McDermott + CONSULTING | HEALTH LOBBYING ANALYTICS POLICY

CMS/CMMI Payment Models in 2019

Date Announced	Model Name	Description	Mandatory or Voluntary	Performance Year	Additional Resources
July 10, 2019	Radiation Oncology (RO) Model	In this model, participants will receive prospective, site-neutral, episode-based payment amounts for radiotherapy (RT) for 17 different cancer types. Payments are separated into two components: professional component payment and the technical component payment, reflecting that RT professional and technical services can be furnished by separate providers. Payment amounts are determined based on national base rates, trend factors and participant specific factors. CMS will further adjust payment rates through a discount factor based on number of incomplete episodes and beneficiary experience. Participants can earn back quality and patient experience withholds based on quality measure reporting and clinical data reporting.	**Mandatory**	January 1, 2020 – December 31, 2024	+ RO Model Fact Sheet
July 10, 2019	End-Stage Renal Disease Treatment Choices (ETC) Mandatory Model	This model incentives participating ESRD facilities and managing clinicians to provide additional resources to patients to utilize at home dialysis and kidney transplants. Payment adjustments would apply to the adjusted ESRD Prospective Payment System per treatment base rate as well as the monthly capitation payment rate to managing clinicians. Two potential adjustments, based on home dialysis rate and transplant rate performance, could apply to selected facilities and managing clinicians: • Positive adjustment on Medicare claims for home dialysis and related services. • Positive or negative adjustments applying to both at home and in-center dialysis and related claims.	**Mandatory**	Payment adjustments will apply to Medicare claims from January 1, 2020 through June 30, 2026	+ ETC Model Fact Sheet
July 10, 22019	Kidney Care Choices Model (KCC)	The KCC Model builds on the elements used in the Comprehensive ESRD Care Model that began in 2015. • For the Kidney Care First (KCF) Option, nephrologists and nephrology practices will receive adjusted capitated payments for managing beneficiaries with chronic kidney disease (CKD) stages 4 and 5 and ESRD. • For the Comprehensive Kidney Care Contracting Option (CKCC) Option, nephrologists and nephrology practices must partner with transplant providers, and may partner with dialysis facilities to become Kidney Contracting Entities (KCEs). KCE nephrologists will receive adjusted capitated payments for managing beneficiaries with CKD stages 4 and 5 and ESRD.	**Voluntary**	January 1, 2021 – December 31, 2023 with the option of extending for a period of one or two additional years	+ KCC Fact Sheet + KCC Request for Applications

For more information visit the McDermottPlus Payment Innovation Resource Center or contact Deb Godes at 202-204-1455/dgodes@mcdermottplus.com, Sheila Madhani at 202-204-1459/smadhani@mcdermottplus.com, Mara McDermott at 202-204 1462/mmcdermott@mcdermottplus.com or John Warren at 202-204-1451/jwarren@mcdermottplus.com.
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April 22, 2019	Direct Contracting	This is a set of three payment models designed to create opportunities for larger organizations to participate in the next evolution of risk sharing arrangements. The model builds on lessons learned from the Medicare Shared Savings Program and the Next Generation ACO Model. Direct Contracting will have three payment model options: • Professional – 50 percent savings/losses risk sharing arrangement and a primary care capitated payment for enhanced primary care services. • Global – 100 percent savings/losses with two payment options – primary care capitation or total care capitation. • Geographic – similar payment arrangements to global but the participants would assume responsibility for all Medicare FFS beneficiaries in a defined target region.	**Voluntary**	2020 will serve as an initial alignment year; performance periods will begin in January 2021 and the models are expected to run for five years	+ The Direct Contracting Fact Sheet + Direct Contracting Model Webpage
April 22, 2019	Primary Care First	This model is aimed at smaller practices who would get a capitated payment and have incentives to care for complex chronically ill patients. Primary care first would have two payment model options: • General – focuses on practices that are ready to assume financial risk in exchange for reduced administrative burden and performance-based payments. The model introduces new, higher payment for practices that care for complex, chronically ill patients. • High need populations – encourages primary care practices to take responsibility for high need, seriously ill beneficiaries who currently lack a primary care provider and/or effective care coordination. These populations are referred to as the Seriously Ill Population or SIP.	**Voluntary**	The model will be tested over six years with two staggered cohorts; first cohort will run from 2021-2025 and the second will run from 2022-2026	+ Primary Care First Fact Sheet + Primary Care First Model Webpage + Primary Care First Request for Applications
Feb. 14, 2019	Emergency Triage, Treat, and Transport (ET3) Model	A five-year payment model where CMS will pay participating ambulance suppliers and providers to 1) transport an individual to a hospital emergency department (ED) or other destination covered under the regulations, 2) transport to an alternative destination (such as a primary care doctor's office or an urgent care clinic), or 3) provide treatment in place with a qualified health care practitioner, either on the scene or connected using telehealth. The key participants in the ET3 Model will be Medicare-enrolled ambulance service suppliers and hospital-owned ambulance providers.	**Voluntary**	2020	+ ETS Model Webpage + ETS Model Fact Sheet + ETS Model Press Release

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Jan. 18, 2019	Part D Payment Modernization Model	A 5-year model that is intended to create new incentives for plans, patients, and providers to choose drugs with lower list prices to address rising costs in Part D. CMS will encourage plans to take additional risk for spending in the catastrophic phase of Part D. CMS will establish a spending target for participating plans and plans will share in savings/losses in comparison to that target.	**Voluntary**	2020	+ Part D Payment Modernization Webpage + Part D Payment Modernization Fact Sheet
Jan. 18, 2019	Medicare Advantage Value-Based Insurance Design Model (MA VBID)	VBID allows health insurers to structure enrollee cost sharing and plan benefit design to encourage the use of high value health care services. In 2017, CMS began testing VBID in Medicare Advantage in seven states. In January 2019, CMS announced that, consistent with the Bipartisan Budget Act of 2018, it will expand the VBID model to all 50 states. In addition, plans will be able to test new interventions, including targeting the social determinants of health, Part D rewards programs, increasing access to telehealth networks, and coordinated approaches to wellness and advance care planning. Beginning in 2021, VBID models will also test inclusion of the Medicare hospice benefit in MA.	**Voluntary**	2020 and 2021 ***(Note***: this model ran in 2017, 2018 and 2019).	+ MA VBID model webpage + MA VBID Fact Sheet
Dec. 21, 2018	Medicare Shared Savings Program (MSSP) Final Rule	The final rule transitions the four existing MSSP tracks 1, 1+, 2 and 3, into two new options: BASIC and ENHANCED. CMS shortens the amount of time an ACO can remain in an upside-only arrangement from six years under the old program to two years (with some exceptions). After that time, MSSP ACO participants will have to move to downside risk (i.e., repaying losses if they overspend their benchmarks).	**Voluntary**	Begins July 2019	+ MSSP Final Rule + MSSP Fact Sheet + McDermott's +Insight
Oct. 25, 2018	International Price Index (IPI)	A model that seeks to align Medicare payments for physician-administered drugs to prices in other countries. IPI would create a system in which private vendors procure drugs, distribute the drugs to doctors and hospitals, and assume responsibility for Medicare billing. Vendors would aggregate purchasing and compete for providers' business, with the intent of generating additional competition. Instead of the current ASP+6 formula, physicians and hospitals would receive a set payment amount that is not tied to drug prices.	**Mandatory**	Begins Spring 2020	+ Advanced Notice of Proposed Rulemaking + IPI Fact Sheet + HHS's IPI Overview + McDermott OTS + McDermott Webinar

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