ACCOUNTABLE CARE ORGANIZATION & ALTERNATIVE PAYMENT MODEL SUMMIT

The Centers for Medicare and Medicaid Services

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CMS INVESTING IN A SYSTEM FOR **BETTER CARE, SMARTER SPENDING,** AND **HEALTHIER PEOPLE**

Public and Private Sectors

Key characteristics

- Producer-centered
- Incentives for volume
- Unsustainable
- Fragmented care

Key characteristics

- Patient-centered
- Incentives for outcomes
- Sustainable
- Coordinated care

A VALUE-BASED SYSTEM REQUIRES FOCUSING ON HOW WE **PAY PROVIDERS**, **DELIVER CARE**, AND **DISTRIBUTE INFORMATION**

Improving the way providers are incentivized, the way care is delivered, and the way information is distributed will help provide better care at lower cost across the health care system.

Source: Burwell SM. Setting Value-Based Payment Goals — HHS Efforts to Improve U.S. Health Care. NEJM 2015 Jan 26; published online first.

CMS IS ALIGNING WITH PRIVATE SECTOR AND STATES TO DRIVE DELIVERY SYSTEM REFORM

CMS Strategies for Aligning with Private Sector and States

Convening Stakeholders

Incentivizing Providers

Partnering with States

MARCH 2016

HHS announced that goal of 30% payments tied to quality through APMs achieved one year ahead of schedule!

Medicare Fee-for Service

GOAL 30%

Medicare payments are tied to quality or value through **alternative payment models** (categories 3-4) by the end of 2016

Next Steps

1. **Testing of new models and expansion of existing models**
2. **Health Care Payment Learning and Action Network**

PHYSICIAN PAYMENT REFORM

MACRA AND THE QUALITY PAYMENT PROGRAM

THE QUALITY PAYMENT PROGRAM

Clinicians have two tracks from which to choose:

MIPS

The Merit-based Incentive Payment System (MIPS)

If you decide to participate in traditional Medicare, you may earn a performance-based payment adjustment through MIPS.

OR

Advanced APMs

Advanced Alternative Payment Models (APMs)

If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model.

WHAT IS THE MERIT-BASED INCENTIVE PAYMENT SYSTEM?

Performance Categories

Quality

Cost

Improvement Activities

Advancing Care Information

- Comprised of four performance categories.
- Provides MIPS eligible clinician types included in the 2017 Transition Year with the flexibility to choose the activities and measures that are most meaningful to their practice.

ADVANCED ALTERNATIVE PAYMENT MODELS

Clinicians and practices can:

Receive **greater rewards** for taking on some risk related to patient outcomes.

Advanced APMs

Advanced APM- specific rewards

+

5% lump sum incentive

"So what?" - It is important to understand that the Quality Payment Program does not change the design of any particular APM. Instead, it creates **extra incentives** for a sufficient degree of participation in Advanced APMs.

QUALITY PAYMENT PROGRAM

- Improve beneficiary outcomes
- Reduce burden on clinicians
- Increase adoption of Advanced APMs
- Maximize participation
- Improve data and information sharing
- Ensure operational excellence in program implementation
- Deliver IT systems capabilities that meet the needs of users

Quick Tip: For additional information on the Quality Payment Program, please visit qpp.cms.gov

ADVANCED APMS IN 2017

For the 2017 performance year, the following models are Advanced APMs:

- Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1- CEHRT)
- Comprehensive End Stage Renal Disease Care Model (Two-Sided Risk Arrangement)
- Shared Savings Program Track 3
- Shared Savings Program Track 2
- Comprehensive Primary Care Plus (CPC+)
- Next Generation ACO Model
- Oncology Care Model (Two-Sided Risk Arrangement)

The list of Advanced APMs is posted at QPP.CMS.GOV and will be updated with new announcements as needed.

