



December 2016

MEDICARE VALUE-BASED PAYMENT MODELS

Participation Challenges and Available Assistance for Small and Rural Practices

Accessible Version

GAO Highlights

Highlights of [GAO-17-55](#), a report to congressional committees

Why GAO Did This Study

In recent years, the Centers for Medicare & Medicaid Services (CMS) has used its authority to develop and implement value-based payment models. Providers may receive additional payments for providing high-value care based on quality and cost metrics designed for each model or be financially penalized for care that does not meet certain standards.

The Medicare Access and CHIP Reauthorization Act of 2015 included a provision that GAO examine organizations that can assist small physician practices with participation in these models. This report describes (1) stakeholders' perspectives on the challenges faced by small and rural physician practices when trying to participate in Medicare value-based payment models; and (2) the types of organizations that help these practices participate, and the activities they conduct. GAO defined small and rural practices as those with 15 or fewer physicians and those located outside of an urban area, respectively.

To address the objectives, GAO reviewed literature and CMS documents on value-based payment models and interviewed 38 stakeholders, including CMS, providers, and organizations that assist with value-based payment models. GAO identified stakeholders through research and referrals from the stakeholders interviewed. GAO's findings are not generalizable beyond the stakeholders interviewed.

CMS provided technical comments on a draft of this report, which GAO incorporated as appropriate.

View [GAO-17-55](#). For more information, contact James Cosgrove at (202) 512-7114 or cosgrovej@gao.gov.

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Participation Challenges and Available Assistance for Small and Rural Practices

What GAO Found

Based on a review of literature and interviews with 38 stakeholders, GAO identified challenges faced by small and rural physician practices when participating in Medicare's new payment models. These models, known as value-based payment models, are intended to reward health care providers for resource use and quality, rather than volume, of services. The challenges identified are in five key topic areas.

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

Key topic area	Examples of challenges
Financial resources and risk management	Practices may lack financial resources needed to make initial investments, such as those to make electronic health record (EHR) systems interoperable, and recouping investments may take years.
Health IT and data	Practices need to hire and train staff, as well as develop experience using EHR systems and analyzing data needed for participation.
Population health management care delivery	Patient populations in diverse geographic locations can affect practices' ability to manage their care, especially rural physician practices whose patients may have to travel long distances.
Quality and efficiency performance measurement and reporting	Small and rural practices with small patient populations may have quality and efficiency measurement more susceptible to being skewed by patients that require more or more expensive care.
Effects of model participation and managing compliance with requirements	Practices with fewer staff have difficulty balancing and finding the time needed for direct patient care, care management activities, and additional administrative duties needed for model participation.

Source: GAO analysis of literature and stakeholder interviews. | GAO-17-55

According to the stakeholders GAO interviewed, organizations offer a variety of services that can help small and rural physician practices with challenges to participating in Medicare's value-based payment models, but not all small and rural practices can access these services. Organizations include group practices, private companies, nonprofit groups, and universities. GAO grouped the organizations that can assist into two categories: partner and non-partner organizations. Partner organizations share financial risk associated with model participation and provide comprehensive services that can mitigate challenges. These services may include sharing resources, such as data systems and care management staff, and conducting analysis to manage patient care. Non-partner organizations do not share financial risk but provide specific services that can help with certain challenges, such as health IT and data challenges. However, not all small and rural practices have access to organizations and the services they provide. For example, some partner organization stakeholders told GAO that they are selective about the practices they will form partnerships with. Further, some stakeholders said that small and rural practices may have limited financial resources that prevent them from hiring the organizations that could best assist them with participation.

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Abbreviations

ACO	accountable care organization
BPCI	Bundled Payments for Care Improvement
CHIP	State Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CPC	Comprehensive Primary Care
EHR	electronic health record
HHS	Department of Health and Human Services
IT	information technology
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MIPS	Merit-based Incentive Payment System
PPACA	Patient Protection and Affordable Care Act
PTN	Practice Transformation Network
QIN-QIO	Quality Innovation Network-Quality Improvement Organization
REC	Regional Extension Center

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December 9, 2016

The Honorable Orrin Hatch Chairman The Honorable Ron Wyden
Ranking Member Committee on Finance United States Senate

The Honorable Fred Upton Chairman The Honorable Frank Pallone
Ranking Member Committee on Energy and Commerce House of
Representatives

The Honorable Kevin Brady Chairman The Honorable Sander Levin
Ranking Member Committee on Ways and Means House of
Representatives

In 2015, Medicare expenditures for services provided by physicians totaled approximately \$70 billion, which represented about 11 percent of all Medicare expenditures in that year. Under traditional Medicare, physicians and other providers have historically been paid on a fee-for-service basis, which means that each distinct service is generally paid for separately. We have reported that this system of payment largely rewards the volume and complexity of health care services provided to beneficiaries, rather than the value of those services.¹

In recent years, the Centers for Medicare & Medicaid Services (CMS) has used its authority to develop and implement several new payment models—referred to in this report as value-based payment models—which focus on physicians (and other providers) sharing in the financial risk of caring for beneficiaries.² Value-based payment models generally include what is known as “upside risk,” where physicians receive additional payments for providing high-value care that is based on certain quality and efficiency metrics.³ Some models also include what is known

¹GAO, *High-Risk Series: An Update*, [GAO-15-290](#) (Washington, D.C.: Feb. 11, 2015).

²See Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, §§ 3021, 3022, 10306, 10307, 124 Stat. 119, 389, 395, 939, 940 (2010). References to physicians in this report encompass other health care providers who are eligible to participate in Medicare value-based payment models, such as physician assistants or nurse practitioners.

³CMS uses a variety of measures to assess health care quality and efficiency in order to hold physicians and other providers accountable for the health care they deliver. Both quality and efficiency measures used can vary by model. In addition, measures used may vary by provider preference, since providers may choose from a list of approved measures the ones they would like to report.

as “downside risk,” where physicians may be financially penalized for increased expenditures and care that does not meet quality and efficiency standards. CMS has been trying to encourage physicians to participate in models with both upside and downside risk by including larger financial incentives for positive results in those models than it does in models with upside risk only. In accordance with the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), beginning in 2017 CMS will implement the Quality Payment Program, which will include the Merit-based Incentive Payment System (MIPS) for physicians and other providers, as well as incentives for participation in certain alternative payment models.⁴ MIPS will consolidate components of programs currently used to tie payments to quality and provide incentives for quality, resource use, clinical practice improvement activities, and advancing care information through the meaningful use of electronic health record (EHR) technology.⁵

Many small practices lack experience with value-based payment models and their requirements, such as performance reporting, and rural practices may face unique challenges when participating in a value-based payment model due, in part, to the geographic dispersion of their patients.⁶ Some organizations provide services meant to help physician practices participate in value-based payment models.⁷ However, some stakeholders believe these services are insufficient and at least one organization has requested that Congress and CMS allow organizations

⁴Pub. L. No. 114-10, § 101, 129 Stat.87, 89 (2015); Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, 81 Fed. Reg. 77008 (Nov. 4, 2016).

⁵81 Fed. Reg. 77010. Components of the previously separate Physician Quality Reporting System, Physician Value-based Payment Modifier program, and Medicare EHR incentive program will be merged into MIPS so that payments for most physicians will reflect physician performance on both quality measures and EHR use.

⁶MACRA refers to small practices as those with 15 or fewer providers. The American Medical Association surveyed its membership and found that about 61 percent of physicians worked in small practices with 10 or fewer physicians in 2014. According to the United States Census Bureau, a rural area encompasses all population, housing, and territory not included within an urban area. An urban area is defined as having a population of at least 2,500, representing densely developed territory, and encompassing residential, commercial, and other nonresidential urban land uses.

