Alternative Payment Model Design Toolkit

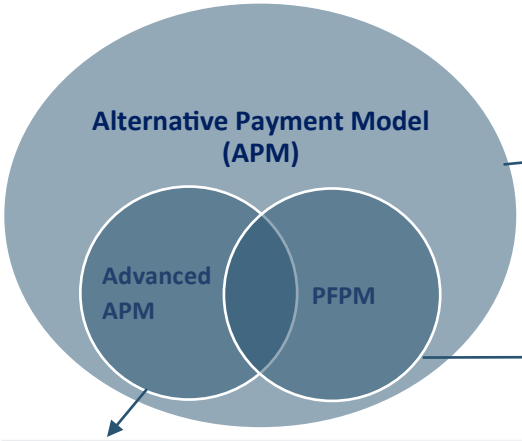
The Centers for Medicare & Medicaid Services (CMS) through the Center for Medicare and Medicaid Innovation (the Innovation Center) routinely considers new ideas for Alternative Payment Models. Many factors are used in the selection of models to be tested.

Model Design Factors

Factors CMS would not expect stakeholders to focus on in designing APMs are marked with an asterisk (*)

Based on the factors used in the selection of models, this Alternative Payment Model Toolkit provides an overview of certain key elements that stakeholders should consider in designing Alternative Payment Models.

Element 1. What type(s) of Alternative Payment Model(s) would your design be?



Alternative Payment Model (APM)

- Innovation Center Models (other than a health care innovation award)
- Demonstration under the Health Care Quality Demonstration Program
- Medicare Shared Savings Program
- Demonstration under federal law

Physician-Focused Payment Model (PFPM)

- Is an Alternative Payment Model
- Includes Medicare as a payer
- Physicians or other eligible clinicians play a core role in implementing the payment methodology
- Targets quality and costs of services eligible clinicians provide, order, or significantly influence

Advanced Alternative Payment Model (Advanced APM)

- Is an Alternative Payment Model
- Requires Participants to Use Certified EHR Technology
- Bases payment on quality measures comparable to those in MIPS
- Participants Bear More than Nominal Financial Risk, **OR**
- APM is a Medical Home Model Expanded under Innovation Center authority

Examples of APMs:

Next Generation Accountable Care Organization Model:

ACOs are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to the Medicare patients they serve. The Next Generation ACO Model is an initiative for ACOs that are experienced in coordinating care for populations of patients and whose provider groups are ready to assume higher levels of financial risk and reward. More information available at: https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/

Comprehensive ESRD Care (CEC) Model:

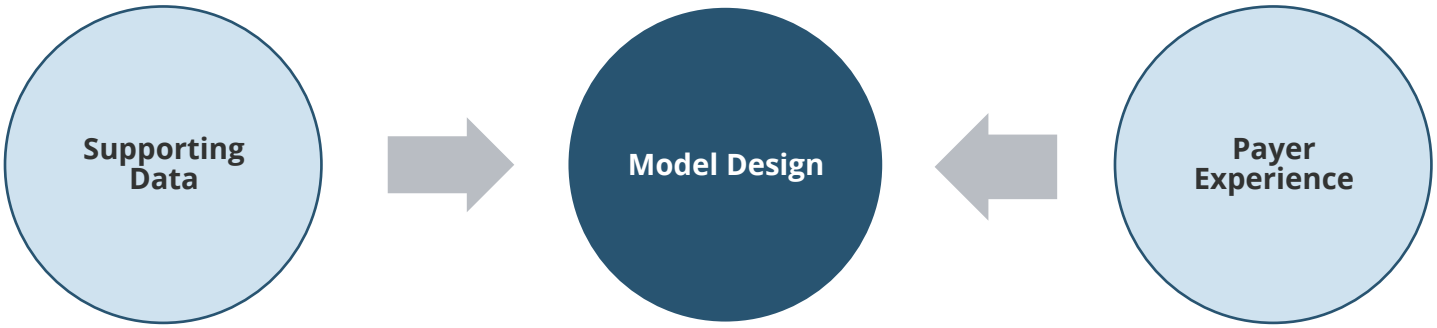
ESRD Seamless Care Organizations test and evaluate a new model of payment and care delivery specific to Medicare beneficiaries with ESRD. The goals of the model are to improve beneficiary health outcomes and reduce per capita Medicare expenditures. More information available at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-04-15.html

Element 2. How will your Alternative Payment Model result in clinical practice transformation?

