Types of Alternative Payment Models (APMs)

Total Cost of Care

Examples: Medicare Shared Savings Program (MSSP), Direct Contracting (DC), Next Generation ACO (NGACO), Comprehensive ESRD Care (CEC) Model

- Participants are accountable for cost and quality of care for target patient population
- Benchmark is established based on historical spending (participant and/or region)
- Beneficiaries are aligned to participants based on a specified criteria (e.g., plurality of primary care visits)
- Payment mechanisms can vary:
  - Continue to be paid under fee-for-service (FFS) and payments are reconciled against benchmark
  - Receive capitated payment instead of FFS
  - Combination of both (reduction in FFS claims and receive capitated payment)
- Participants can achieve shared savings if expenditures are lower than benchmarks. (Participants may owe shared losses if expenditures exceed benchmark.)

Episode-Based Payments

Examples: Bundled Payments for Care Improvement (BPCI) Advanced, Comprehensive Care for Joint Replacement (CJR), Oncology Care Model (OCM)

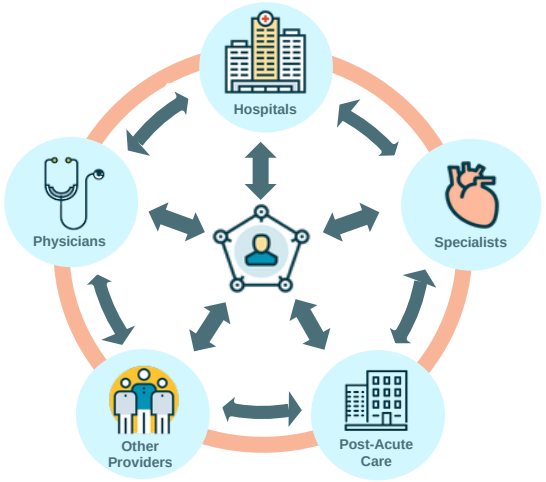
- Participants are accountable for cost and quality of care that beneficiaries receive during an episode of care
- Episodes are usually initiated by an event (e.g., hospitalization) and extend for a set period of time (e.g., 90-days)
- Target price is established for defined set of services/items received during the episode
- Payment mechanisms can vary
  - Continue to be paid under FFS and expenditures are reconciled against a target price (retrospective bundle)
  - Receive set target price instead of submitting FFS claims (prospective bundle)
- Participants can receive a positive reconciliation payment if expenditures are lower than the target price for the episode. (Participants may owe money to CMS, known as negative reconciliation payment, if spending exceeds target prices.)

Primary Care Transformation

Examples: Primary Care First (PCF), Comprehensive Primary Care Plus (CPC+)

- Focuses on strengthening and increasing access to primary care
- Advanced primary care practices (or medical homes) utilize team-based approach to improve health outcomes and reduce costs, with emphasis on prevention, care coordination, and shared decision making
- Models sometimes include an increased payment to providers to cover investments in infrastructure or increased costs from care coordination.
- May also be combined with other model types, such as total cost of care

What is a Total Cost of Care (TCOC) Model?



Partnership between providers and suppliers focused on improving patient outcomes and lowering costs for a target population.

Held accountable for:

- Patient outcomes
- Quality of care
- Healthcare costs

TCOC Example

Accountable Care Organization (ACO). *Group of health care providers who take responsibility for both the total cost and quality of care delivered to their patients*

Payment Mechanisms

Participants usually receive a capitated payment or are held accountable against a benchmark, or some combo of both:

Capitation: Receive capitated payment (e.g., per member per month payment) which covers all services for a target population. Replaces claims-based payments under fee for service.

Benchmark: Continue to be paid under fee-for-service system, but held accountable for total spending for a target population against benchmarks.

Common Terms

Total Cost of Care: All of the health care expenses incurred by a person with very limited exceptions

Benchmark: The projected total cost of care for a given year agreed upon by a payer (Medicare, Medicaid, private insurance, employer, etc.) and an ACO. Also referred to a budget or a target. Often based on multiple weighted historical years of expenditure data, trended forward with some regional adjustment.

Savings: The amount actual total cost of care for a year differs from the benchmark. Can be a negative number if costs are higher than benchmark.

Share Rate: The amount of the savings that goes to the ACO, usually at least 50% and dependent on how much downside risk the ACO takes. May include minimum share rate before savings/loss eligibility; discount from benchmark that CMS receives before sharing; and/or cap on total savings/losses.

Participant Provider: A Medicare-enrolled provider or supplier participating in the model that is eligible for beneficiary alignment.

Preferred Provider: A Medicare-enrolled provider or supplier that is partnering with participants but is not eligible for beneficiary alignment.