PROPOSED RULE FOR YEAR 2 OF QPP

PROPOSED RULE FOR YEAR 2

Request for Comments: MIPS Proposals

Proposals	Seeking Comments
Raising the low-volume threshold to exclude individual MIPS eligible clinicians or groups who bill ≤ $90,000 Part B billing **OR** provide care for ≤ 200 Part B enrolled beneficiaries	Opt-in option
Virtual groups	Definition and composition, election process, agreements, reporting requirements).
Facility-based measurement	Participation through opt-in or opt-out
Provisions for small practices including bonus points and ACI hardship exception	Should the same policies apply to rural practices
Cost weight for 2018	Retaining it at 0% as indicated in the transition year final rule

PROPOSED RULE FOR YEAR 2

Advanced APMs: Generally Applicable Nominal Amount Standard

Transition Year 1 Final

- Total potential risk under the APM must be equal to at least either:
  - 8% of the average estimated Parts A and B revenue of the participating APM Entities for the QP performance period in 2017 and 2018, or
  - 3% of the expected expenditures an APM Entity is responsible for under the APM for all performance years.

Year 2 Proposed

- The 8% revenue-based standard is extended for two additional years, through performance year 2020.

PROPOSED RULE FOR YEAR 2

All-Payer Combination Option: Summary

- The All-Payer Combination Option is, along with the Medicare Option, one of two pathways through which eligible clinicians can become a QP or Partial QP.
- QP Determinations under the All-Payer Combination Option will be based on an eligible clinicians' participation in a combination of both Advanced (Medicare) APMs and Other Payer Advanced APMs.
- QP Determinations are conducted sequentially so that the Medicare Option is applied before the All-Payer Combination Option. Only clinicians who fail to become QPs under the Medicare Option will need to participate in the All-Payer Combination Option.
- The All-Payer Combination Option is available beginning in the 2019 QP Performance Period.

MEDICARE ACCOUNTABLE CARE ORGANIZATION TRACK 1+ MODEL

MEDICARE ACO TRACK 1+ MODEL

- CMS Innovation Center Model designed based on feedback from stakeholders for options to facilitate Accountable Care Organizations' (ACOs') transition to performance-based risk.
    - Lower levels of risk available to qualifying physician-only ACOs and/or ACOs that include small rural hospitals.
- Model based on Shared Savings Program Track 1, but tests a payment design that incorporates more limited downside risk compared to Tracks 2 and 3, as well as elements of Track 3 to help ACOs better coordinate care.

MEDICARE ACO TRACK 1+ MODEL (CONT.)

- Available to eligible new Track 1 ACOs, renewing Track 1 ACOs, and Track 1 ACOs within their current agreement period.
- Expands opportunities for clinicians to participate in Advanced Alternative Payment Models (APMs) under the Quality Payment Program.
- Eligible clinicians in ACOs participating in the Track 1+ Model will have the opportunity to earn the Advanced APM incentive payment.

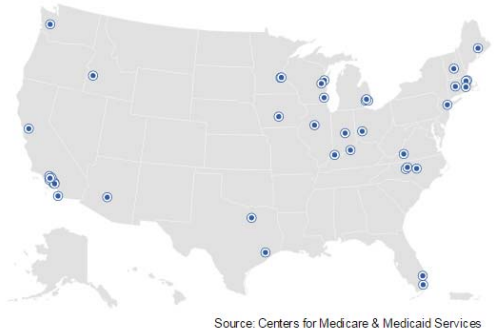
TRACK 1+ MODEL DESIGN OVERVIEW

- Model is based on the Shared Savings Program Track 1.
  - 50 percent sharing rate based on quality performance, once minimum savings rate (MSR) is met or exceeded.
  - Performance payment limit equal to 10 percent of ACO's updated historical benchmark.
- Model incorporates elements of Track 3 including:
  - Prospective beneficiary assignment.
  - Choice of MSR/minimum loss rate (MLR).
  - Option to request a Skilled Nursing Facility (SNF) 3-Day Rule Waiver.
- Model offers lower performance-based risk than Tracks 2 and 3.
  - Fixed 30 percent loss sharing rate, once MLR is met or exceeded.
  - Revenue-based loss sharing limit: calculated as 8 percent of ACO participant Medicare Part A & B fee-for-service (FFS) revenue in 2018.
  - Benchmark-based loss sharing limit: calculated as 4 percent of the ACO'

NEXT GENERATION ACO MODEL

- The Next Generation ACO Model builds upon successes from Pioneer and Shared Savings Program ACOs
- Designed for ACOs with experience coordinating care for patient populations
- NGACOs assume higher levels of financial risk and reward than other Medicare ACO initiatives while maintaining high quality standards
- Menu of options for NGACOs to select level of risk, cash flow mechanism, and benefit enhancements best suited to each organization

