

MIPS Versus APMs: A Comparative Analysis of CMS Quality Payment Programs

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Unintended Consequences

A November 2018 article of *Healthcare Financial Management* summarized the top news stories of the month in the world of healthcare policy and trends. Under the heading *Medicare Quality Pay Leads Practice Regulatory Burden*, the article states, “Medicare quality payment programs pose the greatest hindrance for medical practices, according to a new poll by the Medical Group Management Association. Among the 426 practice executives who responded to the poll, 88 percent named the Medicare Quality Payment Programs, specifically the two arms of Medicare physician compensation, as very or extremely burdensome” (Quick Hits, 2018, p. 14).

Initial Definition of Terms

The “two arms of Medicare physician compensation” referred to in the above quote are the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs). Together these are the two tracks of Quality Payment Programs (QPP) imposed upon physicians and mid-level providers by the Centers for Medicare and Medicaid Services (Quality Payment, Para. 5). The QPP took effect on January 1, 2017 as part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) that “passed with strong bipartisan support (Nuckols, 2017, p. 368).

Gaming the System

The goal of the QPP by the Centers for Medicare and Medicaid Services (CMS) is noble--to drive high-quality, high-value healthcare and positively impact patient outcomes through financial incentives to providers (Nuckols, 2017, p. 368). In addition to the above referenced administrative burden of compliance, Teryl K. Nuckols, MD points out a more alarming unintended consequence in a March 2017 editorial article from the *Annals of Internal Medicine*. He speaks of the risk of providers gaming the system by emphasizing care “that is not subject to incentives” and choosing to focus their practice on healthier patients to drive positive outcomes (p. 369). According to Nuckols, “Clinicians may be deterred not only from treating patients who are sicker or less adherent to treatment recommendations but also from affiliating with clinicians who treat such patients, which could exacerbate socioeconomic disparities in care” (Nuckols, 2017, p. 369).

The Improved Outcomes Question

These unintended consequences raise concern, especially when coupled with very little published evidence that QPP positively impact patient outcomes. In March of 2017 the *Annals of Internal Medicine* published a review of 69 studies (58 from ambulatory settings, 11 from hospital settings) titled *The Effects of Pay-for Performance Programs on Health, Health Care Use, and Processes of Care*. The review concluded, “Pay-for-performance programs may be associated with improved processes of care in ambulatory settings, but consistently positive associations with improved health outcomes have not been demonstrated in any setting” (Mendelson et al., 2017, p. 341).

A 2019 qualitative study published in *Population Health Journal* explored provider perspectives on “whether and how quality payment programs improve diabetes quality of care” (Garabedian, Ross-Degnan, & Wharam, 2019, p. 248). This study stated in conclusion, “Primary care providers in this study generally believed that insurer’s quality payment programs have improved the quality of diabetes care in their practices, mainly by providing incentives and resources for practice-level quality improvement initiatives” (Garabedian et al., 2019, p. 253). However, this study focused on provider perceptions of quality of care and acknowledged its own shortcoming in providing empirical evidence to support QPP impact on patient-centered outcomes (Grabedian et al., 2019).

In CMS’ first annual report on one of their own Alternative Payment Models (APMs) called Comprehensive Primary Care Plus (CPC+), the takeaways stated, “There were few effects on cost, service use, and quality for Medicare FFS beneficiaries in the first year. Effects on patient outcomes may emerge with more time...” (CPC Plus First, n.d., Para 10).

Deficiencies of Past Literature

Evidence suggests the QPP create significant administrative burden on providers in terms of compliance, provoke the possible unintended consequence of providers gaming the system, and presently provide little empirical evidence of positive impact on patient outcomes. Although the author was able to find informative resources defining each of the QPP, there are few if any published resources empirically comparing the various QPP options in terms of administrative simplicity, risk assumption, and financial incentive. This is likely due to the recent legal implementation of these programs as the oldest of them took effect on January 1, 2017 (Quality Payment, n.d.). Viewing this healthcare payment landscape as an administrative professional in a rural acute care hospital with a vibrant physician’s clinic, the author desires to explore QPP from that perspective for the benefit of my own healthcare system and other providers as well.