Attribution: The methodology for determining whether a given person is included in the ACO based on their relationship with ACO health care providers. Also referred to as beneficiary assignment or alignment, which can be:

- *Prospective:* Attributed to the participant at the start of the performance period based on historical claims.
- *Retrospective:* Attribution is finalized after the end of the performance period based on claims during the performance period. Participants usually receive quarterly updates on attributed beneficiaries throughout performance period, but lists are not finalized until reconciliation.

Fast Facts: Medicare Shared Savings Program (MSSP)

Permanent Statutory Program that was created under the Affordable Care Act

Model Type: Total cost of care

Participation: Any health care providers who come together into an ACO that meets the minimum requirements

Performance Period: Annual, with 5-year Agreement. First full year of the program was 2013.

All Tracks Qualify as an APM

Advanced APM: Basic Level E and Enhanced

Track Options

Pathways to Success, which was finalized in 2018, created a glide path to two-sided risk. Participants have several track options (depending on MSSP experience) and transition to higher levels of risk:

	BASIC (Levels A-B)	BASIC (Levels C-E)	ENHANCED
Shared Savings	40%	50%	75%
Shared Losses	N/A	30%	40%
Max. Losses	N/A	Based on finances of ACO	15% total cost of care

Size: 10.9 million traditional beneficiaries in 2019

Impact: According to CMS the program saved **$749 million** dollars in 2018 and **$1.2 billion** dollars in 2019 even after paying the ACOs their shared savings

Independent research by Harvard has confirmed difference-in-difference savings every year the program has been running saving Medicare money by any measure

Fast Facts: Next Generation ACO (NGACO) Model

Voluntary model that builds on the experiences of other ACO models/programs (e.g., MSSP) and provides an opportunity for participants to assume higher levels of financial risk and reward

Geography: Nationwide

Participation: 41 ACOs

Performance Period: January 1, 2016 – December 31, 2021

Model Type: Total Cost of Care

Risk Arrangements: Participants can select between two different risk arrangements:

- **Partial Risk:** 80% shared savings/losses
- **Full Risk:** 100% shared savings/losses
- Optional stop-loss protections are also available

Prospective Benchmark: CMS updated the methodology for the final two years of the model:

- Benchmark is based on a rolling two-year average of historical spending
- Discounts to the benchmark vary based on risk arrangement: 1.25% (full risk) or 0.5% (partial risk)
- Regional adjustment applied (+10% to -2%) based on ACO's efficiency relative to region (e.g., if ACO's baseline expenditures are below the average regional expenditures, an amount will be added to the ACO's baseline.)

Qualifies as an Advanced APM under the Quality Payment Program (QPP)

Payment Mechanisms

Participants can choose from four different payment mechanisms. Goals are to provide stable and predictable cash flow and to facilitate investments in care coordination and infrastructure.

Normal FFS	• Continue to be paid through FFS
Normal FFS + Monthly Infrastructure Payment	• Allows ACOs to invest infrastructure to support ACO activities • ACO chooses PBPM amount (up to a max. of $6 PBPM) • Recouped during reconciliation
Population-Based Payment (PBP)	• ACO determines percentage reduction in FFS payments for participants and preferred providers • CMS pays ACO total annual amount taken out of base FFS rates on monthly basis
All-Inclusive Population-based Payment (AIPP)	• Participants and preferred providers (who opt to) reduce FFS claims by 100%. • ACO is responsible for paying participating and preferred providers.

Direct Contracting: Overview

Voluntary model that builds on lessons learned from accountable care initiatives and leverages approaches from Medicare Advantage and private sector risk-sharing arrangements.

Model Type: Total cost of care focused on primary care transformation

Geography: Nationwide (for *Global and Professional Tracks*); Select regions (for *Geographic Tracks*)

Performance Periods:

- *Professional and Global Tracks:* April 1, 2021 – Dec. 31, 2026
  - Implementation period began October 2020
  - Cohorts beginning April 1, 2021 (First) and Jan. 1, 2022 (Second)
- *Geographic Track*:* Two 3-year performance periods:
  - Jan. 1, 2022-Dec. 31, 2024 (for 2021 applicants)
  - Jan. 1, 2025-Dec. 31, 2027 (for 2024 applicants)

Track Options

	Professional	Global	Geographic
Shared Savings/ Losses	Up to 50%	100%	100%
Payment Mechanism	Primary Care Capitation	Total Care Capitation OR Primary Care Capitation	Total cost of care for target region
Discounts	None	2-5% (varies by PY)	*Bid by participants**

**Eligible participants will propose a discount as part of their applications, which would be applied to a region's Performance Year Benchmark. CMS will select applicants with the highest average discount. As of December 2020, CMS anticipates the discount could range from an expected regional min. of 2-3% to expected max. discount of 8-9% (max. to be actuarially sound)*