Examples from existing and announced APMs:	Oncology Care Model (OCM):	Comprehensive Primary Care Plus (CPC+) Model:	Accountable Health Communities (AHC) Model:
Includes specific changes in how clinical care is delivered	Provides enhanced services to Medicare beneficiaries such as care coordination, navigation, and national treatment guidelines for care.	Modifies the way primary care practices deliver care, centered on the following key functions: (1) Access and Continuity; (2) Care Management; (3) Comprehensiveness and Coordination; (4) Patient and Caregiver Engagement; and (5) Planned Care and Population Health.	Model will address a critical gap between clinical care and community services in the current health care delivery system by testing whether systematically identifying and addressing the health-related social needs of beneficiaries' impacts total health care costs, improves health, and quality of care.
Tests difference in payment, effect on paying for value over volume	Practices may enter into payment arrangements that include financial and performance accountability for episodes of care surrounding chemotherapy administration to cancer patients.	Practices receive a Management Fee plus Performance Based Incentive Based On Utilization And Quality/Experience Components plus Visit And Non-Visit Based Payments.	The model will test the impact of the interventions on total health care costs and inpatient and outpatient health care utilization, as well as health and quality of care for Medicare and Medicaid beneficiaries. CMS will test whether community referral, community service navigation, or community service alignment impacts total cost of care, emergency department visits, inpatient hospital admissions, and quality of care for high-risk Medicare and Medicaid beneficiaries.

Examples from existing and announced APMs:	Oncology Care Model (OCM):	Comprehensive Primary Care Plus (CPC+) Model:	Accountable Health Communities (AHC) Model:
Describes amount of any new payments proposed	A $160 per-beneficiary Monthly Enhanced Oncology Services (MEOS) payment assists participating practices in effectively managing and coordinating care for oncology patients during episodes of care, while a potential performance-based payment incentivizes practices to lower the total cost of care and improve care for beneficiaries during episodes.	Per beneficiary per month (PBPM) **Management Fee** *Track 1* $15 (average) PBPM *Track 2* $28 (average) PBPM $100 (complex) PBPM	CMS will make awards through cooperative agreements to successful applicants to implement the model. Applicants will partner with state Medicaid agencies, clinical delivery sites, and community service providers and are responsible for coordinating community efforts to improve linkage between clinical care and community services.
Different Medicare payment methodology	The two forms of payment include a per-beneficiary MEOS payment for the duration of the episode and the potential for a performance-based payment for episodes of chemotherapy care.	**Care Management Fee:** Risk-adjusted for each practice to account for the intensity of care management services required for the practice's specific population. **Performance-based incentive payment:** Prospectively pay and retrospectively reconcile a performance-based incentive based on how well the practice performs on patient experience measures, clinical quality measures, and utilization measures that drive total cost of care. **Payment under the Medicare PFS:** For Track 2 practices, a portion of FFS payments goes into Comprehensive Primary Care Payments, which are paid in a lump sum, quarterly, absent a claim.	Award recipients will use their award monies to fund interventions intended to connect community-dwelling beneficiaries with those offering such community services. CMS funds for this model cannot pay directly or indirectly for any community services (e.g., housing, food, violence intervention programs, and transportation) received by community-dwelling beneficiaries as a result of their participation in any of the three intervention tracks.
More Information available at:	https://innovation.cms.gov/initiatives/Oncology-Care/	https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus/	https://innovation.cms.gov/initiatives/ahcm/

Element 3. What is the rationale for your Alternative Payment Model?



