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Financial Risk Acceptance among Rural Health Care Providers Participating in the Quality Payment Program

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Purpose

This policy brief summarizes non-metropolitan and metropolitan health care providers' participation in different tracks and subdivisions in the Centers for Medicare & Medicaid Services (CMS) Quality Payment Program and evaluates provider and patient-panel characteristics associated with financial risk acceptance.

Key Findings

- In 2018, a lower proportion of non-metropolitan providers (11.3 percent of primary care providers and specialists) participated in Medicare Advanced Alternative Payment Models (APMs) with two-sided risk, compared to metropolitan providers (16.6 percent of primary care providers and specialists).
- In both non-metropolitan and metropolitan areas, higher proportions of primary care providers (15.4 percent in non-metropolitan areas and 21.4 percent in metropolitan areas) participated in two-sided risk models than specialists (9.0 percent in non-metropolitan areas and 14.7 percent in metropolitan areas).
- Non-metropolitan providers accepting no financial risk served fewer Medicare beneficiaries than non-metropolitan providers accepting financial risk. In contrast, metropolitan providers accepting no financial risk served more Medicare beneficiaries than metropolitan providers accepting financial risk.
- In both non-metropolitan and metropolitan areas, providers who accepted no financial risk received more than two times higher payment per beneficiary and had lower average Hierarchical Condition Category (HCC) risk scores than providers accepting financial risk.

Background

The U.S. Department of Health and Human Services is committed to shifting Medicare payments toward value-based arrangements [1]. As part of this shift, the Medicare Access and CHIP Reauthorization Act (MACRA) instituted the Quality Payment Program (QPP) to reward Medicare providers for high-quality, value-based care. The QPP requires that health care providers accept financial risk for the services that they deliver. An important policy question is whether rural providers are as prepared as their urban counterparts to accept financial risk. Answering this question requires comparing rural and urban providers' participation in various risk-bearing payment models in the QPP.

The QPP offers two tracks for providers. The first track is the Merit-based Incentive Payment System (MIPS), through which providers are subject to a performance-based payment adjustment based on CMS's evaluation of their performance across four categories: quality, promoting interoperability, improvement activities, and cost [2]. The second track is the Alternative Payment Model (APM), which is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs are subdivided into MIPS APMs and Advanced APMs. MIPS APMs allow MIPS-eligible

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clinicians to participate in certain APMs on their CMS-approved participation list [3]. Advanced APMs offer a 5 percent incentive payment if providers are eligible for the Qualifying Participants (QPs) designation (defined as those who participate in qualified value-based payment models, meet payment or patient thresholds through the APMs, and bear a significant financial risk) [4].

The QPP tracks tie Medicare payments to quality and value using different methods, resulting in providers accepting different types of financial risk. This policy brief analyzes non-metropolitan and metropolitan providers' participation in different QPP tracks and subdivisions and evaluates provider and patient-panel characteristics associated with financial risk acceptance.

Data and Methods

We used 2018 MIPS eligibility and APM participation data obtained from CMS. Rural-Urban Commuting Area (RUCA) codes were used to identify non-metropolitan (RUCA codes 3-12) and metropolitan (RUCA codes 1 and 2) providers based on their practice location's ZIP code. We used Medicare Physician and Other Supplier Aggregate Table data to identify provider characteristics. Our sample included all providers who billed Medicare Part B for covered professional services during 2018 and thus were subject to the QPP rules. We classified providers into two specialty groups—Primary Care Providers (PCPs, including family practice, general practice, geriatric medicine, internal medicine, pediatric medicine, physician assistants, and nurse practitioners) and Specialists (including all other specialties).

We adapted the health care payment framework published by the Health Care Payment Learning & Action Network (HPL-LAN) [5] to classify the types of financial risk for QPP tracks and subdivisions in 2018 (Table 1).

Table 1. Type of Financial Risk under QPP in 2018

Type of Financial Risk	QPP Tracks & Subdivisions[1]
No Risk: fee-for-service, no link to quality and value	QPP exempted, MIPS non-eligible and non-APM
Pay-for-Performance Risk: fee-for-service, link to quality and value	MIPS Only/Non-APM
One-Sided Risk: APMs with shared savings	MIPS APMs • Accountable Care Organization (ACO) Track 1 • Oncology Care Model (OCM) one-side risk • Comprehensive End-Stage Renal Disease (ESRD) Care Model non-large dialysis organizations (non-LDO) one-side risk
Two-Sided Risk: APMs with shared savings and downside risk	Advanced APMs • ACO Tracks 1+, 2, & 3 • ACO Next Generation • ESRD LDO & non-LDO two-side risk • Comprehensive Primary Care Plus (CPC+)

1. Some tracks and subdivisions have changed since 2018. For example, the Medicare Shared Savings Program has changed ACO Tracks from 1, 1+, 2, and 3 to Basic (with multiple levels) and Enhanced, and the Next Generation ACO model has been discontinued.

