ONLINE APPENDIXES 2

Medicare's new framework for paying clinicians

ONLINE APPENDIX 2-A

Number of beneficiaries in various models

The number of beneficiaries in eligible alternative payment entities (EAPEs) will depend on CMS's rulemaking and how they interpret each of the three statutory criteria. As a reminder, the pool of all alternative payment models (APMs) is:

- all models in the Center for Medicare & Medicaid Innovation (CMMI) except for Innovation Awards,
- models under Medicare demonstration authority through Section 1866(c) of the Social Security Act,
- the Medicare Shared Savings Program, or
- a demonstration required by law.

EAPEs are entities that participate in models that must meet three criteria in statute:

- require certified EHR technology,
- have a set of quality measures comparable to MIPS, and
- bear risk above a nominal amount or be medical homes meeting the criteria for national expansion.

At this point, there are some models that appear to at least meet the third statutory criterion: that the model participants bear more than nominal risk. CMMI is also running a few demonstrations that can be considered medical home models (Table 2-A1). ■

TABLE 2–A1

Number of beneficiaries in various models

Model	Description	Number of Medicare participants
Bear downside risk for all (or nearly all) Part A and Part B costs		
MSSP Track 2 and Track 3	As of January 2016, there are 6 ACOs in Track 2 and 16 ACOs in Track 3 (411 in Track 1, in which ACOs bear upside-risk only)	60,000 in Track 2, 390,000 in Track 3 (7.2 million in Track 1)
Pioneer ACOs	Original ACO demonstration program began with 32 ACOs; 9 currently participating	600,000 as of April 2015
Next Generation ACOs	21 ACOs participating	Not announced
Comprehensive ESRD care model—LDOs	ACO-type model for ESRD beneficiaries. LDOs bear downside risk. Non-LDOs are shared savings only. 13 ESCOs accepted.	Not announced
Bear some risk		
Bundled payments for care improvement	Model 1 pays hospitals a discounted FFS price. Models 2–4 are three different episode payment models for an inpatient hospitalization and subsequent services.	130,000
Oncology care model	Payment model makes a $160 monthly per beneficiary payment for six months after initiating chemotherapy. Shared savings only based on episode costs for the first two years. At year 3, practices can elect two-sided risk for episode payment.	Not yet available. CMMI currently reviewing applications.
Medical home models		
Comprehensive Primary Care Initiative	Payment model includes a monthly care management fee plus shared savings. Practices pursue advancements in five areas: risk stratification, 24/7 access, care planning, patient engagement, and coordination. Ends December 2016.	335,000
Comprehensive Primary Care Plus	This new model will run from 2017–2021. Builds off of CPCI, with slight revisions to the payment model: care management fee, at-risk payment, and option for partial capitation.	Not yet available
Multipayer Advanced Primary Care Practice Demonstration	CMS is participating in multipayer reform initiatives that are currently being conducted by states to make advanced primary care practices more widely available.	900,000
Independence at Home	Home-based primary care practices can receive shared savings on all Part A and Part B services for attributed beneficiaries.	8,400
Federally Qualified Health Center Advanced Primary Care Practice Demonstration	Per member per month payment for FQHCs to achieve Level 3 medical home certification. Ended October 2014.	207,000

Note: MSSP (Medicare Shared Savings Program), ACO (accountable care organization), ESRD (end-stage renal disease), LDO (large dialysis organization), ESCO (ESRD Seamless Care Organization), FFS (fee-for-service), CMMI (Center for Medicare & Medicaid Innovation), FQHC (federally qualified health center). CMMI does not refer to the models in the medical home category as "medical homes," but instead categorizes them as "primary care transformation."

Source: Center for Medicare & Medicaid Innovation.

ONLINE APPENDIX 2-B

Examples of attribution in Medicare

Attribution for accountable care organizations (ACOs). Beneficiaries are attributed to ACOs based on their claims history. Using three years of claims, a beneficiary is attributed to the ACO that has the plurality of primary care claim spending (spending is used rather than the number of claims to prevent ties). Primary care claims are defined as a set of evaluation and management claims; for example, office visits are included, but visits in hospitals are not. In the Medicare Shared Savings Program (MSSP), a beneficiary has to have a triggering visit to an ACO physician; after that, claims with the ACO count regardless of whether the provider is a physician, a nurse practitioner (NP), or a physician assistant (PA). A second step of alignment to a specialist is allowed in some cases. The Commission has suggested moving to a one-step attribution model with claims from NPs, PAs, or physicians all being counted at once and ACOs being allowed to designate certain specialists as providing primary care and thus used for attribution. Specialists who are so designated would have to be exclusive to the ACO. The Commission has also favored prospective attribution versus retrospective attribution. Prospective attribution is used in the Pioneer and Next Generation ACO demonstrations and will be used in Track 3 of the MSSP. Its advantages are that the ACO knows which beneficiaries it is responsible for at the beginning of the year and has a strong incentive to keep those beneficiaries satisfied.

Attribution for value-based payment modifier, or value modifier (VM). CMS uses a two-step attribution process similar to that in the ACO program for attributing certain claims-based measures to physicians, for example, readmissions and per capita costs for attributed beneficiaries. In the first step, a beneficiary is attributed to a group taxpayer identification number (TIN) if that TIN's primary care physicians provided the plurality of primary care services to the beneficiary. If a beneficiary did not receive any primary care service from a primary care provider (PCP), he or she can be attributed if a non-PCP in the TIN provided a primary care service, in which case all primary care visits are counted in the TIN, including those with NPs and PAs. In 2017 and thereafter, NPs and PAs will be included in the first step.

Enrollment for chronic condition management (CCM) payment. CCM requires the provider to receive written consent from the beneficiary to receive the CCM services, which requires cost sharing from the beneficiary. The written consent is valid for one year (and the provider can bill monthly for services). Only one practitioner can furnish and be paid for these services during a calendar month, but the beneficiary is free to get care from any provider for other services.

Attribution for the Comprehensive Primary Care Initiative (CPCI). The CPCI uses the plurality of primary care visits over the previous 24 months to attribute patients. However, it also uses the most recent CCM visit, which is the determining factor. In a sense, this method combines attribution with attestation.

Attribution for bundles. There is no attribution required for a bundled payment. A beneficiary is included in the bundled payment if the beneficiary undergoes the triggering event (such as a joint replacement) at the particular facility or practice in the bundling arrangement. ■