Examples from existing APMs:

Comprehensive Care for Joint Replacement (CJR) Model:

Despite the high volume of hip and knee replacement surgeries, quality and costs of care for these surgeries vary significantly among providers. For instance, the rate of complications like infections or implant failures after surgery can be more than three times higher at some facilities than others, increasing the chances that the patient may be readmitted to the hospital. And, the average Medicare expenditure for surgery, hospitalization, and recovery ranges from $16,500 to $33,000 across geographic areas. More information available at: https://innovation.cms.gov/initiatives/cjr/index.html

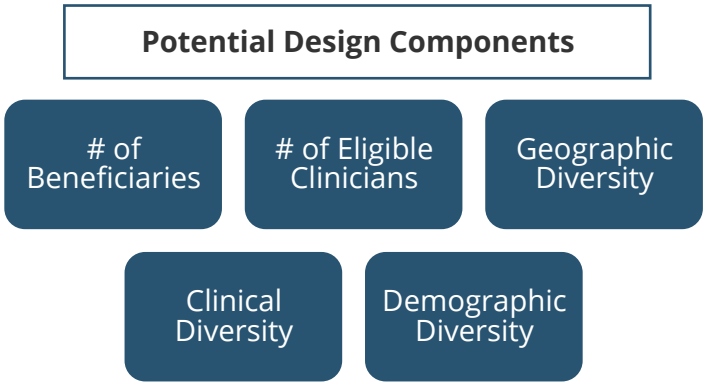
Pioneer Accountable Care Organization (ACO) Model:

The payment models tested in the first two years of the Pioneer ACO Model were a shared savings payment policy with generally higher levels of shared savings and risk for Pioneer ACOs than levels in the Medicare Shared Savings Program. In year three of the program, participating ACOs that showed a specified level of savings over the first two years were eligible to move a substantial portion of their payments to a population-based model. These models of payments are flexible to accommodate the specific organizational and market conditions in which Pioneer ACOs work. More information available at: https://innovation.cms.gov/initiatives/Pioneer-ACO-Model/

Bundled Payments for Care Improvement (BPCI) Initiative:

The BPCI initiative bundles payment for services that patients receive across a single episode of care to encourage efficient, coordinated care among different providers. Traditional Medicare payments do not hold providers accountable for related care a patient receives in other settings. Recognizing the diversity of providers' needs, the BPCI initiative offers four different models for types of care provided to Medicare beneficiaries who have been hospitalized. More information available at: https://innovation.cms.gov/initiatives/Pioneer-ACO-Model/

Element 4. What is the scale of your Alternative Payment Model?



Scale*

What is the anticipated size and scope of the APM in terms of health care services? What is the burden of disease or illness on the target population in terms of morbidity and/or mortality? Who are the APM Entities-the entities participating in the APM (for example, Physician Group Practices)?

Examples from existing APMs:

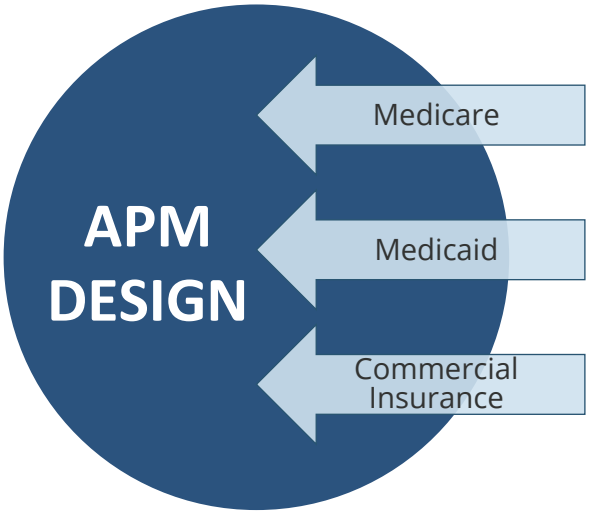
Comprehensive ESRD Care (CEC) Model:

More than 600,000 Americans have end stage renal disease (ESRD) and require life sustaining dialysis treatments several times per week. Many beneficiaries with ESRD suffer from poorer health outcomes, often the result of underlying disease complications and multiple co-morbidities. These can lead to high rates of hospital admission and readmissions, as well as a mortality rate that is higher than that of the general Medicare population. In 2013, ESRD beneficiaries comprised less than 1% of the Medicare population, but accounted for an estimated 7.1% of total Medicare fee-for-service spending, totaling over $30.9 billion. Because of their complex health needs, beneficiaries often require visits to multiple providers and follow multiple care plans, all of which can be challenging for beneficiaries if care is not coordinated. The CEC Model seeks to create incentives to enhance care coordination and to create a person-centered, coordinated, care experience, and to ultimately improve health outcomes for this population. Therefore, the scale of this model, while geographically diverse, is limited in its clinical and demographic diversity. More information available at: https://innovation.cms.gov/initiatives/comprehensive-esrd-care/

Comprehensive Care for Joint Replacement (CJR) Model:

CMS has implemented the CJR model in 67 geographic areas, defined by metropolitan statistical areas (MSAs). MSAs are counties associated with a core urban area that has a population of at least 50,000. Non-MSA counties (no urban core area or urban core area of less than 50,000 population) were not eligible for selection. Except for those participating in Model 1 or Models 2 or 4 of the Bundled Payments for Care Improvement (BPCI) initiative for lower extremity joint replacement (LEJR) episodes, hospitals paid under the Inpatient Prospective Payment System (IPPS) and located in the MSAs selected are required to participate in the CJR model. As of November 16, 2015, approximately 800 hospitals are required to participate in the CJR model. Hospitals outside the selected geographic areas are not able to participate. Therefore, the scale of this model, while geographically diverse, is limited in its clinical and demographic diversity. More information available at: https://innovation.cms.gov/initiatives/CJR/

Element 5. How does your Alternative Payment Model align with other payers and CMS programs?



Leveraging Investments*

Are enough payers participating in the model or aligned with your proposal to create a strong business case and supportive business relationships for providers to participate?

Examples from existing APMs:

State Innovation Model (SIM) Initiative:

The State Innovation Models (SIM) Initiative provides financial and technical support to states for the development and testing of state-led, multi-payer health care payment and service delivery models that will improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid and Children's Health Insurance Program (CHIP) beneficiaries—and for all residents of participating states. More information available at: https://innovation.cms.gov/initiatives/State-Innovations/

Comprehensive Primary Care Plus (CPC+) Model:

CPC+ brings 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. CMS will enter into a Memorandum of Understanding (MOU) with selected payer partners to document a shared commitment to align on payment, data sharing, and quality metrics throughout the five year initiative. More information available at: https://innovation.cms.gov/initiatives/State-Innovations/

Accountable Health Communities (AHC) Model:

AHC Model applicants will partner with state Medicaid agencies, clinical delivery sites, and community service providers and are responsible for coordinating community efforts to improve linkage between clinical care and community services. CMS funds for this model cannot pay directly or indirectly for any community services (e.g., housing, food, violence intervention programs, and transportation) received by community-dwelling beneficiaries as a result of their participation in any of the three intervention tracks. Award recipients, however, must use their award monies to fund interventions intended to connect community-dwelling beneficiaries with those offering such community service. More information available at: https://innovation.cms.gov/initiatives/ahcm/

Element 6. How is improved clinical quality or better patient experience of care measured under your Alternative Payment Model?