⁷Organizations that provide such services include multispecialty clinics, nonprofit groups, private companies, independent practice associations, hospitals or health systems, and universities.

to have more flexibility working with CMS to support small and rural practices' transition to value-based payment models.⁸

MACRA includes a provision for GAO to examine the organizations that can assist small physician practices with participation in value-based payment models.⁹ This report describes

1. stakeholders' perspectives on the challenges faced by small and rural physician practices when trying to participate in Medicare value-based payment models, and
2. the types of organizations that help small and rural physician practices participate in Medicare value-based payment models, and the activities they conduct.

To describe stakeholders' perspectives on the challenges faced by small and rural physician practices, we reviewed relevant literature and interviewed stakeholders. We identified the literature through a search of several databases using terms such as "Medicare," "small or rural physician practices", and "value-based payments," as well as through recommendations from stakeholders we interviewed.¹⁰ In total, we identified and reviewed 47 documents published between 2012 and 2016 that met our search criteria and that we deemed to be relevant to our work. We identified stakeholders to interview by conducting internet searches on organizations that assist small and rural practices with value-based payment model participation and through referrals from other stakeholders we interviewed—an iterative process often referred to as "snowball sampling." We selected and interviewed 38 stakeholders, which included small and rural physician practices; associations that represent physician practices, including small and rural providers; organizations that assist physician practices with participation in value-based payment models; associations that represent these organizations; and CMS officials. We analyzed information that we collected from the literature and stakeholders to identify a list of challenges, by key topic areas, that small and rural physician practices face when participating in Medicare value-

⁸Dan Haley, letter from athenahealth to the Chairmen and Ranking Minority Members of the Senate Finance and House Ways and Means Committees, commenting on the committees' draft proposal to repeal the Sustainable Growth Rate and reform the Medicare physician payment system, November 12, 2013.

⁹Pub. L. No. 114-10, § 101(c)(2)(C), 129 Stat. 87, 114.

¹⁰Databases searched included Scopus, Web of Science, ProQuest, PolicyFile, and PubMed.

based payment models, such as accountable care organizations (ACO).¹¹ Although the challenges we identified may not all be unique to small and rural practices, in this report, we indicate how the challenge affects small and rural practices in particular.

To describe the types of organizations that help small and rural physician practices participate in value-based payment models, and the activities they conduct, we interviewed the same 38 stakeholders described above, as well as reviewed documentation from CMS and organizations that assist practices with participation. Of the 38 stakeholders, 16 were organizations that assisted physician practices with value-based payment model participation; the other 22 stakeholders included physician practices that have experience with these organizations and practices and associations that are knowledgeable about the types of organizations available and the services that they can provide. We compared the information collected with the list of challenges we identified for small and rural physician practices to assess the extent to which the organizations identified could help the practices participate in value-based payment models.

The 38 stakeholders we interviewed are a nonprobability sample. Our findings from these interviews are not generalizable beyond the stakeholders we interviewed; however, they can provide insights into the challenges faced by small and rural practices when deciding whether to participate or when participating in value-based payment models. Similarly, our analysis identified many types of organizations that can assist small and rural practices with value-based payment models, but the information we present is limited to our sample and therefore may not represent the universe of organizations that assist small and rural practices.

We conducted this performance audit from November 2015 to December 2016 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.

¹¹ACOs are groups of physicians, hospitals, and other health care providers who voluntarily work together to give coordinated care to the Medicare patients they serve.

Background

Transition to Value-based Payment

According to CMS documentation, the transition to value-based payment generally involves two major shifts from traditional fee-for-service payment.

1. **Accountability for both quality and efficiency.** Value-based payment models link payments to providers to the results of health care quality and efficiency measures. CMS uses a variety of measures to assess health care quality and efficiency and to hold physicians and other providers accountable for the health care they deliver. Quality measures include process and outcome measures. Process measures assess the extent to which providers effectively implement clinical practices (or treatments) that have been shown to result in high-quality or efficient care. Examples of process measures are those that measure care coordination, such as the percentage of patients with major depressive disorder whose medical records show that their physician is communicating with the patients' other physicians who are treating comorbid conditions. Outcome measures track results of health care, such as mortality, infections, and patients' experiences of that care. Efficiency measures may vary across models. For example, models may require that a minimum savings rate be achieved, which is established using a benchmark based on fee-for-service claims as well as other information such as patient characteristics, or that cost targets are achieved for various episodes of care.
2. **Focus on population health management.** Value-based payment models encourage physicians to focus on the overall health and well-being of their patients. Population health management includes provider activities such as coordination of patient care with other providers; identification and provision of care management strategies for patients at greatest risk, such as those with chronic conditions; promotion of health and wellness; tracking patient experience; and using health information technology (IT) to support population health.

In value-based payment models, physicians and other providers are paid and responsible for the care of a beneficiary for a long period and accountable for the quality and efficiency of the care provided. In contrast, Medicare fee-for-service payments to providers are tied only to volume, rewarding providers, for example, on the basis of the number of tests run,

patients seen, or procedures performed, regardless of whether these services helped (or harmed) the patient.

This shift in care delivery can require substantial investments by providers. For example, providers may need to invest in health IT to manage patients and record data necessary for quality and efficiency measurement and reporting. Providers may also need to hire additional staff to assist with population health management activities, such as care coordination.

The CMS Innovation Center has developed and is testing a number of value-based payment models.¹² The following are examples of Medicare value-based payment models in which physician practices can participate. These models are often referred to as alternative payment models.

- **ACOs.** As noted earlier, ACOs are groups of physicians—including independent physician practices—hospitals, and other health care providers who voluntarily work together to give coordinated care to the Medicare patients they serve. When an ACO succeeds in delivering high-quality care and spending health care dollars more efficiently, part of the savings generated goes to the ACO and part is kept by Medicare. ACOs participate in models with upside risk only or models with both upside and downside risk.¹³
- **Bundled payment models.** Bundled payment models provide a “bundled” payment intended to cover the multiple services beneficiaries receive during an episode of care for certain health conditions, such as cardiac arrhythmia, hip fracture, and stroke. If

¹²The CMS Innovation Center was created by PPACA to test innovative payment and service delivery models that have the potential to reduce Medicare expenditures while preserving or enhancing the quality of care for beneficiaries. Pub. L. No. 111-148, § 3021(a), 124 Stat. 119, 389.

¹³In addition to ACO models tested by the CMS Innovation Center, ACOs are operating in the Medicare Shared Savings Program, which is enacted as an ongoing part of the Medicare program and not a CMS Innovation Center model. See 42 U.S.C. § 1395jjj. The Medicare Shared Savings Program has an ACO track in which there is only upside risk. The CMS Innovation Center ACO models generally include both upside and downside risk. CMS states that allowing these different risk models provides an entry point for organizations with less experience with value-based payment models to gain experience with population health management. It also provides an opportunity for more experienced ACOs to enter into an arrangement that allows for a greater share of savings, but with the risk of repaying Medicare for a portion of any losses.

providers are able to treat patients with these conditions for less than the target bundled payment amount and can meet performance accountability standards, they can share in the resulting savings with Medicare. CMS's initiative, Bundled Payments for Care Improvement (BPCI), tests four broadly defined models of care, under which organizations enter into payment arrangements that include financial and performance accountability for episodes of care.

- **Comprehensive primary care models.** Comprehensive primary care models are designed to strengthen primary care. CMS has collaborated with commercial and state health insurance plans to form the Comprehensive Primary Care (CPC) initiative.¹⁴ The CPC initiative provides participating primary care physician practices two forms of financial support: (1) a monthly non-visit-based care management payment and (2) the opportunity to share in any net savings to the Medicare program. In January 2017, CMS will build upon the CPC initiative, which ends December 31, 2016, by beginning CPC Plus, a comprehensive primary care model that includes downside risk.

