

## Alternative Payment Model Design Toolkit

*Dear Health Care Colleague:*

*We appreciate all you do to care for beneficiaries of Medicare, Medicaid, and the Children's Health Insurance Program. We understand that changes in health care payment can create challenges, not just in reporting, but also in how you serve patients and manage your practice. But these challenges are opportunities, as well.*

*The Centers for Medicare & Medicaid Services (CMS) is working to facilitate reporting, support improvement and innovation, and provide guidance as you adapt to health care transformation. Efforts include new payments for care coordination, chronic care management, and psychiatric collaborative care model services, among other things. They have included developing various Alternative Payment Models (APMs), including Accountable Care Organizations and new initiatives in Population Health and technical assistance through the Transforming Clinical Practice Initiative (TCPI).*

*The bipartisan Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) also affords new opportunities. The Quality Payment Program, which was established to implement MACRA, aims to improve health outcomes, promote smarter spending, minimize burden of participation, and provide fairness and transparency in operations through the Merit-based Incentive Payment System (MIPS) and incentive payments for sufficient participation in Advanced Alternative Payment Models (Advanced APMs). This APM Toolkit provides information about the Quality Payment Program and other considerations to be taken into account in designing an APM.*

*The APM Toolkit reflects CMS' commitment to listening to and supporting physicians and other health care providers, whose daily experience with patients puts them in a unique position to see what is needed, to innovate, and to find out what works in care delivery and payment. It reflects, as well, CMS's commitment to expanding opportunities for health care transformation. Each new APM provides a path that others in the health care community can learn from and follow.*

*We hope that you find this APM Toolkit a valuable resource for using your ideas to help design new payment and care delivery models that improve quality and provide greater value. Thank you for helping CMS in its efforts to identify new approaches for delivering care and for your ongoing support for meeting our goal of putting patients first.*

Sincerely,



Patrick Conway, MD, MSc  
Deputy Administrator for Innovation and Quality and  
Director, Center for Medicare and Medicaid Innovation

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## Introduction

The Toolkit for Alternative Payment Model Design (APM Toolkit) was produced by the Centers for Medicare & Medicaid Services (CMS) to serve as a resource for any entities or individuals interested in developing ideas for APMs. This APM Toolkit provides a detailed and comprehensive set of resources to help design an APM.

Health care providers and other stakeholders have been eager to help the Medicare program and other parts of the health care system improve and leverage the opportunities ahead. Not surprisingly, some are also concerned, given the challenges of testing new ways of delivering and paying for care under Medicare. However, there appears to be near-universal support for moving toward a future focused on patient care that pays for what works, reduces clinician burden, and better supports and engages the medical community.

CMS is dedicated to expanding the opportunities for physicians to participate in APMs and Advanced APMs. Our goal over the next few years is to have options available that fit the diversity of practices and care across the nation, while continuing to support participation in current and robust model tests that are already encouraging high-value care – the best care at the best price – for our Medicare, Medicaid, and Children’s Health Insurance Program (CHIP) beneficiaries.

The Quality Payment Program, which implements the bipartisan Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), aims to improve health outcomes, promote smarter spending, minimize burden of participation, and provide fairness and transparency in operations through the Merit-based Incentive Payment System (MIPS) and incentive payments for sufficient participation in Advanced Alternative Payment Models (Advanced APMs). This APM Toolkit provides information and resources for designing an APM.

The APM Toolkit has been organized into several sections to serve as a guide through the process of developing an idea for an APM and identifying key design elements. The Background section provides summary information about the following topics: Transforming the Health Care Delivery System; the CMS Center for Medicare and Medicaid Innovation’s (CMS Innovation Center’s) Role in Model Testing; The Alternative Payment Model Framework; the Quality Payment Program: MACRA, MIPS, and APMs; the Physician-focused Payment Model Technical Advisory Committee; and How the CMS Innovation Center Assesses Ideas for New Models. The second section describes APM Design Elements to take into account when developing an idea for a model. The third section addresses Opportunities for Innovations that are Not Alternative Payment Models. This is followed by sections covering Frequently Asked Questions, Resources, and Glossaries of Acronyms and Quality Payment Defined Terms, and the CMS Alternative Payment Model Design Worksheet in an Appendix.

## Background

This section provides general information about transforming the health care system and developing Alternative Payment Models (APMs). The following topics are presented: Transforming the health care delivery system, the CMS Innovation Center's role in model testing, the Quality Payment Program, the Physician-Focused Payment Model Technical Advisory Committee (PTAC), and how the CMS Innovation Center assesses ideas for new models.

### Transforming the Health Care Delivery System

To help put patients first, the Department of Health and Human Services (HHS) is working in concert with partners in the private, public, and non-profit sectors to transform the nation's health system to emphasize value over volume.

An APM is a payment approach, developed in partnership with the clinician community, that provides added incentives to deliver high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population. This is a broad definition of an APM. As subsequently discussed, MACRA defines APMs more narrowly, as particular initiatives.

All APMs and payment reforms that seek to deliver better care at lower cost share a common pathway for success: providers, payers, and others in the health care system must make fundamental changes in their day-to-day operations that improve quality and reduce the cost of health care. Making operational changes will be viable and attractive only if new APMs and payment reforms are broadly adopted by a critical mass of payers. When health care providers encounter new payment strategies for one payer but not others, the incentive to change is weak. When payers align their efforts, the incentive to change is stronger, and the obstacles to change are reduced.