We calculated the proportions of providers accepting different types of financial risk and compared the proportions based on metropolitan status and medical specialty. Additionally, we characterized patient panels served by providers accepting different risk types by calculating the mean values of panel size, payment per beneficiary, and HCC risk score.

Results

The sample included 1,290,270 unique providers, of which 378,502 (29.3 percent) were PCPs and 911,768 (70.3 percent) were specialists. Table 2 presents the proportions of providers accepting different types of financial risk by participating in different QPP tracks and subdivisions. In the overall sample (non-metropolitan and metropolitan combined), 16.0 percent of providers participated in Advanced APMs with two-sided risk and 23.8 percent participated in MIPS APMs with one-sided risk. Slightly less than half of the providers (48.0 percent) participated in MIPS only, which bore pay-for-performance risk, and 12.2 percent of providers were exempt from the QPP and accepted no risk.

Table 2: QPP Participation and Risk Type - Descriptive Statistics

	Overall (N = 1,290,270)	Non-Metropolitan (N = 143,218)	Metropolitan (N = 1,147,052)
No Risk: MIPS Ineligible/Non-APM	157,916 (12.2%)	18,700 (13.1%)	139,216 (12.1%)
Pay-for-Performance Risk: MIPS Only/Non-APM	618,842 (48.0%)	71,383 (49.8%)	547,459 (47.7%)
One-Sided Risk: MIPS APMs	307,110 (23.8%)	36,945 (25.8%)	270,165 (23.6%)
Two-Sided Risk: Advanced APMs	206,402 (16.0%)	16,190 (11.3%)	190,212 (16.6%)

Compared to metropolitan providers, a lower proportion of non-metropolitan providers participated in Advanced APMs with two-sided risk (11.3 percent, compared to 16.6 percent). Slightly higher proportions of non-metropolitan providers participated in MIPS APMs with one-sided risk (25.8 percent, compared to 23.6 percent) and MIPS only with pay-for-performance risk (49.8 percent, compared to 47.7 percent), or were exempted from the QPP (13.1 percent, compared to 12.1 percent).

Figure 1 compares financial risk acceptance by providers in different specialties. In both non-metropolitan and metropolitan areas, higher proportions of PCPs than specialists participated in two-sided risk models. Higher proportions of PCPs and specialists in metropolitan areas (21.4 percent of PCPs and 14.7 percent of specialists) than non-metropolitan areas (15.4 percent of PCPs and 9.0 percent of specialists) participated in two-sided risk models.