Participant Types: Designed to attract a range of entities – including those with limited experience in Medicare and Innovation Center models, and Medicaid Managed Care Organizations (MCOs)*

On Hold / Pending Review

Direct Contracting: Professional and Global Tracks

- Three types of **Direct Contracting Entities (DCEs)**:
  1. **Standard DCEs**: Experienced serving Medicare FFS beneficiaries
  2. **New Entrant DCEs**: Limited experience with Medicare FFS
  3. **High Needs Population DCEs***:* Serve Medicare FFS beneficiaries with complex needs, including dual eligible.
- Beneficiaries aligned to a DCE based on either **claims-based alignment** or **voluntary alignment**.
- DCEs form relationships with two types of providers or suppliers: **DC Participant Providers** and **Preferred Providers**.
  - Participant Providers used to align beneficiaries and must accept payment from DCE
- **Financial methodology** varies based on type of DCE, type of beneficiary alignment, and performance year:
  - Benchmark set using similar methods as Medicare Advantage Rate Book, and/or ACO benchmark methodology
- DCEs paid monthly capitated amount based on claims reductions for Participant Providers and Preferred Providers – through one of the **Capitation Payment Mechanisms**:
  - **Total Care Capitation (TCC):** Applies to all Medicare Parts A and B services provide to aligned beneficiaries (*Global Track only*)
  - **Primary Care Capitation (PCC):** Applies only to certain primary care services provided to aligned beneficiaries
    - Can opt to take on risk and receive payment for non-PCC services (**Advanced Payment Option**)

Direct Contracting Payment Details

Performance Year (PY) Benchmark Methodology

Inclusive of total cost of care (Medicare Parts A & B). Approach varies based on participant type, beneficiary alignment (for Standard DCEs), and performance year (PY):

	Standard DCE		New Entrant	High Needs
	Claims-based	Voluntary	Both	Both
PY1	**Standard Benchmarking Approach:** Blend of aligned beneficiary historical expenditures (CY 2017-2019) and Adjusted MA Rate Book (Regional)	**Regional Benchmarking Approach** (PYs 1-3)**:** Composed entirely of adjusted MA Rate Book for PY. (Note: Standard Benchmarking approach is used for voluntarily aligned beneficiaries that could also be aligned to a Standard DCE based on claims.)		
PY2				
PY3				
PY4		**Modified Standard Benchmarking Approach** (PYs 4-5): Blend of adjusted MA Rate Book and historical expenditures		
PY5				

Discounts and Withholds

PY Benchmarks and payments are subject to several different reductions:

– 2 to 5%	**Benchmark discount (Global only):** applied to the PY benchmark. Ranges from 2% (PY1) to 5% (PY5). Represents savings to Medicare.
– 5%	**Quality Withhold:** 5% of the PY benchmark is withheld and can be "earned back" based on quality performance
– 2%	**Retention Withhold**: additional 2% of the benchmark is withheld in PYs 1 and 2 to incentivize continued participation in the model. Refunded if participant is still in model at time of PY1 reconciliation.
TBD	**Leakage Withhold:** Amount is withheld to account for utilization by providers not in the capitated payment and/or Preferred Providers who did not reduce claims by 100%. Calculated based on historical spending.

Payment Mechanisms

Total Care Capitation (TCC): DCEs receive monthly capitation payment for total cost of care minus a leakage withhold. Participant providers reduce claims by 100%. Preferred Providers reduce claims between 1-100%.

Monthly TCC = **PY Benchmark*** – **Leakage Withhold**

**Subject to discounts and withholds*

Primary Care Capitation (PCC): DCEs receive monthly capitation payment equal to 7% of the PY Benchmark. Participant providers reduce claims for primary care based services by 100%. Preferred Providers reduce claims for primary care between 1-100%

Monthly PCC

Equal to 7% of **PY Benchmark**, includes:

Base Primary Care Capitation

Based on historical primary care spend for aligned beneficiaries

+

Enhanced Primary Care Capitation

Additional payment that will be recouped at end of PY. Enables DCEs to invest in primary care

OPTIONAL: Advanced Payment with Prospective Claims Reduction

- ✓ Option to reduce claims payment for non-primary care claims (1- 100% as determined by DCE)
- ✓ CMS will pay Advanced Payment based on historical expenditures
- ✓ Applicable for participant and preferred providers

