STRATEGIC HEALTH CARE

Quality Payment Program
Qualifying Advanced APMs

June 7, 2016

On April 27, 2016, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule to implement key provisions of the Medicare Access and Summary CHIP Reauthorization Act of 2015 (MACRA), bipartisan legislation that replaced the flawed Sustainable Growth Rate formula with a new approach to paying clinicians for the value and quality of care they provide. To read the CMS summary of the proposed rules, click here. Comments are due on June 27th and can be submitted here.

The proposed rule would implement these changes through the unified framework called the Quality Payment Program (QPP). **The QPP includes two paths for clinicians: The Merit-Based Incentive Payment System (MIPS) *and* Advanced Alternative Payment Models (APMs).** This memo details of the Advanced APMs that currently qualify.

Two Paths under QPP

Most clinicians will initially participate in the QPP through MIPS. This new program will combine parts of the Physician Quality Reporting System (PQRS), the Value Modifier (VM or Value-based Payment Modifier), and the Medicare Electronic Health Record (EHR) incentive program into one single program in which Eligible Professionals (EPs) will be measured on quality, resource use, clinical practice improvement, and meaningful use of certified EHR technology.

However, clinicians who participate in certain Advanced APMs would not be required to participate in MIPS. These eligible clinicians would be exempt from the MIPS payment adjustments and would qualify for a 5 percent Medicare Part B incentive payment. The proposed rule includes a list of current models that would qualify under the terms of the proposed rule as Advanced APMs. These include:

- Comprehensive ESRD Care Model (Large Dialysis Organization arrangement)
- Medicare Shared Savings Program—Tracks 2 and 3
- Next Generation ACO Model
- Comprehensive Primary Care Plus (CPC+)
- Oncology Care Model Two-Sided Risk Arrangement

CMS continues to develop new Advanced APMs, such as one that would concentrate on chronic conditions, and works to turn others, such the Comprehensive Care for Joint Replacement (CJR) model, into Advanced APMs in the future. CMS is seeking suggestions and comments from providers specifically on this issue.

Proposed Advanced APMs in QPP

Next Generation ACO Model

The application deadline for 2016 was Next Generation ACO Model May 25, 2017. This is the last round of applications for 2016. To view the request for applications, click here.

The Next Generation ACO Model is an initiative for ACOs that are experienced in coordinating care for populations of patients. It will allow these provider groups to assume higher levels of financial risk and reward than are available under the current Pioneer Model and Shared Savings Program (MSSP). The goal of the Model is to test whether strong financial incentives for ACOs, coupled with tools to support better patient engagement and care management, can improve health outcomes and lower expenditures for Original Medicare fee-for-service (FFS) beneficiaries.

ACOs in this Model will be evaluated on their ability to deliver better care for individuals, better health for populations, and lower growth in expenditures. CMS will publicly report the performance of the Next Generation Pioneer ACOs on quality metrics, including patient experience ratings, on its website. The Model consists of three initial performance years and two optional one-year extensions. The application deadline was May 25, 2016. Please note that this is the final round of applications for the Next Generation ACO Model and ACOs selected from this final round cannot defer their participation.

For more on this model, click here.

Comprehensive ESRD Care (CEC) (Large Dialysis Organization Arrangement)

*The Comprehensive End-Stage Renal Disease (ESRD) Care Model application deadline is **July 15, 2016**. To read the request for applications, click here. For the application portal for CEC, click here.*

In CEC, dialysis clinics, nephrologists and other providers join together to create an ESRD Seamless Care Organizations (ESCOs) to coordinate care for matched beneficiaries. ESCOs are accountable for clinical quality outcomes and financial outcomes measured by Medicare Part A and B spending, including all spending on dialysis services for their aligned ESRD beneficiaries. This model encourages dialysis providers to think beyond their traditional roles in care delivery and supports them as they provide patient-centered care that will address beneficiaries' health needs, both in and outside of the dialysis clinic.