Figure 1: Risk Acceptance of Providers by Specialty Type and Metropolitan Status

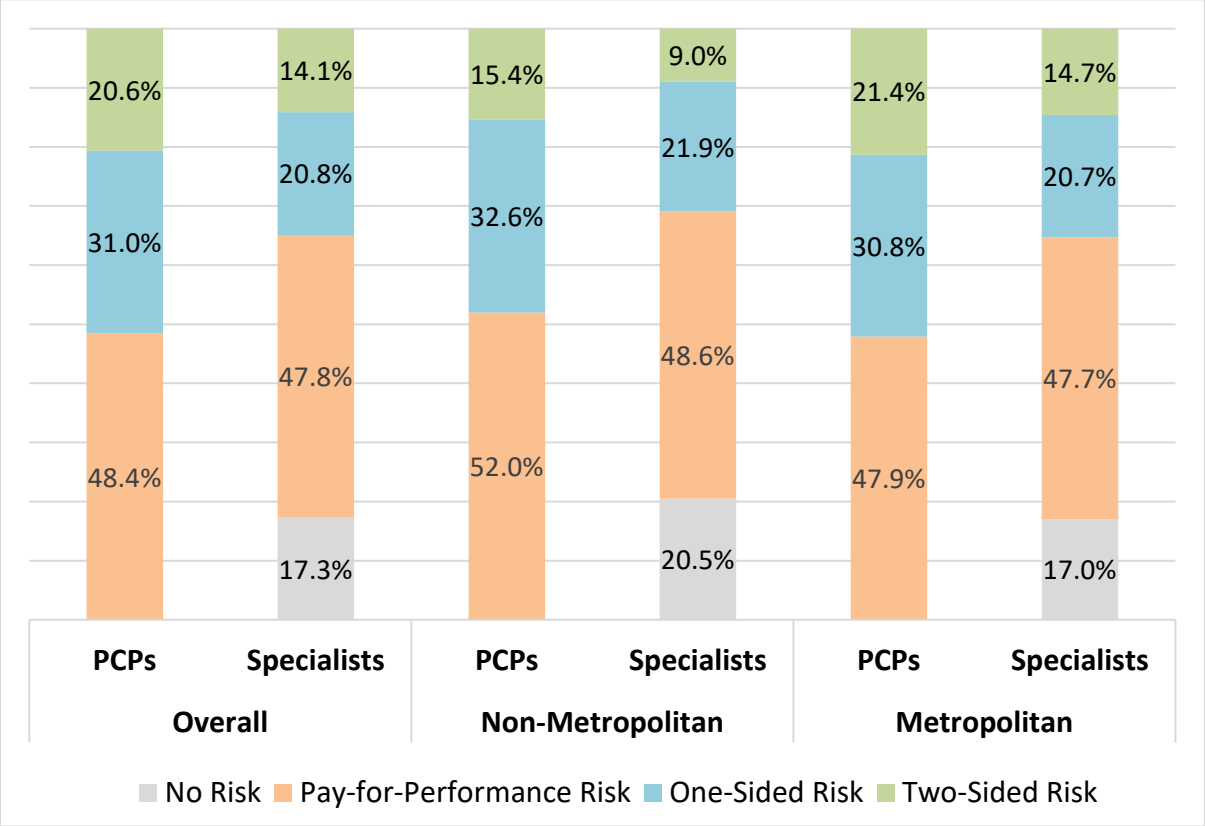

Table 3 presents patient-panel characteristics for providers participating in QPP tracks and subdivisions with different types of risk. On average, non-metropolitan providers who accepted no financial risk served fewer Medicare beneficiaries (209.6) than non-metropolitan providers who accepted pay-for-performance, one-sided, or two-sided financial risk (approximately 350). In contrast, metropolitan providers who accepted no risk served more Medicare beneficiaries (403.8) than metropolitan providers who accepted financial risks (346.9-362.5). In both non-metropolitan and metropolitan areas, providers who accepted no financial risk received higher payment per beneficiary (more than twice as high) and had lower average HCC risk scores than providers who accepted financial risks.

Consistent with previous research findings [6], non-metropolitan providers served Medicare beneficiaries with lower average HCC risk scores than metropolitan providers across risk types.

Table 3: Patient Panel Characteristics by Risk Type

Provider Characteristics	No Risk	Pay-for-Performance Risk	One-Sided Risk	Two-Sided Risk
Average Total Number of Beneficiaries				
Non-Metropolitan	209.6	349.5	346.1	352.4
Metropolitan	403.8	346.9	362.5	358.8
Average Payment per Beneficiary				
Non-Metropolitan	599.5	219.5	219.3	204.3
Metropolitan	673.2	265.1	257.1	243.7
Average HCC Risk Score				
Non-Metropolitan	1.2	1.4	1.5	1.5
Metropolitan	1.3	1.7	1.8	1.8

Conclusion

Under MACRA, the QPP combined multiple quality reporting and value-based payment programs, including the Physician Quality Reporting System, the Electronic Health Record Incentive Program, the Physician Value-Based Payment Modifier, and the Medicare Shared Savings Program, among others, into a single system of assessments and incentives. The program affected almost all health care providers who provided a sufficient volume of services to Medicare beneficiaries and met the program's eligibility criteria. By examining the patterns of participation in the QPP tracks and subdivisions, our analysis assessed the extent to which providers accepted financial risks for the services that they delivered. The results showed that a lower proportion of providers in non-metropolitan areas than metropolitan areas accepted two-sided risk. A higher proportion of PCPs accepted two-sided risk than specialists in both non-metropolitan and metropolitan areas. Our analysis was limited to providers' QPP participation in 2018. As CMS continues to reform Medicare payments and reward health care providers for improving care and accepting risk, it is crucial to track changes in providers' participation in the QPP tracks and subdivisions to inform future policy development.

The gap between health care providers' current and full participation in two-sided risk models will need to close. As shown in this brief, that gap is wider in rural areas than in urban places. Further research is needed to understand the reasons for that differential, and based on those reasons, incentives to convert providers' acceptance of financial risk could be adapted to rural circumstances.

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