CMS's Quality Payment Program and Support for Small and Rural Practices

In November 2016, CMS published a final rule with comment period to implement a Quality Payment Program under MACRA, which established a new payment framework to encourage efficiency in the provision of health care and to reward health care providers for higher-quality care instead of a higher volume of care.¹⁵ The Quality Payment Program is based on eligible Medicare providers' participation in one of two payment methods: (1) MIPS or (2) an advanced alternative payment model. Under MIPS, providers will be assigned a final score based on four performance categories: quality, cost, clinical practice improvement activities, and advancing care information through the meaningful use of EHR technology. This final score may be used to adjust providers' Medicare payments positively or negatively. CMS will begin assessing providers' performance in three of the four performance categories in 2017. Cost will

¹⁴Participating primary care practices receive payments to facilitate the provision of a core set of five primary care functions: (1) risk-stratified care management—identification of patients with higher needs and implementation of care management for those patients, (2) access and continuity, (3) planned care for chronic conditions and preventive care, (4) patient and caregiver engagement, and (5) coordination of care across medical neighborhoods.

¹⁵Pub. L. No. 114-10, § 101, 129 Stat. 89; 81 Fed. Reg. 77008.

not be measured in the first year. The first year that payments will be adjusted is 2019 (based on the 2017 performance year).¹⁶ Under the final rule, an alternative payment model will qualify as an advanced alternative payment model if it has downside risk, among other requirements.¹⁷ Providers with sufficient participation in advanced alternative payment models are excluded from MIPS and qualify to receive incentive payments beginning in 2019 (based on performance in 2017). Providers who participate in alternative payment models that do not include downside risk, such as some ACO models, will be included in MIPS. The final rule refers to these models as MIPS “alternative payment models.”¹⁸ To coincide with the final rule, CMS also issued a fact sheet with information on the supports available to providers participating in the Quality Payment Program.¹⁹

In the final rule, CMS stated that protection of small, independent practices was an important thematic objective and that in performance year 2017 many small practices will be excluded from the new MIPS

¹⁶In its final rule, CMS refers to the first performance year of the Quality Payment Program as the “transition year”—which corresponds to the first performance period of the program, calendar year 2017, and the first payment year, calendar year 2019. CMS has established special policies for 2017 in the final rule. CMS states that it envisions that it will take a few years to reach a steady state in the program, and therefore the agency anticipates a ramp-up process and gradual transition with less financial risk for clinicians in at least the first 2 years of the program. 81 Fed. Reg. 77010.

¹⁷To be considered an advanced alternative payment model, an alternative payment model must meet all three of the following criteria: (1) the alternative payment model must require the use of certified EHR technology, (2) the alternative payment model must provide for payment for covered professional services based on quality measures which may be comparable to those in the quality performance category under MIPS, and (3) the alternative payment model must include a component of downside risk (i.e., alternative payment model entities bear risk for monetary losses of a more than nominal amount under the alternative payment model, or be an expanded medical home model—a type of comprehensive primary care model). See 81 Fed. Reg. 77549 (Advanced APM criteria codified at 42 C.F.R. § 414.1415).

¹⁸81 Fed. Reg. 77537 (APM definition codified at 42 C.F.R. § 414.1305). Not all value-based payment models may qualify as MIPS alternative payment models or advanced alternative payment models. For example, BPCI models would not qualify as either; however, CMS officials told us that the agency intends to implement a new voluntary bundled payment model for calendar year 2018 that builds on BPCI and would be designed to meet the criteria to be an advanced alternative payment model.

¹⁹See Centers for Medicare & Medicaid Services, *Quality Payment Program, Fact Sheet*, (Baltimore, Md.: Oct. 14, 2016), accessed November 14, 2016, https://qpp.cms.gov/docs/QPP_Where_to_Go_for_Help.pdf.

requirements due to the low-volume threshold.²⁰ CMS also stated that while it is not implementing “virtual groups” for 2017—which would allow small practices to be assessed as a group across the four MIPS performance categories—the agency looks forward to stakeholder engagement on how to structure and implement virtual groups in future years of the program.²¹ Further, CMS is reducing the number of clinical practice improvement activities that small and rural practices will have to conduct to receive full credit in this performance category in performance year 2017.²²

CMS also announced in April 2016 that it intends to solicit and award multiple contracts to qualified contractors for MACRA quality improvement direct technical assistance. Direct technical assistance through this program will target providers in small group practices of 15 or fewer, and especially those in historically under resourced areas, such as rural areas. CMS indicated that the purpose of the contracts is to provide a flexible and agile approach to customized direct technical assistance and support services to ensure success for providers who either participate in MIPS or want to transition to an alternative payment model, thereby easing the transition to a payment system based on performance and patient outcomes.

In addition, CMS has been testing models aimed at helping small and rural providers participate in value-based payment models. For example, in 2016, CMS began the ACO Investment Model, which provides advanced up-front and monthly payments to providers so they can make important investments in their care coordination infrastructure.²³ According to information on CMS’s website, the ACO Investment Model was developed in response to stakeholder concerns and available research suggesting that some providers lack access to the capital to

²⁰The low-volume threshold has been set at less than or equal to \$30,000 in Medicare Part B allowed charges or less than or equal to 100 Medicare patients.

²¹81 Fed. Reg. 77012.

²²81 Fed. Reg. 77015.

²³Participants receive both variable and fixed up-front payments, which, according to CMS documentation, are to help address both the fixed and variable costs associated with forming an ACO. These advance payments are repaid by the ACO to CMS from the future shared savings earned. Prior to the ACO Investment Model, CMS tested the Advance Payment ACO model, which also provided up-front and monthly payments to small and rural providers to help them make important investments in their care coordination infrastructure.

invest in infrastructure that is necessary to successfully implement population care management.²⁴

Small and Rural Physician Practices Face a Number of Challenges when Deciding Whether to Participate or when Participating in Value-based Payment Models

According to literature we reviewed and the 38 stakeholders we interviewed, small and rural physician practices face many challenges associated with deciding whether to participate, when to begin participating, or whether to continue participating in value-based payment models. We identified 14 challenges that can be classified into five key topic areas: (1) financial resources and risk management, (2) health IT and data, (3) population health management care delivery, (4) quality and efficiency performance measurement and reporting, and (5) effects of model participation and managing compliance with requirements. (See table 1.) These 14 challenges are discussed in detail in the sections that follow.

²⁴Centers for Medicare & Medicaid Services, *ACO Investment Model*, accessed July 5, 2016, <https://innovation.cms.gov/initiatives/aco-investment-model/>.

Table 1: Challenges to Small and Rural Physician Practices' Participation in Value-based Payment Models, by Key Area

Key topic area	Challenge
Financial resources and risk management	Limited ability to take on financial risk because of having fewer financial resources/reserves compared with larger providers
	High costs of initial and ongoing investments needed for participation
	Difficulties with recovering investments in a timely manner
Health IT and data	Difficulties with data system interoperability and limited ability to access data outside the practices' own systems
	Difficulties with educating and training staff about EHR systems and the data entry, management, and analysis needed for participation
Population health management care delivery	Patient preferences and geographic location affect practices' ability to implement population health management care delivery and account for total cost of care
	Provider resistance to making adjustments needed for population health management care delivery
Quality and efficiency performance measurement and reporting	Difficulties with receiving timely performance feedback
	Misalignment of quality measures between various value-based payment models and payers
	Performance measurement accuracy for practices with a small number of Medicare patients
Effects of model participation and managing compliance with requirements	Difficulties with maintaining practice independence
	Limited time of staff and physicians to complete administrative duties required for model participation
	Difficulties with understanding and managing compliance with the terms and conditions of waivers related to various fraud and abuse laws
	Difficulties with staying abreast of regulatory changes and managing compliance with multiple requirements of value-based payment models

Source: GAO analysis of literature and stakeholder interviews. | GAO-17-55

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

Financial Resources and Risk Management

Small and rural practices need financial resources to make initial investments, such as those to make EHR systems interoperable, and need financial reserves or reinsurance to participate in models that have downside risk. Recouping investments may take years because the models must have a year of performance data, which then must be analyzed to determine any shared savings payment.