Model Features



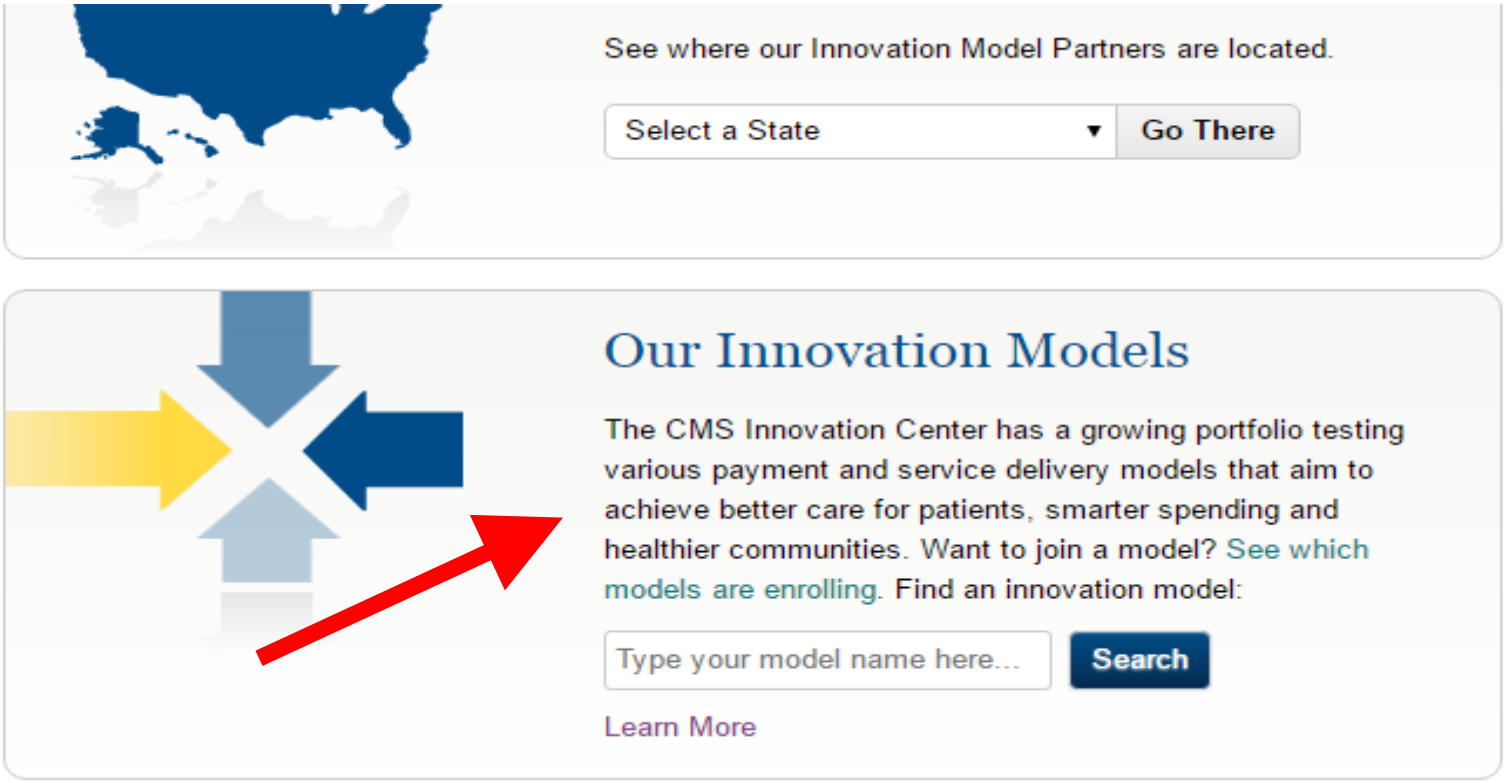
Source: Centers for Medicare & Medicaid Services

44 ACOs spread among 20 states serving 1.4 million beneficiaries

- Prospective alignment
- Financial model for long-term stability
- Three payment options as alternatives to traditional FFS
- Benefit enhancements that improve patient experience and protect freedom of choice (e.g., telehealth, SNF, and post-discharge home visits)
- Voluntary alignment

HOW TO CHECK WHICH CMS INNOVATION CENTER MODELS ARE ENROLLING

On the CMS Innovation Center website homepage, in the **Our Innovation Models** section, select the 'See which models are enrolling' link.



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