CEC includes separate financial arrangements for larger and smaller dialysis organizations, Large Dialysis Organizations (LDOs), which have 200 or more dialysis facilities, will be eligible to receive shared savings payments. These large dialysis organizations will also be liable for shared losses, and will have higher overall levels of risk compared with their smaller counterparts.

Click here for more on the program.

Medicare Shared Savings Program – Tracks 2 and 3 (MSSP)

*The Medicare Shared Savings Program (MSSP) Notice of Intent to Apply (NOIA) is due **May 31st**. The deadline for applications is **July 29th**. For all Tracks : click here for the NOIA Memo, and here for the*

application Tool Kit, here for the application manual, here for the initial application, and here for a renewal application. For the fact sheet detailing the finalized changes to MSSP, click here.

Under the Medicare Shared Savings Program (MSSP), ACO providers and suppliers continue to be paid for services rendered to Fee-For-Service Medicare beneficiaries in the same manner as they would otherwise. ACOs that meet or exceed a minimum savings rate (MSR) and satisfy minimum quality performance standards are eligible to receive a portion of the savings they generated (shared savings). This means that an ACO has an incentive to improve the coordination and quality of care for all patients seen by its participating providers and suppliers.

To participate in MSSP, eligible providers and suppliers must form a Medicare ACO, and the ACO must apply to CMS. An existing ACO will not be automatically accepted into the Shared Savings Program. To be accepted, ACOs must serve at least 5,000 Medicare Fee-For-Service patients, meet all other eligibility and program requirements, and agree to participate in the program for at least 3 years.

Medicare ACOs can choose to accept either one-sided or two-sided financial risk. Under the one-sided model (Track 1), an ACO may receive shared savings if it meets the applicable requirements, but it will not be liable for shared losses (***please note, Track 1 IS NOT an eligible Advanced APM***).

Under the two-sided models (Track 2 and Track 3), the ACO may share both savings and losses. To provide a greater incentive for ACOs to become accountable for shared losses, two-sided risk models offer the opportunity for greater reward in comparison to the one-sided model. Track 2 and Track 3 ACOs can receive a shared savings payment of up to 60 percent and 75 percent, respectively, of all savings under the benchmark. ACOs entering two-sided models are required to establish a repayment mechanism at the beginning of a three-year agreement period. ACOs must demonstrate that they would be able to repay shared losses incurred at any time of the agreement and for the "tail period" or reasonable window of time at the end of each agreement.

ACOs that enter the Shared Savings Program under Track 2 remain under the two-sided model for the term of their initial agreement and any subsequent agreement. Under this model, the ACO will be eligible for a higher sharing rate, with a higher performance payment limit, than is available under the one-sided model. For ACOs entering Track 2 for agreement periods beginning January 2016 or later, ACOs may choose one of the following options for establishing their MSR/MLR:

- Zero percent MSR/MSL (meaning the ACO would share in first-dollar losses and savings);
- Symmetrical MSR/MLR in a 0.5 percent increment between 0.5 percent and 2.0 percent; or
- Symmetrical MSR/MLR that varies based on the ACO's number of assigned beneficiaries under the Track 1 model.

The new Track 3 is an even higher level MSSP than Track 2 and would integrate some elements of the Pioneer ACO program, which CMS created as a companion program for more sophisticated ACOs prepared to accept more risk for both savings and losses. Track 3 has a higher loss sharing ratio than Track 2 and allows for prospective beneficiary assignments and the opportunity to apply for a waiver for the three-day SNF rule, which would allow payment for SNF services when a beneficiary is admitted to a SNF without a prior three-day inpatient stay.