Direct Contracting: Geographic (Geo) Track*

- **DCEs** assume full risk for all aligned Medicare FFS beneficiaries in defined target region
- Providers in region can opt into value-based payment arrangement with DCE **(Preferred Providers)**
  - Providers who do not enter arrangement will be paid at 100% FFS
- Two **capitation payment mechanisms** available:
  - *Total Capitation*. Reduces Preferred Providers' FFS billing by 100%
  - *Partial Capitation*. Reduces Preferred Providers' FFS billing between 1-50%
- CMS will select DCEs based on their **proposed discounts** – bidding process
  - Applied to region's PY benchmark
  - CMS anticipates discounts will range from 2-9%
- Beneficiaries will be **aligned to DCE based on**:
  1. Voluntary alignment
  2. Medicaid managed care organization (MCO) alignment
  3. ACO-based alignment
  4. Limited claims-based alignment
  5. Random alignment

**** Model is currently on hold pending review by new Administration***

Potential Geo Model CBSAs:

CMS considering 10 geographic regions for first performance period:

1. Atlanta
2. Dallas
3. Houston
4. Los Angeles
5. Miami
6. Orlando
7. Philadelphia
8. Phoenix
9. San Diego
10. Tampa

Fast Facts: Comprehensive ESRD Care (CEC) Model

Voluntary model that builds on the experience of other ACO models to test accountable care for Medicare beneficiaries with end-stage renal disease (ESRD)

Geography: Nationwide

Participation: 33 ESRD Seamless Care Organizations (ESCOs) – partnership between dialysis clinics, nephrologists, and other Medicare-enrolled providers/suppliers

Model Type: Total Cost of Care

Performance Period: October 1, 2015 – March 31, 2021

Model Design: Participants are responsible for all Medicare Parts A and B spending for aligned beneficiaries.

Qualifies as an Advanced APM under the Quality Payment Program (QPP)

Track Options

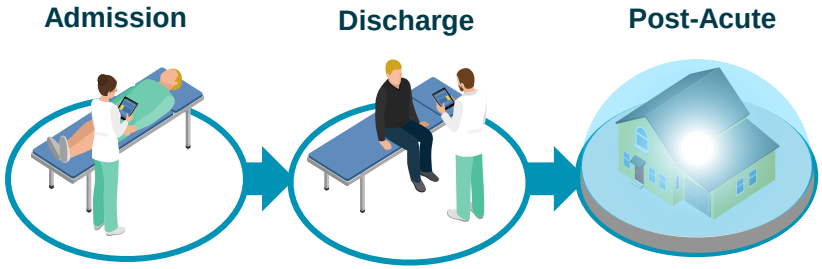
Risk tracks vary based on the size of the dialysis organization. Large dialysis organizations (LDOs) are defined as having 200 or more dialysis facilities.

For non-LDOs, performance is aggregated with other non-LDOs (two-sided or one-sided, depending on selected risk-level) if beneficiary alignment numbers are too low or if the ESCO elects to have beneficiaries grouped in an aggregation pool.

	LDO	Non-LDO	
Risk Level	Two-sided	Two-sided	One-sided
Min. Savings Rate/ Min. Loss Rate (MSR/MLR)[1]	1-2%	1-2%	2-4.75% (varies based on number of aligned beneficiaries)
Shared Savings	75%	75%	50%
Shared Savings/Loss Cap	10-15% (varies by PY)	10-15% (varies by PY)	5%
Discounts[2]	PY2: 1% PY3: 2% PY4+: 3%	None	None

(1) When the MSR/MLR threshold is passed, ESCO shares in savings or losses on difference between benchmark and actual expenditures up to the cap.
(2) Discount is only applied to non-dialysis spending

What is a clinical episode?



CLINICAL EPISODE =

Anchor Stay + 90 days, with 90 days starting on day of discharge

OR

Anchor Procedure + 90 days beginning on the day of completion of the outpatient procedure

Participants are responsible for all costs during the episode (with some limited exceptions)

Common Terms

Target Price: Established price for all items and services included in the bundle. Usually established based on historical data (either for the participant and/or region) and includes a discount, which represent savings to Medicare.

Reconciliation Payment: The amount that CMS owes to the participant if expenditures are lower than the target price or the amount owed by the participant back to CMS if expenditures exceeded the target price.

Anchor Stay: Inpatient stay at an Acute Care Hospital with a qualifying MS-DRG billed to Medicare FFS by an Episode Initiator (EI)

Anchor Procedure: Outpatient procedure (identified by a Healthcare Common Procedure Coding System (HCPCS) code) on an associated Hospital Outpatient facility claim billed to Medicare FFS by an EIA

Episode Initiator (EI): Medicare-enrolled provider that can initiate a clinical episode. In BPCI Advanced, only hospitals or PGPs can be episode initiators.

Convener Participant: Participant that brings together and coordinates Downstream EIs that participate in the model. Bears and apportions financial risk.

Non-Convener Participant: EI that bears financial risk only for itself and does not have any Downstream EIs.

