.gov. Contact points for our Office of Congressional Relations and Public Affairs may be found on the last page of this statement. Other individuals who made key contributions to this testimony include Lori Achman (Assistant Director), Corissa Kiyan-Fukumoto (Assistant Director), Sam Amrhein, Christie Enders, David Jones, Kelly Krinn, Brandon Nakawaki, and Jenny Rudisill. Other staff who made key contributions to the reports cited in the testimony are identified in the source products.

# Appendix I: CMS Actions to Help Providers Transition to Alternative Payment Models

In November 2021, we reported that the Centers for Medicare & Medicaid Services (CMS) had implemented a number of models with certain features that may help providers in rural, shortage, or underserved areas transition to alternative payment models (APM), including Advanced APMs.[1] Examples of features included:

- **Upfront funding.** Upfront funding can help APM participants with costs associated with transitioning to, and participating in, an APM. This predictable, upfront funding was a feature of the Pennsylvania Rural Health Model.[2] It provides a fixed amount to participating providers, set in advance, to cover all inpatient and hospital-based outpatient items and services. The predictable, upfront funding offered by this APM helped participating hospitals focus on transitioning its providers to value-based care rather than volume of services, according to a stakeholder we interviewed.
- **Care transformation organizations to alleviate staffing challenges.** Care transformation organizations, which are included in the Maryland Total Cost of Care Model, are intended to enable provider practices to participate in APMs by addressing the difficulties they may have hiring staff to perform care management services, according to CMS officials.[3] Care Transformation Organizations can leverage economies of scale and deploy resources that would be difficult or uneconomical for small-and medium-sized practices that may lack the economic resources for a full interdisciplinary care management team, according to CMS.
- **APMs with non-EHR tracks.** Some Advanced APMs have tracks for providers who lack certified EHR technology, such as the Radiation Oncology Model. These non-EHR tracks were developed as a means of enabling smaller and rural practices to participate in the APM

[1]See GAO, *Medicare: Information on the Transition to Alternative Payment Models by Providers in Rural, Health Professional Shortage, or Underserved Areas*, GAO-22-104618 (Washington, D.C.: Nov. 17, 2021).

[2]Among other things, the Pennsylvania Rural Health Model seeks to test whether care delivery transformation in conjunction with hospital global budgets increase rural Pennsylvanians' access to high-quality care and improve their health, while also reducing the growth of hospital expenditures across payers, including Medicare. Rural Pennsylvania hospitals began participating in this APM on January 1, 2019, and it has an anticipated end date of December 31, 2024. Although this model is not an Advanced APM (i.e., no financial risk for participants), the Pennsylvania Rural Health Model helps rural providers transition to value-based care, according to a stakeholder we interviewed.

[3]The Maryland Total Cost of Care Model is an Advanced APM. This APM's first performance year began January1, 2019, and is anticipated to end on December 31, 2026.

without necessitating the capital investment in certified EHR technology, according to CMS. Providers participating in the non-EHR tracks are not eligible for the incentive payment.

CMS also conducted, or plans to conduct, other programs and initiatives to help providers in rural, shortage, or underserved areas transition to APMs, according to CMS officials. For example, as we reported in November 2021, CMS contracted with 11 organizations to help small practices and providers in rural, shortage, and underserved areas participate in the Quality Payment Program. Since 2017, the Small, Underserved, and Rural Support Program contractors have directed providers to resources they may need and educated providers interested in participating in an APM on how to make that transition, according to CMS officials.

# Appendix II: Related GAO Reports

*Medicare: Information on Geographic Adjustments to Physician Payments for Physicians' Time, Skills, and Effort*. GAO-22-103876. Washington, D.C.: February 4, 2022.

*Medicare: Information on the Transition to Alternative Payment Models by Providers in Rural, Health Professional Shortage, or Underserved Areas.* GAO-22-104618. Washington, D.C.: November 17, 2021.

*Medicare: Provider Performance and Experiences under the Merit-based Incentive Payment System*. GAO-22-104667. Washington, D.C.: October 1, 2021.

*Medicare Physician Services: Payment Rates, Utilization, and Expenditures of Selected Services in Alaska, Hawaii, and the U.S. Territories*. GAO-21-607R. Washington, D.C.: September 24, 2021

*Medicare: Voluntary and Mandatory Episode-Based Payment Models and Their Participants*. GAO-19-156. Washington, D.C.: December 21, 2018.

*Medicare Value-Based Payment Models: Participation Challenges and Available Assistance for Small and Rural Practices*. GAO-17-55. Washington, D.C.: December 9, 2016.

## GAO's Mission

The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

## Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through our website. Each weekday afternoon, GAO posts on its website newly released reports, testimony, and correspondence. You can also subscribe to GAO's email updates to receive notification of newly posted products.

## Order by Phone

The price of each GAO publication reflects GAO's actual cost of production and distribution and depends on the number of pages in the publication and whether the publication is printed in color or black and white. Pricing and ordering information is posted on GAO's website, https://www.gao.gov/ordering.htm.

Place orders by calling (202) 512-6000, toll free (866) 801-7077, or TDD (202) 512-2537.

Orders may be paid for using American Express, Discover Card, MasterCard, Visa, check, or money order. Call for additional information.

## Connect with GAO

Connect with GAO on Facebook, Flickr, Twitter, and YouTube.
Subscribe to our RSS Feeds or Email Updates. Listen to our Podcasts.
Visit GAO on the web at https://www.gao.gov.

## To Report Fraud, Waste, and Abuse in Federal Programs

Contact FraudNet:

Website: https://www.gao.gov/about/what-gao-does/fraudnet

Automated answering system: (800) 424-5454 or (202) 512-7700

## Congressional Relations

A. Nicole Clowers, Managing Director, ClowersA@gao.gov, (202) 512-4400, U.S. Government Accountability Office, 441 G Street NW, Room 7125, Washington, DC 20548

## Public Affairs

Chuck Young, Managing Director, youngc1@gao.gov, (202) 512-4800
U.S. Government Accountability Office, 441 G Street NW, Room 7149
Washington, DC 20548

## Strategic Planning and External Liaison

Stephen J. Sanford, Managing Director, spel@gao.gov, (202) 512-4707
U.S. Government Accountability Office, 441 G Street NW, Room 7814,
Washington, DC 20548