The Purpose of this Study

The central questions of this research are, of the mandated CMS Quality Payment Programs (QPP), how do MIPS and the available APMs compare in terms of:

1. administrative simplicity
2. risk assumption
3. financial incentive

Based on this information, is MIPS or one of the Alternative Payment Models (APMs) such as Comprehensive Primary Care Plus (CPC+) or the soon available Primary Care First (PCF) and Directly Contracting (DC) models a preferable option to healthcare providers? The purpose of this study is a quantitative comparative analysis of MIPS as the independent variable and the APMs as the dependent variables based on available program definitions and performance data to determine the most suitable compliance option for rural healthcare providers in terms of administrative simplicity, risk assumption, and financial incentive.

Review of Literature

CMS is a major payor source and stakeholder in healthcare. The QPP under review in this study are defined and administered by CMS under the authority of MACRA 2015. For this reason, this study relies heavily on program definitions and progress reports published by CMS. The author

suspects the relative lack of scholarly QPP comparisons and evaluations is due to the recent implementation of the QPP, which took effect January 1, 2017 (Quality Payment, n.d.). The *Quality Payment Program Overview* published by CMS briefly sets forth the legal history and timeline that established the QPP and briefly defines the two tracks of the QPP, namely MIPS and APMs (n.d.). It also explains the reasons the QPP were implemented to replace the Sustainable Growth Rate (SGR) model. Under the SGR, Medicare capped spending increases according to the size of the Medicare population and a modest inflation adjustment (Quality Payment, n.d.). This capped spending resulted in diminished reimbursement for increased service utilization and was ultimately unsustainable (Quality Payment, n.d.).

Merit-based Incentive Payment System (MIPS)

MIPS is the default track of the QPP unless a provider is on an APM path. The CMS publication, *MIPS Overview*, explains how all clinicians of eligible types who “meet the low volume threshold” are required to participate (n.d., p. 13). MIPS updated and consolidated several previous CMS programs; including, “Medicare Electronic Health Records (EHR) Incentive Program for Eligible Clinicians, Physician Quality Reporting System (PQRS), and the Value Based Payment Modifier (VBM)” (MIPS Overview, n.d., p. 1). It also provides basic definition of the four performance categories that compositely formulate a provider’s MIPS score—“Quality, Improvement Activities, Promoting Interoperability (formerly Advancing Care Information), and Cost” (MIPS Overview, n.d., p. 1).

The *2019 Merit-based Incentive Payment System (MIPS) Quality Performance Category Fact Sheet* defines the MIPS QPP in more detail, including updates and data specific to the current year 2019 (United States, 2019). This publication defines in detail the percentage weight of each performance category in the composite score, the types of individual provider and group participation, new terminology, the 7 types of quality measures, the data submission types, and the point scoring system (United States, 2019).

The *2017 Quality Payment Program Performance Year Data* publication summarizes the MIPS data for the first performance year 2017 (United States, 2018). MIPS operates on a continuous three-year cycle and 2017 was the first year of the program (United States, 2018). The cycle includes a year to collect data, reporting the data to CMS by March 31st of the subsequent year, and the composited score on the submitted data positively or negatively impacts a providers Medicare reimbursement in third year (United States, 2019). Hence, 2019 was the first year for participant payment adjustments under MIPS. The maximum positive adjustment received in 2019 for the 2017 performance year was 1.88% and the maximum penalty was -4.00% (United States, 2018). The author will discuss the implications of this fact later in this study.

Alternative Payment Models (APMs)

The *APMs Overview* (n.d., p. 1) publication defines an APM as, “a payment approach that gives added incentive payments to provide high-quality and cost-efficient care” and “can apply to a specific clinical condition, a care episode, or a population.” The article also differentiates 2 types of APMs—MIPS APMs and Advanced APMs (APMs Overview, n.d.). It also mentions the “All-Payer/Other-Payer Option” available to eligible clinicians “starting in performance year 2019” (APMs Overview, n.d., p. 2).