Fast Facts: Bundled Payments for Care Improvement (BPCI) Advanced

Voluntary episode-based payment model that sets a single bundled payment for a clinical episode of care with the goal of incentivizing high quality and efficient care delivery

Geography: Nationwide

Model Type: Episode-based Payment

Model Design: Retrospective bundled payment with a 90-day Clinical Episode duration. Participants continue to be paid under Medicare FFS. CMS reconciles expenditures against an episode target price

Participation: 1299 participants. Open to *both* hospital and physician group practices

Performance Period: October 1, 2018 – December 31, 2023

Target Prices: Prospectively set. All subject to 3% discount

Reconciliation: Performed semi-annually

Qualifies as an Advanced APM under the Quality Payment Program (QPP)

Clinical Episodes

Clinical episodes include all services furnished during the episode window (with some exclusions). Starting in MY4, participants must select **Clinical Episode Service Line Groups** and are accountable for all episodes in the group. (Prior to MY4, participants could select individual episodes.):

- ✓**Cardiac Care**
- ✓**Cardiac Procedures**
- ✓**Gastrointestinal Surgery**
- ✓**Gastrointestinal Care**
- ✓**Neurological Care**
- ✓**Medical and Critical Care**
- ✓**Spinal Procedures**
- ✓**Orthopedics**

Fast Facts: Comprehensive Care for Joint Replacement (CJR) Model

Mandatory episode-based payment model focused on hip and knee replacements, the most common inpatient surgeries for Medicare beneficiaries.

Geography: 67 Metropolitan Statistical Areas (MSAs).

Participation: Hospitals located in selected MSAs that are paid under Medicare's Inpatient Prospective Payment System (IPPS):

- For PYs 1-2, all hospitals located in the 67 MSAs were required to participate. Excluded rural and low-volume hospitals.
- Starting in PY3, only hospitals located in 34 of the 67 MSAs are required to participate. Hospitals located in the other 33 MSAs have option to participate. (Low-volume and rural hospitals can op-in to the model.)

Model Type: Episode-based Payment Initiative

Performance Period: April 1, 2016 – September 30, 2021

- Proposed rule to extend model three years (through CY 2023) for hospitals located in mandatory MSAs

Model Design: Retrospective bundled payment. Participants continue to be paid under Medicare FFS. CMS reconciles expenditures against an episode target price

Clinical Episodes: Triggered by an inpatient admission for MS-DRG 469 or MS-DRG 470 (i.e., lower extremity joint replacement (LEJR)). Episode includes all items and services paid under Medicare Parts A and B (with the exception of certain exclusions) for the inpatient stay and 90 days following discharge.

Target Prices: Benchmarks are based on a blend of a hospital's historical spending and regional expenditures in PYs 1-3 and 100% historical regional expenditures in PYs 4-5. All subject to 3% discount.

Qualifies as an Advanced APM under the Quality Payment Program (QPP): Only Track 1

Radiation Oncology (RO) Model Overview

Mandatory model focused on promoting quality and financial accountability for episodes of care centered on radiation therapy (RT) services

Geography: CMS randomly selected geographic areas stratified by Core-Based Statistical Areas (CBSAs) to participate:

Participation: Physician group practices (PGPs), Hospital Outpatient Provider-based Departments (HOPDs), and freestanding radiation therapy centers located in selected geographic areas

Performance Period: *Delayed until at least January 1, 2022*

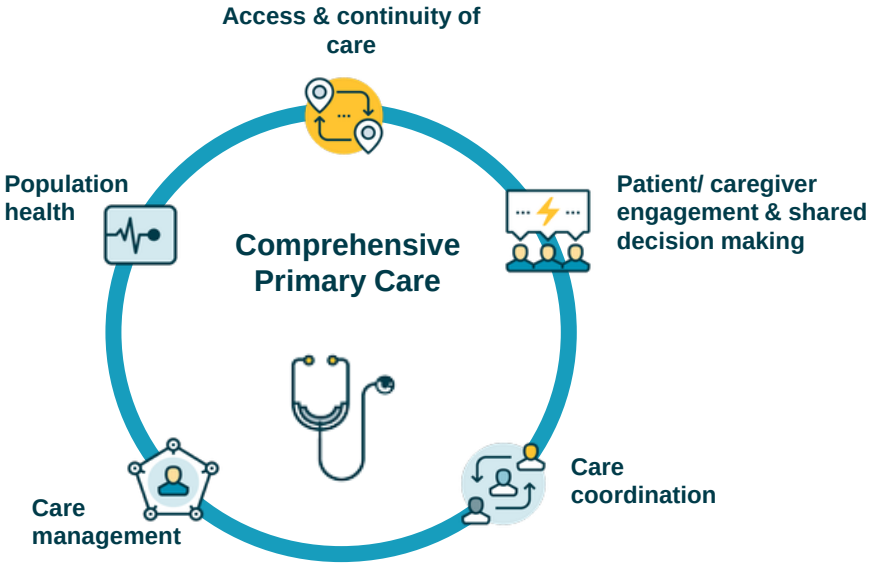
Model Design: Prospective site-neutral payment for certain RT costs during a 90-day episode of care for 16 different cancer types commonly treated with RT