- Limited ability to take on financial risk because of having fewer financial resources/reserves compared with larger providers.** Some stakeholders told us that small and rural practices have few financial resources and financial reserves. This limits their ability to take on the downside risk associated with some value-based payment models. In some value-based payment models, providers are

financially responsible if their actual spending for treating Medicare beneficiaries exceeds the payment amount they receive from Medicare. In other models, a provider's spending is compared to its historical spending, and if spending is higher than the historical benchmark, the provider has to repay a portion of the exceeded spending to Medicare. As a result, in order to participate, practices need either to have financial reserves to cover instances such as patients with unexpectedly costly medical events or to purchase reinsurance to cover such expenditures, according to some stakeholders we interviewed. Some stakeholders suggested that for reinsurance to help small and rural practices, it must be affordable, and the types of reinsurance currently available are costly.

- **High costs of initial and ongoing investments needed for participation.** Some stakeholders reported that significant investments are needed for participation in value-based payment models. Initial investments can cost practices thousands if not millions of dollars, and it can be difficult for small practices to pay for this out of their own pockets, according to some stakeholders. For example, one stakeholder told us that most small practices are on a month-to-month budget and have small profit margins. Some stakeholders told us that the costs of making EHR systems interoperable between providers can be expensive and often is the same cost regardless of practice size.²⁵ A stakeholder from a physician practice told us that it cost about \$20,000 for the group to connect two EHR systems, which would be the same cost for a small or large practice. Small practices have fewer physicians to spread these costs among. Additionally, some stakeholders reported that capital is needed to hire additional staff to help with the care coordination activities that are part of model participation.
- **Difficulties with recovering investments in a timely manner.** Small and rural practices often struggle with the amount of time it takes for them to recoup the investments they have made to participate in a model, according to some stakeholders we interviewed and literature we reviewed. After making initial investments, practices must wait for the completion and analysis of a performance year before they can receive a shared savings payment. Some stakeholders told us that it can take 2 or more years for this to occur. Furthermore, some

²⁵When EHR systems are interoperable, information can be exchanged—sent from one provider to another—and then seamlessly integrated into the receiving provider's EHR system without special efforts, allowing the provider to use that health information to inform clinical care.

stakeholders expressed concern about model sustainability and commented on the unpredictability of the models, which could affect physicians' confidence in their ability to recuperate investments made if a model becomes obsolete or changes significantly. For example, at the beginning of calendar year 2017, CMS is making a significant change by replacing a 4-year-old model, the CPC initiative, with CPC Plus—a model in which practices must take on downside risk to participate. This change may prevent some small and rural practices from participating in the successor model, and consequently affect their ability to recoup the investments they made to participate in the CPC initiative.

Health IT and Data

Small and rural practices need to have access to data that is important for care management and cost control. Also, these practices need to hire and train staff, as well as develop experience using EHR systems and analyzing data needed for participation.

- **Difficulties with data system interoperability and limited ability to access data outside the practices' own systems.** Some stakeholders reported that having access to other providers' data through interoperable EHR systems is beneficial as it can provide information to help coordinate and determine the appropriate care for a patient; however, they also reported difficulties in constructing interoperable systems. One small physician practice stakeholder told us that the practice has had difficulties accessing the results of tests conducted in an outside lab because the lab scans rather than types the test results into its system. The stakeholder said that the practice is working with its EHR vendor to address the problem but that he suspected the vendor may be less concerned about the practice's challenges because the practice is small. He stated that such challenges are common for many rural health care facilities. Separate from interoperability, some stakeholders also reported that providers and payers may not be willing to share information, such as claims and price data, that would aid analysis and help a practice manage patient care—such as tracking when patients visit specialists or fill prescriptions—as well as control costs.²⁶ It may be especially

²⁶CMS officials told us that participants in some of its ACO models may request data from CMS to help manage and coordinate patient care. These data include detailed claims data files for services furnished to a physician's patients by other Medicare-enrolled providers and suppliers.

challenging for small and rural physician practices to gain access to such data as they may not have the relationships with payers that larger practices may have, which is needed for data sharing. According to a publication from our literature review, physician practices reported that price data for services and supplies could be difficult to obtain, maybe in part due to payer confidentiality and agreements with pharmaceutical and device companies regarding rebates or discounts.²⁷

- **Difficulties with educating and training staff about EHR systems and the data entry, management, and analysis needed for participation.** Some stakeholders reported that significant resources are needed for staff education and training to properly enter data required for model participation. These data are often needed for quality measurement associated with a specific value-based payment model, and physician practices need to ensure that staff have accurately and appropriately captured these data for patients to meet the model's requirements. Additionally, some stakeholders stated that managing and analyzing data can be difficult and time-consuming, as small and rural practices often struggle with how to use their EHR systems to obtain data for analysis and timely decision making. For example, one stakeholder told us that practices often do not know how to use their EHR system to make a list of all patients with a certain disease, which could help the practice develop population health management strategies for that particular disease, among other activities. Further, another stakeholder told us that uniquely qualified staff are often needed to complete this work.

Population Health Management Care Delivery

Practices' ability to manage care of their entire patient population is affected by patients' geographic location and preferences, and this is especially true for rural physician practices whose patients may have to travel distances to receive regular wellness visits and seek specialists when recommended. In addition, the transition to value-based care, which focuses on population health management, will require adjustment by some physician practices, such as rural practices, that are generally more

²⁷RAND Corporation, *Effects of Health Care Payment Models on Physician Practice in the United States*, RR-869-AMA (Santa Monica, Calif.: 2015).

experienced with a fee-for-service system, especially as the two systems may have incentives that are difficult to reconcile.

- **Patient preferences and geographic location affect practices' ability to implement population health management care delivery and account for total cost of care.** Literature we reviewed and some stakeholders indicated that physician practices' ability to succeed in value-based payment models can be hindered by the preference and location of patient populations. For example, one stakeholder stated that physicians may have difficulty getting patients to complete wellness visits or other activities necessary for them to stay healthy. This is especially relevant for rural physician practices, as some patients in rural areas may have to travel long distances for wellness care or care from specialists, which can influence how often they actually seek such care. If patients do not receive recommended care, this can affect the rural physician's ability to effectively manage patients' conditions. Patient behavior and location can also make it difficult for providers to control the total cost of patient care or know about all the costs. For example, one stakeholder said that under a bundled payment model, practices are responsible for costs during an entire episode of care, but practices cannot influence where the patient receives post-acute care, which could affect the total cost of patient care. Additionally, another stakeholder told us that it can be difficult to engage patients using technology. This ACO has tried to manage patients' post-acute care by communicating with patients through a technology system. However, the effectiveness of the system has been limited because some patients do not want to use it, preferring to speak with their physician directly.
- **Provider resistance to making adjustments needed for population health management care delivery.** Small and rural physician practices are having difficulty adjusting to a value-based care system, which focuses on population health management, as opposed to being paid based on volume, according to some stakeholders. For example, because providers are paid for each service under Medicare fee-for-service, providers have an incentive to provide a high volume of services without consideration of the costs or value of such services. Rural practices have a larger percentage of their Medicare patients enrolled in fee-for-service compared to non-rural practices, which have a larger percentage of their Medicare patients enrolled in Medicare Advantage, the private plan alternative to Medicare fee-for-service. Therefore, rural practices may be more influenced than others by the incentives under Medicare fee-for-service. In contrast, under value-based payment models, population

health is a major component that requires care coordination and consideration about whether certain services are necessary that might involve additional attention and time from physicians. According to a publication from our literature review, some practices experience conflicting incentives—to increase volume under their fee-for-service contracts while reducing costs under their risk-based contracts—and not knowing which patients will be included in the value-based payment model can also make managing care difficult.²⁸ Additionally, some providers in small and rural practices may be concerned about relying on the care of the other providers over which they have little or no influence, according to some stakeholders. One stakeholder we interviewed told us that this lack of trust in the ability of others to effectively coordinate and co-manage care spawns an unwillingness to enter into value-based payment models that require extensive care coordination across numerous providers to achieve shared savings.