Quality Domains

- Clinical Care
- Safety
- Care Coordination
- Patient and caregiver experience
- Population health and prevention

Examples from existing and proposed APMs:

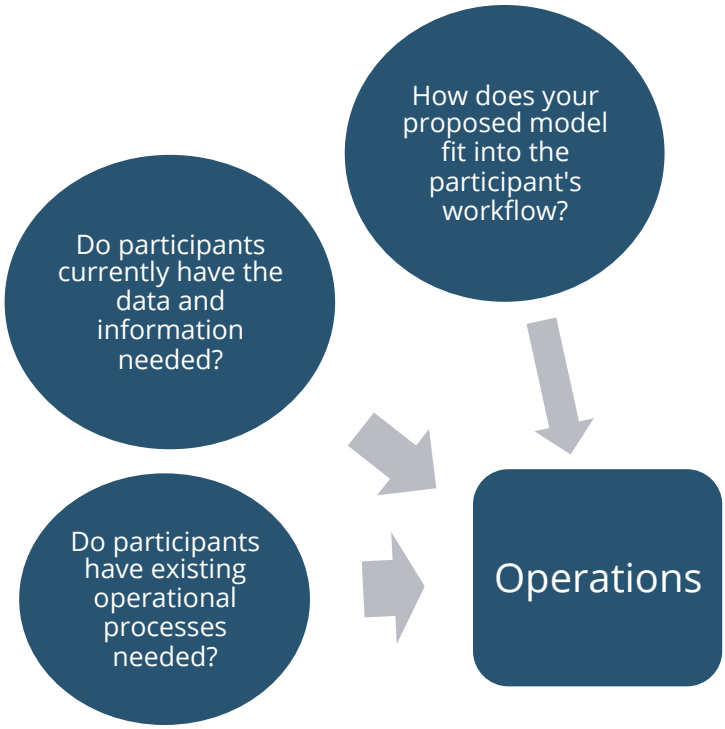
Medicare Shared Savings Program Accountable Care Organization (ACO) and Pioneer Accountable Care Organization (ACO) Model:

The Shared Savings Program and the Pioneer ACO Model show significant improvements in the quality of care providers are offering to an increasing number of Medicare beneficiaries. ACOs are judged on their performance, as well as their improvement, on an array of meaningful metrics that assess the care they deliver. Those metrics include how highly patients rated their doctor, how well clinicians communicated, whether patients are screened for high blood pressure, and their use of Electronic Health Records. More information available at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-08-25.html

Accountable Health Communities (AHC) Model:

This model will test the impact of the AHC interventions on total health care costs and inpatient and outpatient health care utilization, as well as health and quality of care for Medicare and Medicaid beneficiaries. CMS will test whether community referral, community service navigation, or community service alignment impacts total cost of care, emergency department visits, inpatient hospital admissions, and quality of care for high-risk Medicare and Medicaid beneficiaries. More information available at: https://innovation.cms.gov/initiatives/ahcm/

Element 7. How easy would it be for participants to implement your Alternative Payment Model?



Operational Feasibility

How easy would it be for participants to build systems, processes, and infrastructure necessary to operationalize the APM?

Example from existing APMs:

Pioneer Accountable Care Organization (ACO) Model:

The Pioneer ACO Model is designed for health care organizations and providers that are already experienced in coordinating care for patients across care settings. It will allow these provider groups to move more rapidly from a shared savings payment model to a population-based payment model on a track consistent with, but separate from, the Medicare Shared Savings Program. And it is designed to work in coordination with private payers by aligning provider incentives, which will improve quality and health outcomes for patients across the ACO, and achieve cost savings for Medicare, employers and patients. This APM fits in to the workflow because of the experience coordinating care and the existing operational processes were in place, however, the Pioneer ACOs required data and information from CMS. More information available at: https://innovation.cms.gov/initiatives/Pioneer-ACO-Model/

Helpful Links:

Physician-Focused Payment Model Technical Advisory Committee (PTAC): https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee

Center for Medicare and Medicaid Innovation (Innovation Center): https://innovation.cms.gov/

Comprehensive List of APMs: https://qpp.cms.gov/docs/QPP_Advanced_APMs_in_2017.pdf

Quality Payment Program: https://qpp.cms.gov/

Quality Payment Program Final Rule: https://qpp.cms.gov/docs/CMS-5517-FC.pdf

Model Design Factors: https://innovation.cms.gov/Files/x/rfi-websitepreamble.pdf

MACRA Speaker Engagement Requests: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Speaking-Engagement-Criteria.html