- Episode is triggered by initial radiation treatment planning at participating provider
- Splits payment into two components: ***Professional Component (PC) and Technical Component (TC)*** – discounts applied historical Medicare spending:
  - 3.75% for professional component (PC) for nephrology practices
  - 4.75% for technical component (TC) for HOPDs and freestanding radiation oncology centers
- Payment is dispersed in two installments – beginning and end of episode

Qualifies as an Advanced APM under the Quality Payment Program (QPP)

What is a Primary Care Transformation model?

- Focuses on primary care with the goal of improving health outcomes and shrinking overall healthcare costs through prevention, care coordination, and shared decision making
- Models sometimes include an increased payment to providers to cover investments in infrastructure or increased costs from care coordination.
- May also be combined with other model types, such as total cost of care



Common Terms

Enhanced Payment: Additional payment that participants receive that is intended to augment and support population health management and care coordination. Typically paid as a monthly capitated payment (i.e., per member, per month payment).

Performance Based Adjustment: An adjustment applied to payments that is tied to a participant's performance on specific metrics (e.g., achieving a specified quality level)

Seriously Ill Population (SIP): Subset of the Medicare population that are high-cost and high-need. Under Primary Care First, CMS will define the SIP population using claims: either seriously ill based on risk score/signs of frailty and/or based on indicators of fragmented care

Fast Facts: Primary Care First

Voluntary model focused on increasing patient access to advanced primary care services with the goals of improving quality, improving patient experience, and reducing costs.

Model Type: Primary Care Transformation

Participation: Designed for advanced primary care practices

Tracks: General (*PCF-General*) and Severely-ill Population (*PCF-SIP*)

- PCF-SIP participants need to have, or partner with a provider that has hospice and/or palliative care capabilities
- Practices can choose one of the two options, or both

Performance Period: January 2021– December 2025 (*PCF-General)*

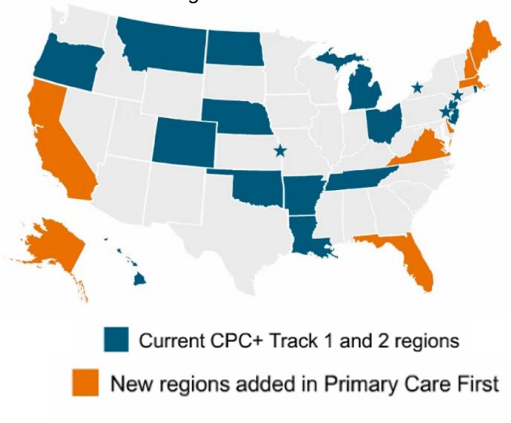
- Second cohort to begin January 1, 2022 (*PCF-General*)
- *PCF-SIP* Component is currently under review by new Administration

Qualifies as an Advanced APM under the Quality Payment Program (QPP) – participants are eligible for bonuses

Geography

18 regions in CPC+, plus 8 additional states

+ Independence at Home participants, regardless of location



Payment Mechanisms: Two types of payments under the model:

- **Total Primary Care Payment:** Made up of a professional population-based payment (monthly capitated payment that varies based on patient risk level) and a flat primary care visit fee ($40.82 per face-to-face encounter)
- **Performance-based Payment Adjustment:** Opportunity for practices to increase revenue by up to 50% based on key performance measures

Additional Models

Community Health Access and Rural Transformation (CHART) Model

- New voluntary Innovation Center model focused on transforming rural healthcare through:
  - Upfront funding
  - Operational Flexibilities *(e.g., regulatory waivers, benefit enhancements, etc.)*
  - Technical and learning system support
- Two Participation Options: ACO Transformation Track and Community Transformation Track

ACO Transformation Track

Builds on lessons learned from the ACO Investment Model (AIM)

20 rural ACOs will receive advanced shared savings as part of joining MSSP

Two types of payments, vary based on number of rural beneficiaries (up to 10,000) and risk-level

- One-time upfront payment, a min. of $200,000 plus $36 per beneficiary
- Prospective per beneficiary per month (PBPM) of $8 for up to 24 months