Quality and Efficiency Performance Measurement and Reporting

Value-based payment models require a full year of performance data, and the time lag between data submission and when a practice receives its performance report delays practices' understanding of actions needed to improve care delivery and receive financial rewards. Further, the number and variation of quality measures required by Medicare and private payers are burdensome for small and rural practices, and practices with small patient populations face quality and efficiency measurement that may be more susceptible to being skewed by patients who require more care or more expensive care.

- **Difficulties with receiving timely performance feedback.** Some stakeholders mentioned a variety of issues related to delays in performance assessments associated with value-based payment models. As noted previously, it takes a full year of performance in addition to the time it takes for data about that year to be analyzed before information is known about a physician practice's performance within a model. According to some stakeholders, this time lag makes it

²⁸RAND Corporation, *Effects of Health Care Payment Models on Physician Practice in the United States*. Patients are attributed to a physician practice for purposes of measuring the practice's performance in a model. For example, in some models, a patient is attributed to the provider who billed for the majority of that patient's care within a given year.

difficult for the practices to efficiently identify the areas that are working well and those that need improvement. For example, one stakeholder told us that a physician may receive the results of his or her performance within a model in 2016 for care that was provided in 2014.²⁹ This limits physicians' ability to make meaningful and timely changes to the care they provide. Additionally, some stakeholders reported that practices may not understand how best to improve their performance due to the limited information they receive from CMS.

- **Misalignment of quality measures between various value-based payment models and payers.** Some stakeholders told us that physician practices can be overwhelmed and frustrated by the number of quality measures that they need to report on for participation in value-based payment models and that the measures used by Medicare value-based payment models are not well-aligned with those used by commercial payers. Even if payers have similar quality measures, there may be slight variations in their calculation, which makes reporting burdensome. One stakeholder who works within an ACO stated that there are 58 unique quality measures across all the payers he works with.
- **Performance measurement accuracy for practices with a small number of Medicare patients.** Since small and rural physician practices often have fewer patients to measure, their performance may be more susceptible to being skewed by outliers, according to some stakeholders we interviewed. Even if these practices have only a few patients that require more comprehensive or expensive care, these few can disproportionately affect their performance negatively, and in turn the financial risk they bear, compared to practices with much larger patient populations. For at least one model type—ACOs—this challenge may be addressed by a requirement that an ACO have a minimum number of patients to participate, as well as by CMS adjusting the performance of some ACOs to account for their size.³⁰ This patient size requirement and adjustment can help ensure statistical reliability when assessing an ACO's performance against

²⁹CMS officials told us that participants in some of its ACO models receive monthly and year-to-date financial reports on the previous month's expenditures and cumulative expenditures for selected categories of services for assigned beneficiaries. CMS also provides quarterly reports to participants' ACOs which they can use to monitor their financial performance throughout the year relative to expected spending levels.

³⁰The minimum patient requirement varies depending on the Medicare ACO model. For example, some ACOs must have at least 5,000 patients, while others must have at least 15,000 patients.

measures. However, some stakeholders told us that this requirement also has its challenges. For example, it can be particularly difficult for rural practices to find other practices to group with to meet this patient requirement.

Effects of Model Participation and Managing Compliance with Requirements

To participate in value-based payment models, small and rural physician practices may feel pressure to join with other practices. Model participation may also mean that physician and other practice staff must take on additional administrative responsibilities to meet conditions of participation. Furthermore, practices must work to stay abreast of regulations and model requirements as the models evolve.

- **Difficulties with maintaining practice independence.** Literature we reviewed and some stakeholders indicated that, in the movement toward value-based payment models, many small and rural practices feel pressure to join other practices or providers (such as a hospital or health system) to navigate these models even if the practices would prefer to remain independent.
- **Limited time of staff and physicians to complete administrative duties required for model participation.** Some stakeholders reported that both physicians and practice staff had to juggle many administrative responsibilities as part of participating in value-based payment models, which may be especially challenging for small and rural practices that tend to have fewer staff. Administrative duties may conflict with time needed for patient care. For example, one stakeholder told us that physicians are often busy seeing patients throughout the day and are unable to complete administrative tasks, such as attending meetings. Small physician practices may have limited staff time to devote to other administrative duties, including completing required documentation or collecting and reporting data on quality measures needed for participation in value-based payment models. Practices that want to add staff may also face challenges, such as finding qualified staff that are experts within their field and that understand the requirements associated with value-based payment models.
- **Difficulties with understanding and managing compliance with the terms and conditions of waivers related to various fraud and abuse laws.** The Secretary of Health and Human Services is authorized to waive certain requirements as necessary to implement

the Shared Savings Program to encourage the development of ACOs and to test innovative payment and service delivery models, such as BPCI.³¹ However, some stakeholders stated that understanding and navigating the terms and conditions of waivers can be difficult and overwhelming for practices to manage.³² This may be especially true for small and rural practices that have less time to develop the knowledge necessary to understand waiver options or the resources to hire assistance in doing so, such as legal counsel.

- **Difficulties with staying abreast of regulatory changes and managing compliance with multiple requirements of value-based payment models.** Some stakeholders said that small and rural physician practices find it challenging to stay informed of and to incorporate regulation and requirement changes associated with value-based payment models. This may be due, in part, to small and rural practices often having fewer staff and resources to monitor changes.

Organizations Offer Services That Can Help Small and Rural Physician Practices Participate in Value-based Payment Models, but Not All Practices Have Access

We found that organizations that can help small and rural practices with challenges to participating in value-based payment models can be grouped into two categories: partner organizations and non-partner organizations. Partner organizations share in the financial risk associated with model participation and provide comprehensive services. Non-partner organizations do not share financial risk but provide specific services that can help mitigate certain challenges. However, not all small

³¹See 42 U.S.C. § 1395jjj(f) (pertaining to the Shared Savings Program (ACOs)); 42 U.S.C. § 1315a(d)(1) (pertaining to innovative payment and service delivery models such as BPCIs).

³²See, e.g., Final Waivers in Connection With the Shared Savings Program, CMS/OIG final rule, 80 Fed. Reg. 66726 (Oct. 29, 2015); CMS/OIG Notices of Waivers of Certain Fraud and Abuse Laws in Connection With the Bundled Payments for Care Improvement (BPCI), Model 1 (Sept. 13, 2012), Models 2 - 4 (Jul. 26, 2013). The final rule and notices provide for the waiver of the application of the physician self-referral law, gainsharing civil money penalties, and federal anti-kickback statute in certain circumstances and provided certain specified conditions are met.

and rural physician practices have access to services provided by these organizations.

Partner Organizations Share Risk and Provide Comprehensive Services That Can Help with Challenges

Based on the 38 stakeholder interviews we conducted and the related documentation collected, we found that some organizations serve as partners to small and rural physician practices. As partners, these organizations share in the financial risk associated with the models and provide comprehensive services that help with challenges in each of the five key topic areas affecting small and rural physician practices. Partner organizations can help with a variety of value-based payment models, including ACOs, comprehensive primary care models, and bundled payments.³³ Certain partner organizations, known as awardee conveners, have binding agreements with CMS to assist providers with participation in BPCI, including helping them plan and implement care redesign strategies to improve the health care delivery structure. Other partner organizations may bring small and rural practices together to help form and facilitate an ACO. In this role, these partner organizations can help small and rural practices fulfill any requirements for an ACO to have a minimum number of patients and facilitate the reporting of performance measures as a larger group while still allowing practices to remain independent. This type of assistance can mitigate two of the challenges stakeholders have identified—performance measurement accuracy for practices with a small number of Medicare patients and maintaining practice independence.