As the author works for an Oklahoma based rural acute-care hospital with a physician's clinic, this study will focus on the Advanced APMs available or soon available in Oklahoma--namely, Comprehensive Primary Care Plus and the soon available Primary Care First and Direct Contracting models (Comprehensive, 2019. Primary Care First, 2019).

Comprehensive Primary Care Plus (CPC+)

The document *Comprehensive Primary Care Plus* from CMS defines CPC+ as an Advanced APM with “two primary care practice tracks with incrementally advanced care delivery requirements and payout options” (2019, p. 1). This APM incorporates a “public-private partnership” comprised of “56 aligned payers in 18 regions” (Comprehensive, 2019, p. 1) and provides clinicians with a “robust learning system...actionable data feedback,” and “the infrastructure to deliver better care” (Comprehensive 2019, p. 2). Both tracks center on 5 key functions of primary care, specifically:

1. Access and continuity
2. Care Management
3. Comprehensiveness and Coordination
4. Patient and Caregiver Engagement
5. Planned Care and Population Health (Comprehensive, 2019, p. 2)

The pay elements are defined as a Care Management Fee (CMF), a performance-based incentive payment, and payment under the Medicare Physician Fee Schedule (Comprehensive, 2019).

These pay elements are fully described in the document.

The document *CPC Plus First Annual Report* informs the reader that CPC+ is “the largest and most ambitious primary care payment and delivery reform ever tested in the United States” (n.d., Para. 1). The number of participating payer sources is updated to 79 (CPC Plus First, n.d.).

Modest findings are presented with the conclusion that “there were few effects on cost, service use, and quality for Medicare FFS (Fee-for-Service) beneficiaries in the first year” and “effects on patient outcomes may emerge with more time as CPC+ practices deepen and expand care delivery changes” (CPC Plus First, n.d., Para. 10).

The *CPC+ 2018 Year in Review* summarizes the 2nd performance year of CPC+ and reports more vigorous results supported with statistical data across the 5 Key Comprehensive Primary Care Functions (CPC+ 2018, n.d.). In the author's opinion, these results begin to formulate a comparison basis to MIPS and are a topic of further discussion later in this study.

Primary Care First (PCF)

A CMS press release from April 22, 2019 entitled, *HHS News: HHS to Deliver Value-based Transformation in Primary Care* announced the arrival of the CMS Primary Care Initiative which “building on lessons from previous models...will reduce administrative burdens and empower primary care providers to spend more time caring for patients” (HHS News, 2019, Para. 1). “For years, policymakers have talked about building a healthcare system that focuses on primary care, pays for value, and places the patient at the center. These new models represent the biggest step ever taken towards that vision,” said U.S. Department of Health and Human Services (HHS) Secretary Alex Azar (HHS News, 2019, Para. 2). Azar continued, “These models will test out paying for health and outcomes rather than procedures on a much larger

scale than ever before.” These 5 new Advanced APMs are Primary Care First (PCF) with two participation options and Direct Contracting with three participation options (HHS News, 2019, Para. 6). The CMS publication *Primary Care Initiative Onepager* (n.d.) briefly defines and describes each of the 5 new models and is useful for surface-level comparison of the new Advance APM opportunities.

The CMS newsroom factsheet *Primary Care First: Foster Independence, Reward Outcomes* (2019) and the CMS document *Primary Care First Model Options* (2019) both define the two PCF model options in detail while explaining the underlying principles and goals of the models. Oklahoma is included as one of the 26 PCF regions targeted for the January 1, 2020 start date (Primary Care First Model, 2019). These documents also reveal that PCF is “based on the underlying principles of the CPC+ model” (Primary Care First: Foster, 2019).

Direct Contracting (DC)

The CMS newsroom factsheet *Direct Contracting* (2019) and the CMS document *Direct Contracting Model Options* (2019) both define the three DC model options in detail while explaining the underlying principles and goals of the models. The DC models are aimed at cutting expense while enhancing care quality for Medicare fee-for-service (FFS) patients (Direct Contracting Model, 2019, p. 1). They are a response to organizations that have “expressed interest in a model that draws upon private sector approaches to risk-sharing arrangements and payment and reduces administrative burden commensurate with the level of downside risk” (Direct Contracting, 2019, Para. 3).