Up to five years to repay advanced payments

Request for Applications now expected in **Spring 2022**

CHART Model

Community Transformation Track

Up to $75M available to 15 rural communities (or $5 M each)

- Up to $2 M for pre-implementation period
- Up to $500,000 each performance period

Eligible communities must be rural (as defined by the Federal Office of Rural Health Policy) and have at least 10,000 Medicare FFS beneficiaries

Lead organization is responsible for engaging with community partners

- Requires participation from at least one hospital
- Medicaid participation required; multi-payer alignment recommended
- Unclear how other providers participate and are included in the payment model

Participants will develop and implement transformation plan – assess community needs and redesign service delivery

Participating hospitals receive capitated payments (instead of fee-for-service) based on historical expenditures and subject to a discount (TBD)

Notice of Funding Opportunity September 2020, with July 2021 start

ESRD Treatment Choices (ETC) Overview

Mandatory model to align incentives to promote in-home dialysis and kidney transplants

Geography: CMS randomly selected geographic areas stratified by Hospital Referral Regions (HRRs) to participate:

- Selected area accounts for 30% of adult ESRD beneficiaries
- Also included HRRs for which at least 20% of zip codes located in Maryland

Participation: ESRD facilities and Medicare-enrolled physicians or non-physician practitioners (NPPs) who furnish and bill the monthly capitation payment (MCP) for managing ESRD beneficiaries (i.e., managing clinicians) located in selected geographic areas

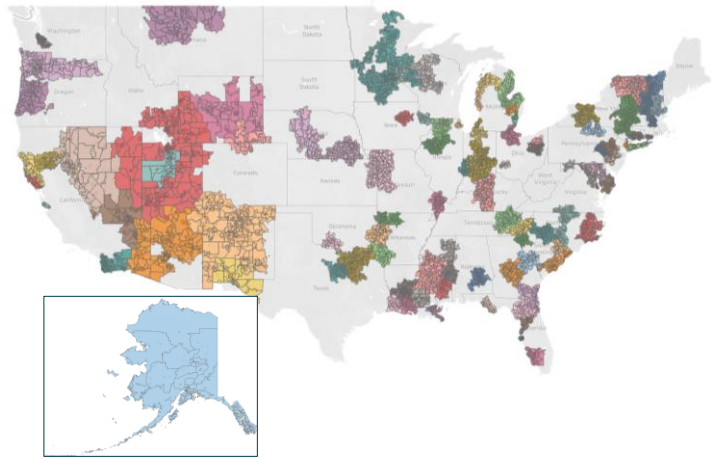
Performance Period: January 1, 2021 – June 30, 2027

Model Design: Participants will be subject to two different adjustments:

- *Home Dialysis Payment Adjustment (HDPA):* Upward adjustment applied to home dialysis and related claims for first three years (2021-2023)
- *Performance Payment Adjustment (PPA):* Upward or downward performance-based adjustment on all dialysis and related claims
  - Adjustment varies based on rates of home dialysis utilization, kidney transplant waitlist, and living donor transplants
  - Applied to claims with service dates between July 1, 2022 and June 30, 2027

Does Not Qualify as an Advanced APM under the Quality Payment Program (QPP)

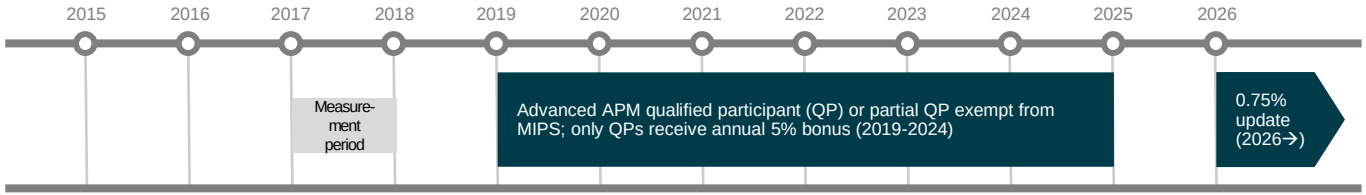
Mandatory Geographic Areas



Advanced APMs and MACRA Bonuses

Advanced Alternative Payment Models (APM) for 2020:

- Comprehensive ESRD (2-sided risk)
- Medicare Shared Saving Program (Tracks 1+, 2, 3, Basic Level E & Enhanced)
- Next Generation ACO
- Oncology Care Model (2-sided risk)
- Comprehensive Primary Care Plus
- Comprehensive Care for Joint Replacement (Track 1)
- BPCI Advanced

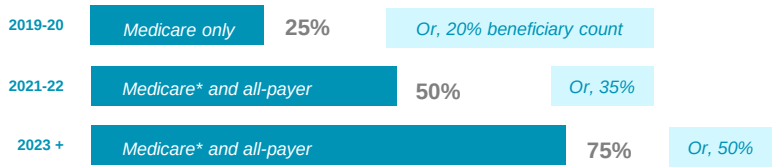


Advanced APM Entities Must:

1. Use certified EHR technology,
2. Pay based on MIPS comparable quality measures, *and*
3. Bear more than "nominal" financial risk for losses.