Depending on the arrangement between the practices and the partner organization, the partner organization may receive all or some of the savings generated by the ACO or bundled payment, as well as share in any financial losses incurred.³⁴ For example, a partner organization stakeholder stated that the organization—which helps form ACOs—retained 40 percent of the shared savings, and the physician practices received the remaining 60 percent. Similarly, another partner organization

³³There are a variety of organizations that can serve as partners, including multispecialty clinics; nonprofit groups; private companies; and independent practice associations, hospitals, or health systems.

³⁴Some partner organizations may also charge a membership fee for the services they provide.

stakeholder told us that the organization took on the entire share of any financial losses incurred and received a third of any gains. In some agreements, practices may receive different distributions of the financial savings based on their performance compared to set performance goals or to other practices in the group. In this type of arrangement with a partner organization, a practice will receive, at most, a portion of its shared savings, which could extend the time it takes practices to realize financial gains. See figure 1 for how sharing financial risk can mitigate a challenge faced by small and rural physician practices.

Figure 1: Challenge That Can Be Mitigated by Partner Organizations Sharing Financial Risk with Small and Rural Physician Practices

SERVICE	CHALLENGE MITIGATED
Share financial risk	<ul style="list-style-type: none">Limited ability to take on financial risk because of having fewer financial resources/reserves compared with larger providers.
EXAMPLE	
<ul style="list-style-type: none">A partner organization can take on part or all downside risk.	

Source: GAO analysis of literature and stakeholder interviews. | GAO-17-55

Comprehensive services provided by partner organizations can either directly or indirectly help to mitigate many of the participation challenges faced by small and rural physician practices. As a way of directly assisting, for example, partner organizations can aid small and rural physician practices with population health management by analyzing data to identify high-risk patients such as those with chronic conditions who need comprehensive care management. Conversely, one challenge identified for small and rural physician practices was their limited ability to take on financial risk because they have fewer financial reserves when compared to their larger counterparts. While partner organizations do not directly address that these practices have fewer financial reserves, they can indirectly assist by taking on part or all of the financial risk of model participation. A small physician practice stakeholder told us that without the services provided by a partner organization, the practice would not be able to participate in the model. While the services offered by partner organizations can vary, they generally include the following.

- Provide or share resources.** Partner organizations can support the cost of resources needed for model participation, such as health IT and care coordination resources, or help share resources across many practices to reduce costs for individual small and rural practices.

For example, an awardee convener stakeholder told us that the organization manages a care innovation center staffed with about 70 nurses who work with patients and providers to make appointments and coordinate services, among other population management activities. Another partner organization stakeholder told us that the organization had formed a pharmacy hub in which the pharmacist works directly with the practices on comprehensive medication management. Further, some stakeholders stated that partner organizations can help reduce the costs of EHR systems and data analytics for the practices by, for example, sharing the EHR system and data analytics staff across practices. One partner organization stakeholder told us that, in another type of arrangement, the partner organization provides up-front funding for technology and other resources in return for 40 percent of any shared savings generated by the ACO. This arrangement can be particularly helpful to small and rural practices that may not have a lot of capital to invest. See figure 2 for the challenges mitigated by partner organizations by providing or sharing resources.

Figure 2: Challenges That Can Be Mitigated by Partner Organizations Providing or Sharing Resources among Small and Rural Physician Practices

SERVICE	CHALLENGES MITIGATED
Provide or share resources	<ul style="list-style-type: none">• High costs of initial and ongoing investments needed for participation.• Difficulties with recovering investments in a timely manner.• Difficulties with data system interoperability and limited ability to access data outside the practices' own systems.• Difficulties with educating and training staff about electronic health record systems and the data entry, management, and analysis needed for participation.• Limited time of staff and physicians to complete administrative duties required for model participation.
EXAMPLES	
<ul style="list-style-type: none">• A partner organization can provide staff, such as care coordinators, and technology resources, which reduce investments needed by individual practices.• A partner organization can facilitate resource sharing across practices to reduce costs incurred by individual practices.	

Source: GAO analysis of literature and stakeholder interviews. | GAO-17-55

- **Manage health IT systems and data.** Partner organizations generally work with practices to enhance the interoperability of the practices' data systems so that data can be shared and easily retrieved for analysis. For example, an awardee convener stakeholder told us that the organization had developed a way to connect providers' EHR systems to its data system, as well as developed software that providers can use to more easily share data among

themselves. Similarly, partner organizations can manage data and provide analytics. Some partner organization stakeholders stated that they conduct analysis and provide reports and data to physicians to help them with population management, such as identifying high-risk patients and practice improvement needs. A partner organization stakeholder told us that the organization collects beneficiary level data from all payers—including those that the partner organization does not work with—to monitor quality improvements and identify where physicians missed opportunities to diagnose patients. See figure 3 for the challenges that are mitigated by partner organizations managing health IT systems and data.

Figure 3: Challenges That Can Be Mitigated by Partner Organizations Managing Health Information Technology Systems and Data for Small and Rural Physician Practices

SERVICE	CHALLENGES MITIGATED
Manage health IT systems and data	
EXAMPLES	
<ul style="list-style-type: none">A partner organization can enhance electronic health record (EHR) interoperability and facilitate data sharing.A partner organization can conduct analysis and provide reports to improve the practices' performance.A partner organization can gather data from others, such as payers, to aid analysis and manage patient care.	<ul style="list-style-type: none">Difficulties with data system interoperability and limited ability to access data outside the practices' own systems.Difficulties with educating and training staff about EHR systems and the data entry, management, and analysis needed for participation.

Source: GAO analysis of literature and stakeholder interviews. | GAO-17-55

- Provide education and training related to population care management.** Partner organizations can provide on-site training and mentoring for the practices' staff related to population management care delivery. This can help small and rural physician practices transition their staff, who may be accustomed to being paid based on volume, to a value-based care system that focuses on population health management. It can also provide practices with tools on how to manage and engage patients, such as patients who are not accustomed to having regular wellness visits or using technology. For example, one partner organization stakeholder we interviewed said that the organization holds quality improvement workshops for physicians every quarter to work on implementing population health

management activities, such as wellness visits. Another partner organization stakeholder said that the organization has practice transformation staff who spend about 4 hours each week working directly with each physician practice to implement a care management program. This stakeholder stated that it was important to provide physician practices with the tools, but it was just as important to provide in-practice support on how to use those tools and help to strengthen the practice. See figure 4 for the challenges that are mitigated by partner organizations providing education and training on population health management.

Figure 4: Challenges That Can Be Mitigated by Partner Organizations Providing Education and Training on Population Health Management to Small and Rural Physician Practices

SERVICE	CHALLENGES MITIGATED
Provide education and training related to population care management	<ul style="list-style-type: none">• Patient preferences and geographic location affect practices' ability to implement population health management care delivery and account for total cost of care.• Provider resistance to making adjustments needed for population health management care delivery.
EXAMPLE	
<ul style="list-style-type: none">• A partner organization can provide training and mentoring for practices' staff related to population health management care delivery, such as implementing wellness visits and facilitating patient engagement.	