The author believes that the articles and documents summarized above provide a basis for valid comparison of the merits of MIPS with the merits of available APMs in Oklahoma, evaluating each through the lens of administrative simplicity, risk assumption, and financial incentive. This will inform the analysis and discussion for the remainder of this study.

Methods

Design

This study is a simple quantitative experimental comparison of the QPP mandated by CMS. MIPS, the default track of the QPP, is the independent variable. The available and soon available APMs in Oklahoma serve as dependent variables.

Procedure

A thorough online search of the OSU Center for Health Sciences Medical Library for subject-related, peer-reviewed articles was conducted utilizing the key words *Quality Payment Programs, Quality Payment Program Comparisons, Quality Payment Program Effectiveness, Quality Payment Program Results on Patient Outcomes, and Provider Perceptions of Quality Payment Programs*. This initial search yielded 9 articles of interest with varying degrees of relevance to the subject. After reviewing these articles, the author utilized information from 5 of them in this study.

It became apparent that very little information to date was available or published in terms of QPP performance results or comparing important aspects of the QPP to one another. As stated previously, this is likely due to the recent enactment of the QPP. This gap in the literature inspired the author to initiate a personal comparative study of the QPP.

The QPP are CMS programs. They are defined, implemented, and administrated through CMS under the larger administration of the United States Department of Health and Human Services. A thorough search of the CMS online QPP resource library at <https://qpp.cms.gov/about/resource-library> yielded 15 articles, fact sheets, and press releases relevant to the programs under investigation in this study. After review, the author narrowed the utilized CMS literature to 13 pieces. Two pieces of available CMS literature were not utilized due to redundant information.

Measures

This study is based on a reference list of 18 resources relying heavily on information published by CMS. The author contemplatively narrowed the points of program comparison to administrative simplicity, risk assumption, and financial reimbursement. As an individual in administration in an Oklahoma rural acute-care hospital that offers many programs and services along with a physician's clinic for primary care, the author believes that these are the points of greatest concern to healthcare provider administration. This study assumes that administrative simplicity is a positive (+) model characteristic and administrative complexity a negative (-), that low-risk assumption is a positive (+) model characteristic and high-risk is a negative (-), and that increased financial reimbursement or the realistic opportunity for it is a positive (+) model characteristic and diminished or penalized financial reimbursement is a negative (-). The QPP compared in this study are the Merit-based Incentive Payment System (MIPS), Comprehensive Primary Care Plus (CPC+), Primary Care First (PCF), and Direct Contracting (DC). Each model is assigned a positive (+) or negative (-) mark on each of the three points of comparison.

Threats to Validity

The greatest threats to the validity of this study are limited program performance data on MIPS and CPC+ and no performance data on the recently unveiled new APMs of PCF and DC. The study utilizes comparison of the best available performance data on the former. On the latter, the comparisons are by conjecture based on the program definitions and information released from CMS. From the comparison, the author's opinions concerning the best available option for rural healthcare providers are subjective and may not prove to be the chosen option or the best option for every provider. These are complex payment models and each provider must draw their own conclusions based on their own administrative capabilities and risk tolerance. The comparisons in this study should provide a partial basis for an informed decision.

Data Analysis

Merit-based Incentive Payment System (MIPS)

Administrative simplicity (-)

MIPS, the default track of CMS QPP, is a relatively complex model. Under MIPS, four performance categories comprise a provider's or provider group's score—quality (45%), cost (15%), improvement activities (15%), and promoting interoperability (25%) (United States, 2019). The "quality" category addresses the quality of care delivered based on performance measures (MIPS Overview, n.d.). The "cost" category assesses that cost of care provided and is calculated by CMS using MIPS "cost measures to gauge the total cost of care during the year or during a hospital stay (MIPS Overview, n.d., p. 5). The "improvement activity" category

contains activities that address the improvement of care processes, patient engagement, and increased access to care (MIPS Overview, n.d.). The “promoting interoperability” category assesses a provider’s capacity to increase “patient engagement and the electronic exchange of health information using certified electronic health record technology (CEHRT)” (MIPS Overview, n.d., p. 3).