The most significant differences among Tracks 1, 2, and 3 are as follows:

- *Prospective Assignment Methodology*. The beneficiary assignment process under Tracks 1 and 2 is prospective (based on data from the previous calendar year) with a retrospective reconciliation. Under Track 3, beneficiaries will be prospectively assigned based on the assignment methodology utilized under Tracks 1 and 2; however, the assignment will be based on data from the most recently available 12 months of data (offset from the calendar year) and there will not be a retrospective reconciliation to add new beneficiaries at the end of the performance year. The only adjustments that would be made to a Track 3 ACO's beneficiary population at the end of the performance year would be to exclude beneficiaries who no longer satisfy the participation eligibility criteria.
- *Historical Benchmark Calculation*. The benchmark calculation for Track 3 will be consistent with the current calculation for Tracks 1 and 2.
- *Shared Savings/Shared Losses Calculation*. To attract new ACO participants to this new risk-based model, CMS has set the shared savings rate and the shared loss rate at 75 percent – shared savings are capped at 20 percent of an ACO's benchmark and shared losses are limited to 15 percent of an ACO's updated benchmark. Like Track 2 ACO participants, Track 3 ACO participants will have the option to choose among the new MSR/MLR options described above.
- *Waiver of the Three-Day Skilled Nursing Facility (SNF) Rule*. Track 3 ACO participants can apply for a waiver of the Three-Day SNF Rule. Under this waiver, Medicare will pay for otherwise covered SNF services when ACO providers/suppliers participating in Track 3 admit a prospectively assigned beneficiary to an eligible SNF without a three-day prior inpatient hospitalization. This waiver has been piloted among the Pioneer ACOs, and CMS believes that the waiver will allow ACOs to improve the quality of care while reducing costs. ACOs under the Pioneer Model are accountable for the total cost of care furnished to their assigned beneficiary population and must accept performance-based risk if costs exceed their benchmark.

Click here to read more on the models.

Comprehensive Primary Care Plus (CPC+)

*For Comprehensive Primary Care Plus (CPC+) payer solicitation and practice applications will be a staggered process. First, CMS will solicit payer proposals to partner with Medicare in CPC+ (**April 15-June 8, 2016**). The choice of up to 20 CPC+ regions will be informed by the geographic reach of selected payers. Next, CMS will publicize the CPC+ regions, and solicit applications from practices within these regions **(July 15-September 1, 2016)**. 2,500 practices will be chosen for each track. For the CPC+ Request for Applications document (contains information for both payers and providers), click here. For solicitation instructions for payers, click here, and the payer solicitation, click here.*

Systems and Practices participating in MSSP Tracks 1, 2, and 3 are now eligible to enter into the CPC+ program. Click here for the FAQs.

Comprehensive Primary Care Plus (CPC+) is a national advanced primary care medical home model that will include two primary care practice tracks with incrementally advanced care delivery requirements and payment options. CPC+ is a five-year model that will begin in January 2017. CPC+ will bring together CMS, commercial insurance plans, and State Medicaid agencies to provide the financial support necessary for practices to make fundamental changes in their care delivery. Practices choosing to participate in CPC+ cannot participate in CCM or an ACO model while participating in CPC+.

Practices in both tracks will make changes in the way they deliver care, centered on key Comprehensive Primary Care Functions: (1) Access and Continuity; (2) Care Management; (3) Comprehensiveness and Coordination; (4) Patient and Caregiver Engagement; and (5) Planned Care and Population Health.

Click here for more on the program.

Oncology Care Model (OCM) Two-Sided Risk Arrangement

CMS is no longer accepting applications for this year. We anticipate another round of applications since this was named as acceptable Advanced APM.

The Oncology Care Model (OCM) is an initiative that encourages participating practices to improve care and lower costs through an episode-based payment model that financially incentivizes high-quality, coordinated care. Practitioners in OCM are expected to rely on the most current medical evidence and shared decision-making with beneficiaries to inform their recommendation about whether a beneficiary should receive chemotherapy treatment. OCM provides an incentive to participating physician practices to comprehensively and appropriately address the complex care needs of the beneficiary population receiving chemotherapy treatment, and heighten the focus on furnishing services that specifically improve the patient experience or health outcomes.

OCM encourages other payers to participate in alignment with Medicare to create broader incentives for care transformation at the physician practice level. Payers who participate will have the flexibility to design their own payment incentives to support their beneficiaries, while aligning with CMS' goals for care improvement and cost reduction. CMS is no longer accepting applications from practices and payers.

For more on this model, click here.