Source: GAO analysis of literature and stakeholder interviews. | GAO-17-55

- **Provide population health management services.** Partner organizations can provide population health management activities, including identifying and tracking high-risk patients, scheduling wellness visits, and managing patients with chronic conditions. For example, an awardee convener stakeholder told us that the organization helps providers by checking on whether the patients have rides to their appointments, setting up patients' appointments, and contacting other social services. Another partner organization stakeholder told us that the organization has care navigators, who work with physician practices to engage with patients and help those at high health risk, as well as patient care advocates, who identify patients with gaps in care or who need annual wellness visits. See figure 5 for the challenges that are mitigated by partner organizations providing population health management services.

Figure 5: Challenges That Can Be Mitigated by Partner Organizations Providing Population Health Management Services for Small and Rural Physician Practices

SERVICE	CHALLENGES MITIGATED
Provide population health management services	<ul style="list-style-type: none">• Patient preferences and geographic location affect practices' ability to implement population health management care delivery and account for total cost of care.• Limited time of staff and physicians to complete administrative duties required for model participation.
EXAMPLES	
<ul style="list-style-type: none">• A partner organization can identify and track high-risk patients, and manage patients with chronic conditions.• A partner organization can engage patients by checking if patients have rides to their appointments, setting up patients' wellness visits, and following up with patient referrals.	

Source: GAO analysis of literature and stakeholder interviews. | GAO-17-55

- **Measure quality and efficiency performance.** Partner organizations can conduct analyses and provide reports to physician practices to help them understand and track their performance. For example, some partner organization stakeholders we spoke with measured physician practice performance against a defined set of quality measures and compared practices with their peers. These reports can help physician practices identify opportunities for quality improvement and savings without waiting for performance feedback from CMS. For example, one partner organization stakeholder told us that the organization analyzes data at the patient and physician level looking for opportunities to help the physician practice gain efficiencies, as well as identify differences in quality among practices. This partner organization also uses the data to educate the physician practices about patient attribution and differences in quality. According to another partner organization stakeholder, the analysis the organization conducts for their physician practices helps these practices manage the number and variety of performance measurements associated with value-based payment models. See figure 6 for the challenges that are mitigated by partner organizations helping physician practices measure their quality and efficiency performance.

Figure 6: Challenges That Can Be Mitigated by Partner Organizations Measuring Quality and Efficiency Performance for Small and Rural Physician Practices

SERVICE	CHALLENGES MITIGATED
Measure quality and efficiency performance	<ul style="list-style-type: none">• Difficulties with receiving timely performance feedback.• Misalignment of quality measures between various value-based payment models and payers.
EXAMPLES	
<ul style="list-style-type: none">• A partner organization can conduct analyses and provide reports to physician practices to help them understand and track their performance.• A partner organization can manage quality measure reporting required by various payers.	

Source: GAO analysis of literature and stakeholder interviews. | GAO-17-55

- **Manage compliance with requirements of value-based payment models.** Partner organizations can provide assistance with value-based payment model requirements, as small and rural physician practices may not be structured to handle this administration. For example, an awardee convener stakeholder stated that it liaisons with CMS and prepares and submits all CMS-required documentation on behalf of providers. Another partner organization stakeholder stated that the organization’s legal counsel explains the various waivers relevant to the ACO, as well as the requirements of these waivers to providers in the ACO. See figure 7 for the challenges that are mitigated by partner organizations helping physician practices manage compliance with the rules and regulations of value-based payment models.

Figure 7: Challenges That Can Be Mitigated by Partner Organizations Managing Compliance with Requirements of Value-based Payment Models for Small and Rural Physician Practices

SERVICE	CHALLENGES MITIGATED
Manage compliance with requirements of value-based payment models	<ul style="list-style-type: none">• Difficulties with staying abreast of regulatory changes and managing compliance with multiple requirements of value-based payment models.• Difficulties with understanding and managing compliance with the terms and conditions of waivers related to various fraud and abuse laws.
EXAMPLES	
<ul style="list-style-type: none">• A partner organization can liaison with CMS and prepare and submit CMS-required documentation on behalf of providers.• A partner organization can provide guidance on waivers relevant to the value-based payment model.	

Source: GAO analysis of literature and stakeholder interviews. | GAO-17-55

Non-Partner Organizations Do Not Share Risk with Physician Practices but Provide Specific Services That Can Help with Some Challenges

Based on the 38 stakeholder interviews we conducted and the related documentation collected, the other category of organizations we identified that help small and rural practices participate in value-based payment models are non-partner organizations. Non-partner organizations provide services that are generally not as comprehensive as partner organizations, and they do not share in the financial benefits or risks with the practices. The specific services they provide—primarily in the key topic areas of health IT and data, quality and efficiency performance measurement and reporting, and population health management care delivery—help with certain challenges. The source of funding for non-partners also varies. For example, non-partner organizations might be hired by the practice itself or funded separately by government grants. The following are the types of non-partner organizations identified in our review and the types of services they can provide to small and rural physician practices.

- **Facilitator conveners.** These organizations have arrangements with providers or awardee conveners to provide administrative and technical assistance to aid with participation in BPCI. Although facilitator conveners do not bear risk, they are similar to awardee

conveners in that they can assist physician practices and other providers with quality measurement and performance activities. For example, a facilitator convener could help track quality measures for providers. They can also help physician practices transition toward population health management care delivery by providing education to physician practices through webinars, for example, and by helping providers develop processes to coordinate episodes of care across providers.

- **Health IT vendors.** These technology companies are hired by physician practices to provide EHR systems, as well as data analytics software and services. Health IT vendors can assist practices with system interoperability challenges. For example, one health IT vendor stakeholder said that the vendor provides a connectivity engine so that physician practices' EHR systems are interoperable with other providers and payers. Health IT vendors can also conduct analyses—such as using data to evaluate physician practices against performance measures to identify additional opportunities for improvement—or help develop population health management processes. Health IT vendors can help practices manage misalignment of quality measures between payers. A health IT vendor stakeholder told us that the organization uses numerous codes within practices' datasets to allow practices to produce reports for multiple payers whose quality measures do not align; however the stakeholder added that this process is time intensive and could increase costs for the practices. Health IT vendors can also provide education and training for physician practices on best practices for EHR integration and optimization. A health IT vendor stakeholder told us that for small physician practices they generally provide EHR services; revenue and practice management service; and patient engagement services, which can include automatic check-in for patients, patient payment collection, and patient portals so practices can communicate electronically with patients.
- **Regional Extension Centers (REC).** RECs provide on-the-ground technical assistance intended to support small and rural physician practices, among others, that lack the resources and expertise to select, implement, and maintain EHRs. According to Department of Health and Human Services' (HHS) documentation, RECs stay involved with physician practices to provide consistent long-term support, even after the EHR system has been implemented. REC services include outreach and education on systems, EHR support (e.g., working with vendors, helping to choose a certified EHR system), and technical assistance in implementing health IT. Technical assistance in implementing health IT includes using it in a

meaningful way to improve care, such as using systems to support quality improvement and population health management activities. Sixty-two RECs were funded through cooperative agreements by HHS's National Learning Consortium.³⁵ RECs include public and private universities and nonprofits.