Inclusion in Advanced APMs may trigger MIPS exclusion.

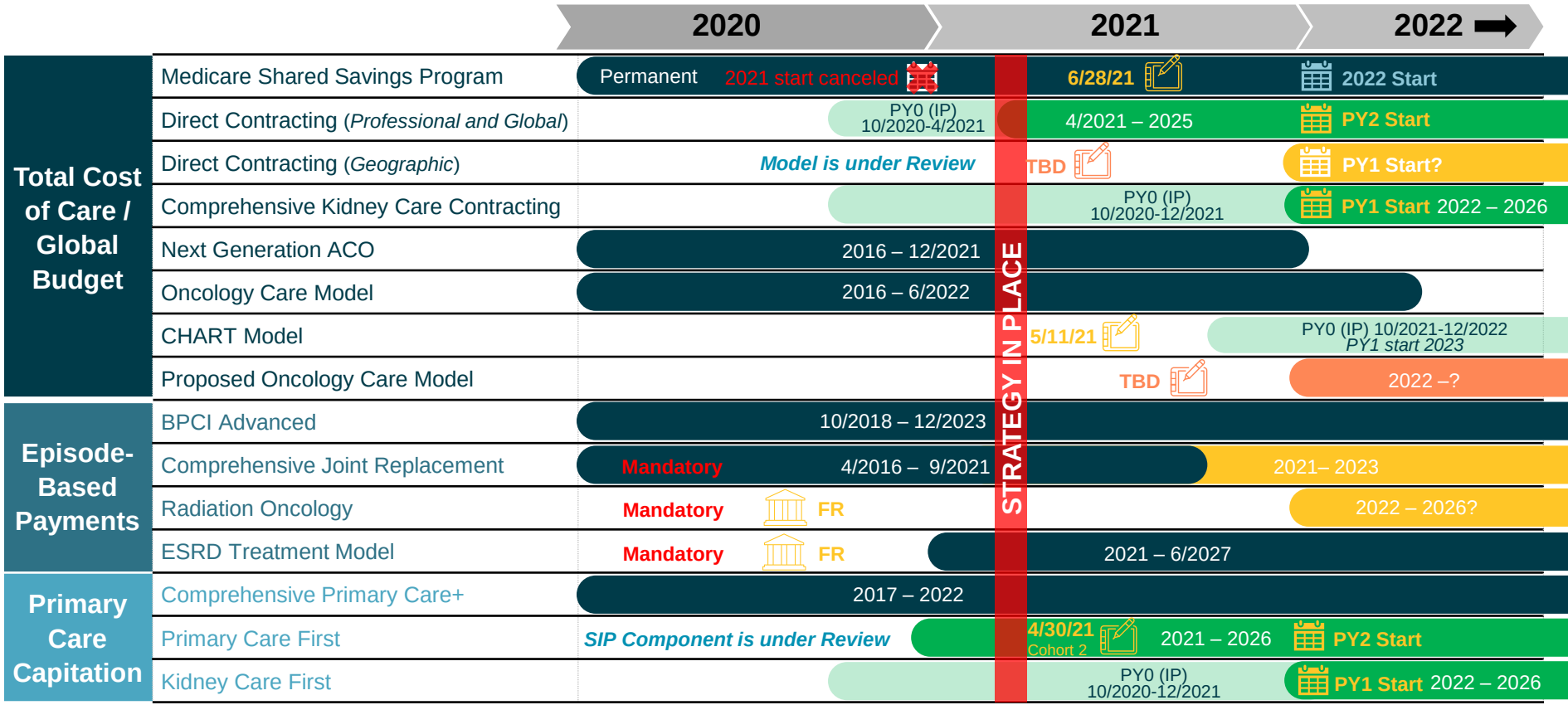
Threshold of payments in an Advanced APM to reach QP status



Total payments exclude payments made by the Secretaries of Defense/Veterans Affairs and Medicaid payments in states without medical home programs or Medicaid APMs.

* All Payer Option: Minimum of 25% of Medicare payments must be in AAPM in all years for QP; 20% for Partial QP; Bonus only for QP and MIPS-exempt; No bonus for Partial QP but is MIPS-exempt unless elects to opt-in to MIPS

Strategy for bearing risk must be in place by 2021



= Current/Ongoing = Announced/Proposed (Awaiting RFA or final rule) = RFA Available = Future