The “quality” performance category factor alone contains over 250 possible quality measures to report and those are sub-divided into 7 types of measures (United States, 2019, pp. 3-4). For the 2019 12-month performance period, a provider or provider group must report 6 quality measures that “must include at least 1 outcome measure or another high priority measure in the absence of an applicable outcome measure” (United States, 2019, p. 6). There are 4 data collection types available to individual providers and 7 available to provider groups (United States, 2019, p. 12). There are 5 data submission types and all data must be submitted by March 31 of the subsequent data collection year (MIPS Overview, n.d.). Data on each measure submitted is converted to a point system, compared to national benchmarks, and impacts reimbursement positively or negatively (United States, 2019, pp. 14-21) in the third year (MIPS Overview, n.d.). MIPS receives a negative (-) mark for administrative simplicity.

Risk assumption (-)

In the MIPS model, providers are scored and compared against one another in a budget neutral environment. The financial incentive bonuses or penalties are competitive (United States, 2019). In 2017 the maximum positive payment adjustment attainable by CMS definitions was 4% and the maximum penalty was -4%. This represents a potential 8% swing in revenue to providers. The 2019 performance year will equate to a maximum positive payment adjustment of 7% with a matching maximum penalty of -7% in the payment year 2021. This represents a potential 14% swing in revenue to providers. For this volatility MIPS receives a negative (-) mark for risk assumption.

Financial incentive (-)

2017 was unique as the first year of the program and a transitional year for providers (United States, 2018). Requirements to avoid penalty were less strict and the first year focused on flexibility “to reduce participation burden” (United States, 2018, para. 1). For 2017, 71% of participating providers earned the maximum payment adjustment, 22 % earned a positive payment adjustment, 2% received a neutral adjustment with no increase or decrease, and 5 % received a negative payment adjustment (United States, 2018).

Due to the requirement for budget neutrality and the high percentage of providers receiving positive adjustment, the maximum 2019 positive payment adjustment received by any provider for the 2017 performance year was 1.88% and the maximum penalty -4% (United States, 2018). This indicates that maximum financial penalties are upheld while maximum positive payment adjustments are curved to maintain budget neutrality. The potential positive payment adjustment may perform better in future payment years and CMS implements more strict program requirements. At this point, MIPS receives a negative (-) mark for financial incentive.

Comprehensive Primary Care Plus (CPC+)

Administrative simplicity (+)

This advanced primary care model “aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation (Comprehensive, 2019, p. 1). CPC+ offers considerable administrative support and equips providers with “a robust learning system, as well as actionable data feedback to guide their decision making” and “ensures practices have the infrastructure to deliver better care” (Comprehensive 2019, p. 2). In the first year, CPC+ supported participating providers with payments over and above what they previously received for providing care (CPC+ First, n.d.). Participating providers also received actionable data feedback, individualized and group learning supports, and health IT vendor support (CPC+ First, n.d.). CPC+ offers greater program support than MIPS and receives a positive (+) mark for administrative simplicity in comparison.

Risk assumption (+)

There are 3 pay elements in CPC+---namely, Care Management Fee (CMF), Performance-based Incentive Payment, and payment under the Medicare Physician Fee Schedule (Comprehensive, 2019, p. 2). The Care Management Fee (CMF) is not visit-based and paid per-beneficiary-per-month with the amount risk-adjusted for each practice (Comprehensive, 2019, p. 2). The Performance-based Incentive Payment in CPC+ is a proactively paid and retrospectively reconciled incentive “based on how well a practice performs on patient experience measures, clinical quality measures, and utilization measures that drive the total cost of care” (Comprehensive, 2019, p. 2)

The two primary care practice tracks of CPC+ center on “payment under the Medicare Physician Fee Schedule (Comprehensive, 2019, p. 2). “Track 1 continues to bill and receive payment from Medicare FFS as usual” (Comprehensive, 2019, p. 2). Track 2 providers “also continue to bill as usual, but the FFS payment will be reduced to account for CMS shifting a portion of the Medicare FFS payments into Comprehensive Primary Care Payments (CPCP)” paid in a lump sum quarterly (Comprehensive 2019, p. 2). It is important to note that the Track 2 “practices are expected to increase the comprehensiveness of care delivered;” hence, “the CPCP amounts will be larger than the FFS payment amounts they are intended to replace” (Comprehensive, 2019, p. 2). The combination of the 3 pay elements of CPC+ mitigates the potential for adverse financial performance. CPC+ receives a positive (+) mark for risk assumption in comparison to MIPS.