- **Quality Innovation Network-Quality Improvement Organizations (QIN-QIO).** QIN-QIOs work with small and rural physician practices, among others, to improve the quality of health care for targeted health conditions. For example, if a QIN-QIO has an initiative related to a specific health condition, such as a heart condition, the QIN-QIO would help practices improve clinical quality measures for patients with this condition, such as measures for blood pressure, cholesterol, and smoking cessation. The assistance provided and work performed by QIN-QIOs can vary greatly. A QIN-QIO stakeholder we interviewed told us that the QIN-QIO helps providers learn how to produce a quality report, how to interpret quality measures, and how to improve those measures, as well as educates providers on various requirements of value-based payment models. Other activities the network performs include educating physician practices on how to capture and understand EHR data since, according to this same stakeholder, small and rural physician practices often struggle with proper documentation for quality and performance management. The 14 QIN-QIOs each cover a region of two to six states and are awarded contracts from CMS.
- **Practice Transformation Networks (PTN).** PTNs are learning networks designed to coach, mentor, and assist clinicians in developing core competencies specific to population health management to prepare those providers that are not yet enrolled in value-based payment models. According to CMS officials, PTNs work with physician practice leadership to assist with patient engagement, use data to drive transformation of care toward population health management, and develop a comprehensive quality improvement strategy with set goals. The degree of help provided by the PTN depends on how far along the physician practice is in transforming to value-based care, according to CMS officials. PTNs provide technical assistance to physician practices on topics such as how to use data to manage care and move toward population health management. For example, a PTN stakeholder told us that the PTN makes sure the

³⁵The period of performance for the awards was from January 2010 through September 2016. According to a National Learning Consortium official, most of the 62 RECs have the potential to remain operational post-award.

physician practice creates a registry to track high-risk patients and then uses the registry to perform outreach to patients to initiate follow-up care appointments. Similarly, PTNs can help ensure that practices use a referral tracking system, such as a system to determine whether a patient that a practice referred for a mammogram actually had the mammogram. PTNs can also provide other educational resources such as live question-and-answer chat sessions, peer-to-peer webinars, and computer modules that cover topics including quality improvement and patient engagement. The 29 PTNs receive funding through CMS grants and are part of CMS's Transforming Clinical Practice Initiative.³⁶ The PTNs include public and private universities, health care systems, and group practices.³⁷

The services of non-partner organizations could help assist with some challenges we identified for small and rural practices. (See fig. 8.)

³⁶According to information on CMS's website, the Transforming Clinical Practice Initiative is designed to help clinicians achieve large-scale health transformation and is one part of a strategy advanced by PPACA to strengthen the quality of patient care and spend health care dollars more wisely. The initiative is designed to support more than 140,000 clinician practices over the next 4 years in sharing, adapting, and further developing their comprehensive quality improvement strategies. The anticipated period of performance for PTNs is May 1, 2015, through April 30, 2019. The 4-year period of performance for this model includes one 12-month base period and three option periods of 12 months each. CMS has also supported 10 Support and Alignment Networks through the initiative, which provide workforce development utilizing physician associations and specialty medical societies. For example, these networks may provide online modules that physician practices can access on topics such as quality measurement activities and comprehensive primary care. In June 2016, CMS announced a second round funding opportunity announcement of the Support and Alignment Networks—referred to as Support and Alignment Networks 2.0, and on September 29, 2016, the agency announced funding to two awardees. Through this initiative, these awardees will identify, enroll, and provide tailored technical assistance to advanced practices in an effort to reduce Medicare program expenditures by helping transition the practices to participate in alternative payment models and enhancing the quality, efficiency, and coordination of care they deliver.

³⁷Organizations that are PTNs may also have other roles that help small and rural practices participate in value-based payment models. For example, one organization we spoke with was a PTN providing practices with assistance in moving toward population health management. At the same time, this organization helped certain small and rural physician practices in additional capacities through its role as a partner organization for those practices.

Figure 8: Challenges That Can Be Mitigated by Services Provided to Small and Rural Physician Practices by Non-Partner Organizations

SERVICE	EXAMPLES	CHALLENGES MITIGATED
Manage health IT systems and data	<ul style="list-style-type: none"> A non-partner organization can help select, implement, and manage EHR systems. (health IT vendors, RECs) A non-partner organization can provide technical assistance and training to educate practices on how to meaningfully use their EHR systems. (health IT vendors, PTNs, RECs, QIN-QIOs) 	<ul style="list-style-type: none"> Difficulties with data system interoperability and limited ability to access data outside the practices' own systems. Difficulties with educating and training staff about EHR systems and the data entry, management, and analysis needed for participation.
Provide education and training related to population care management	<ul style="list-style-type: none"> A non-partner organization can provide educational resources and training on how to use technology for patient engagement and to improve population health management processes. (health IT vendor) A non-partner organization can provide educational resources, such as manuals, online modules, and webinars, on topics such as quality improvement, patient engagement, and care coordination. (facilitator conveners, health IT vendors, PTNs) 	<ul style="list-style-type: none"> Patient preferences and geographic location affect practices' ability to implement population health management care delivery and account for total cost of care. Provider resistance to making adjustments needed for population health management care delivery.
Measure quality and efficiency performance	<ul style="list-style-type: none"> A non-partner organization can help with quality and efficiency measurement, performance monitoring, and data analysis, including how to run a quality report and identifying areas to improve performance. (facilitator conveners, health IT vendors, PTNs, QIN-QIOs) 	<ul style="list-style-type: none"> Difficulties with receiving timely performance feedback. Misalignment of quality measures between various value-based payment models and payers.
Manage compliance with requirements of value-based payment models	<ul style="list-style-type: none"> A non-partner organization can provide guidance on the participation requirements of value-based payment models. (QIN-QIOs) 	<ul style="list-style-type: none"> Difficulties with staying abreast of regulatory changes and managing compliance with multiple requirements of value-based payment models.

Legend: EHR= electronic health record; REC= Regional Extension Center; PTN= Practice Transformation Network; QIN-QIO= Quality Innovation Network-Quality Improvement Organization.

Source: GAO analysis of literature and stakeholder interviews. | GAO-17-55

Not All Small and Rural Physician Practices Can Access Services Provided by Organizations

Although we found that organizations can assist with many of the challenges identified for small and rural practices, not all such practices can access these services for a variety of reasons. First, some stakeholders we interviewed said that small or rural physician practices do not necessarily have access to an organization, such as an organization that forms ACOs. For example, some ACO stakeholders told us that they used criteria to determine which physician practices they would reach out to for inclusion in the ACO. One ACO stakeholder stated

that the organization analyzes public data to identify the physician practices that look like good candidates for population health management and then talks to the practices about a possible partnership. Therefore, some small or rural physician practices struggling with changes needed to deliver population health management may not be contacted by an organization that forms ACOs.

Second, we heard from some stakeholders that the limited resources of many small and rural physician practices may hinder their access to services provided by organizations. For example, small and rural physician practices may not have the financial resources to hire organizations that could assist them with participation, such as health IT vendors. Also, according to some stakeholders, organizations' ability to assist practices is hindered when the practices struggle to make the initial investments needed to participate, such as hiring new staff or developing necessary data systems.

Last, even if practices have access to an organization, that organization may not offer the services that the practice needs since the services offered can vary by organization. For example, not all partner organizations that form ACOs have access to and use other payers' data to aid in the management of patient care. When we asked one partner organization stakeholder how the organization received access to data, the stakeholder stated that it was because of long-standing relationships it had with payers. Other partners that form ACOs may not be able to provide similar data to share. Additionally, according to CMS officials, each facilitator convener and awardee convener has discretion in the services it provides, and the services can vary, as can the services provided by CMS and HHS grantees—RECs, QIN-QIOs, and PTNs.

Agency Comments

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

We are sending copies of this report to the appropriate congressional committees, the Secretary of Health and Human Services, and the CMS administrator. In addition, the report is available at no charge on the GAO website at <http://www.gao.gov>.

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

A handwritten signature in black ink, appearing to read 'James Cosgrove', with a stylized, cursive script.

James Cosgrove
Director, Health Care

Appendix I: GAO Contact and Staff Acknowledgments

GAO Contact

James Cosgrove, (202) 512-7114, cosgrovej@gao.gov

Staff Acknowledgments

In addition to the contact named above, Greg Giusto, Assistant Director; Christie Enders, Analyst-in-Charge; Deirdre Gleeson Brown, Analyst-in-Charge; and Samantha Pawlak made key contributions to this report. Also contributing were George Bogart, Beth Morrison, and Vikki Porter.

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