Financial incentive (+)

The *Comprehensive Primary Care Plus Initiative (CPC+) First Annual Report* states that the median CPC+ practice received \$88,000 on Track 1 and \$195,000 on Track 2 in CPC+ Care Management Fees over and above traditional payments (CPC Plus First, n.d.) In comparison to MIPS, the CPC+ model receives a positive (+) mark for financial incentive.

Primary Care First (PCF)

Administrative simplicity (+)

Primary Care First will be “tested for 5 years and is scheduled to begin in January 2020” (HHS News, 2019, para. 9). It is based on “the underlying principles of the existing CPC+ model (Primary Care First Model, 2019, p. 1). There are two payment options under the Primary Care

First APM. “*Primary Care First – General*” is the first option with the stated goal to “test whether delivery of advanced primary care can reduce total cost of care” (Primary Cares Initiative, n.d.). This model “focuses on advanced primary care practices ready to assume financial risk in exchange for reduced administrative burden and performance-based payments” (Primary Cares Initiative, n.d., para 5). It also offers “higher payments for practices that care for complex, chronically ill patients” (Primary Cares Initiative, n.d., para. 5).

The second PCF model is “*Primary Care First – High Needs Populations Payment Model Option*” (Primary Cares Initiative, n.d., para 6). It is designed to encourage providers to “take responsibility for high need, seriously ill beneficiaries who currently lack a primary care practitioner and/or effective care coordination,” referred to in this model as Seriously Ill Population (SIP) (Primary Cares, n.d., para. 6). With a stated goal of reducing administrative burden, the PCF models score a positive (+) mark in comparison to MIPS on administrative simplicity.

Risk assumption (-)

PCF puts forth a simple payment structure that “allows care to be driven by clinicians rather than administrative requirements and revenue cycle management” (Primary Care First Foster, 2019, pp.2-3). It includes a “population-based payment to provide more flexibility in the provision of patient care along with a flat primary care visit fee” coupled with a “performance based adjustment providing an upside of up to 50% of revenue as well as a small downside (10% of revenue)...assessed and paid quarterly” (Primary Care First Foster, 2019, p. 3). The flat primary care visit fee and strong quarterly performance-based adjustment of PCF offer stronger revenue potential than MIPS, but with the provider assuming more risk. PCF receives a negative (-) mark on risk assumption compared to MIPS.

Financial incentive (+)

As stated in the above paragraph on PCF risk assumption, the payment mechanisms offer potentially stronger revenue in comparison to MIPS. With no historical performance data on this new model, PCF speculatively receives a positive (+) mark compared to MIPS on financial incentive.

Direct Contracting (DC)

Administrative simplicity (+)

Direct Contracting offers 3 payment model options designed to allow providers to assume risk and earn rewards in the Medicare fee-for-service (FFS) environment (Direct Contracting Fact, 2019, p. 1). These payment models also present a “higher set of quality measures that focuses more on outcomes and beneficiary experience than on process” (Direct Contracting Fact, 2019, p. 1). “They are expected to reduce burden, support a focus on beneficiaries with complex, chronic conditions, and encourage participation from organizations that have not typically participated in Medicare FFS or CMS Innovation Center models” (Direct Contracting Model, 2019, p. 1). The DC models receive a positive (+) mark in comparison to MIPS on administrative simplicity.

Risk assumption (-)

As stated above, these models offer less administrative restriction in exchange for greater assumed risk and potential greater rewards. In comparison to MIPS, the DC models receive a negative (-) mark on risk assumption.

Financial incentive (+)

Providers have payment “choices through Population-based Payment (PBP), beneficiary alignment, and benefit enhancements (Primary Cares Initiative, n.d., para. 8). In the “*Direct Contracting – Professional*” model Direct Contracting Entities (DCEs) “assume risk for 50% of shared savings/shared losses on the total cost of care (i.e. all Parts A and B services) for aligned beneficiaries (Primary Cares Initiative, n.d., para 9). Participating providers receive a “Primary Care Capitation”, which is a “capitated, risk-adjusted monthly payment for enhanced primary care services equal to 7% of the total cost of care for primary care services” (Primary Cares Initiative, n.d., para 9).

In the “*Direct Contracting – Global*” model Direct Contracting (DC) Population-Based Payment (PBP) entities bear risk for “100% of shared savings/shared losses on the total cost of care (i.e. all Parts A and B services) for aligned beneficiaries” (Primary Cares Initiative, n.d. para. 10). Global PBP DCEs have two payment options: the “Primary Care Capitation described above, or Total Care Capitation”, which is “a capitated, risk-adjusted monthly payment for all services provided by DC Participants and Preferred Providers with whom the DCE has an agreement” (Primary Cares Initiative, n.d., para. 10).

The “*Direct Contracting – Geographic*” model positions PBP DCEs to bear risk “for 100% of shared savings/shared losses on the total cost of care (i.e. all Parts A and B services) for aligned beneficiaries in a target region” (Primary Cares Initiative, n.d., para. 11). Geographic PBP DCEs will “be selected as part of a competitive application process and commit to providing CMS a specified discount amount off of total cost of care for the defined target region” (Primary Cares Initiative, n.d., para 11). The DC models offer greater risk-sharing for greater potential revenue, yet as with PCF, there is no historical performance data on the new DC models. DC speculatively receives a positive (+) mark compared to MIPS on financial incentive.

Results and Interpretation

Table 1
Criteria-Based Comparison of MIPS versus APMs – Positive (+) or Negative (-) Rating Scale

	Administrative Simplicity (+ or -)	Risk Assumption (+ or -)	Financial Incentive (+ or -)
MIPS	-	-	-
CPC+	+	+	+
PCF	+	-	+
DC	+	-	+

The independent variable of this study, the CMS QPP MIPS, scored negative marks on administrative simplicity, risk assumption, and financial incentive. The APM CPC+ scored positive marks compared to MIPS on all three criteria. Both new 2020 APMs, PCF and DC, scored positive marks compared to MIPS on administrative simplicity, negative marks compared to MIPS on risk assumption, and positive marks compared to MIPS on financial incentive. It bears repeating that with no historical data on the new APMs, PCF and DC, their evaluation is based on recently released model definitions and financial speculation.

One possible concern under the new upcoming APM models, with provider's assuming more risk and greater financial incentive for less administrative oversight and control from CMS, is the potential for providers to selectively ration care to beneficiaries to preserve revenue. Both PCF models appear to mitigate this risk with "*Primary Care First – General*" paying higher reimbursement to care for chronically ill and complex patients and "*Primary Care First – High Needs Populations Payment Model Option*" designed to incentivize providers to undertake care of the SIP (Seriously Ill Population). In the author's opinion, this particular risk is greater with and inherent to the Direct Contracting Models. This bears watchful scrutiny in the future as a possible unintended consequence.

Conclusion

From the results of this study, it is the author's opinion that CPC+ is currently the best QPP option for rural healthcare providers in Oklahoma, offering the most advantages in terms of administrative simplicity, minimal risk assumption, and potential for positive financial incentive. The new APMs, PCF and DC, warrant further examination after they take effect in 2020 and performance data is available in subsequent years. This study is a snapshot of the CMS QPP models currently, but the healthcare payment landscape is constantly evolving and a longitudinal study over time is useful and necessary to stay informed and make prudent administrative decisions in healthcare.

As previously stated under threats to validity, the author's opinions concerning the best available option for rural healthcare providers are subjective and may not prove to be the chosen option or the best option for every provider. These are complex payment models and each provider must draw their own conclusions based on their own administrative capabilities and risk tolerance. The comparisons in this study should provide a partial basis for an informed decision.

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