The Health Care Payment Learning and Action Network (LAN)<sup>1</sup> collaborative network was created in 2015 as a forum for public-private partnerships to help the U.S. health care system move increasingly towards value-based payments and APMs. Supported by the CMS Innovation Center, the LAN provides a mechanism for public and private payers, purchasers, health care providers, consumers, and states to align and increase development of APMs that improve the quality and value of health care. The LAN provides a forum for generating evidence, sharing best practices, developing common approaches to the design and monitoring of APMs, and removing barriers to health care transformation across the U.S. health care system. The 2017 refresh of the Alternative Payment Model (APM) Framework White Paper<sup>2</sup> was released in July 2017.

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<sup>1</sup> Health Care Payment Learning and Action Network (LAN): <https://hcp-lan.org/>

<sup>2</sup> [Alternative Payment Model \(APM\) Framework White Paper Refreshed 2017](#)





The CMS Innovation Center’s model tests focus on enhancing incentives for quality and value, improving the way care is delivered, and facilitating the sharing of lessons learned and best practices in order to achieve better care at lower cost across the entire health care system.

## **CMS Innovation Center’s Role in Model Testing**

The CMS Innovation Center<sup>3</sup> was established by section 1115A of the Social Security Act (the Act) (as added by section 3021 of the Affordable Care Act). Congress created the CMS Innovation Center to test “innovative payment and service delivery models to reduce program expenditures . . . while preserving or enhancing the quality of care” furnished to Medicare, Medicaid, or CHIP beneficiaries. The CMS Innovation Center models are helping to drive the national effort to move toward value-based care and away from fee-for-service payment, which often rewards the quantity of care delivered, rather than care quality and outcomes. To improve care and value, these model tests focus on reducing program expenditures while improving the quality of care.

The CMS Innovation Center focuses on testing innovative payment and service delivery models with a substantial evidence base in clinical and payment research, with special attention to ideas on improvements in care delivery and payment developed by health care providers and other innovators. In addition to this work, the CMS Innovation Center has responsibility for implementing a number of specific demonstration projects authorized and funded by statutes other than 1115A.

## **Quality Payment Program: MACRA, MIPS, and APMs**

In April 2015, Congress passed the bipartisan MACRA,<sup>4</sup> which repealed the Sustainable Growth Rate (SGR), consolidated and streamlined components of three existing programs, the Physician Quality Reporting System (PQRS), the Physician Value-based Payment Modifier (VM), and the Medicare Electronic Health Record (EHR) Incentive Program for Eligible Professionals (EPs), into one new system known as Merit-based Incentive Payment System (MIPS), and provides incentives for eligible clinicians who achieve threshold levels of participation in Advanced APMs. On October 14, 2016, HHS issued its final rule with comment period implementing the Quality Payment Program that is part of MACRA. MIPS and incentives for sufficient participation in Advanced APMs together form the two paths of the Quality Payment Program.<sup>5</sup> The Quality Payment Program will accelerate the adoption of APMs by

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<sup>3</sup> CMS Innovation Center: <https://innovation.cms.gov/index.html>

<sup>4</sup> MACRA: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-LAN-PPT.pdf>

<sup>5</sup> Quality Payment Program: <https://qpp.cms.gov/>


building on existing efforts to tie payment to quality and improvements in care delivery, as well as modernizing the way Medicare pays clinicians.

MACRA defines an APM as a model under section 1115A of the Act (excluding a health care innovation award), the Medicare Shared Savings Program under section 1899 of the Act, a demonstration under section 1866C of the Act (the Health Care Quality Demonstration Program), or a demonstration required by federal law. Advanced APMs are a subset of APMs that: (1) require participants to use certified electronic health record technology, (2) provide payment for covered professional services based on quality measures comparable to those used in the quality performance category of MIPS, and (3) are either a Medical Home Model expanded under CMS Innovation Center authority or require participating APM Entities to bear more than a nominal amount of financial risk for monetary losses. Physician-Focused Payment Models, defined through rulemaking, are a subset of APMs that: include Medicare as a payer, physicians or other eligible clinicians play a core role in implementing the payment methodology, and targets quality and costs of services physicians or other eligible clinicians provide, order, or significantly influence. They may or may not also be Advanced APMs. These definitions are also presented in Table 1 below.

**Table 1. Types of Alternative Payment Models as Defined under the Quality Payment Program**

Alternative Payment Model (APM)	Physician-Focused Payment Model (PFPM)	Advanced Alternative Payment Model (Advanced APM)
<ul style="list-style-type: none"> <li>• Innovation Center Models (other than a health care innovation award).</li> <li>• Demonstration under the Health Care Quality Demonstration Program</li> <li>• Medicare Shared Savings Program.</li> <li>• Demonstration required under federal law.</li> </ul>	<ul style="list-style-type: none"> <li>• Includes Medicare as a payer.</li> <li>• Physicians or other eligible clinicians play a core role in implementing the payment methodology.</li> <li>• Targets quality and costs of services physicians or other eligible clinicians provide, order, or significantly influence.</li> <li>• May be an APM or Advanced APM.</li> </ul>	<ul style="list-style-type: none"> <li>• Requires participants to use certified EHR technology.</li> <li>• Bases payment for covered professional services on quality measures comparable to those in MIPS.</li> <li>• Participant APM Entities bear more than nominal financial risk, or APM is a Medical Home Model Expanded under Innovation Center authority.</li> </ul>

Eligible clinicians may only qualify for the five percent bonus under the Quality Payment Program, described below, through sufficient participation in Advanced APMs. Participants in other (non-Advanced) APMs may receive both APM-specific rewards (such as enhanced payment for model-specific services, shared savings, or gain sharing) and favorable scoring in certain MIPS performance categories.



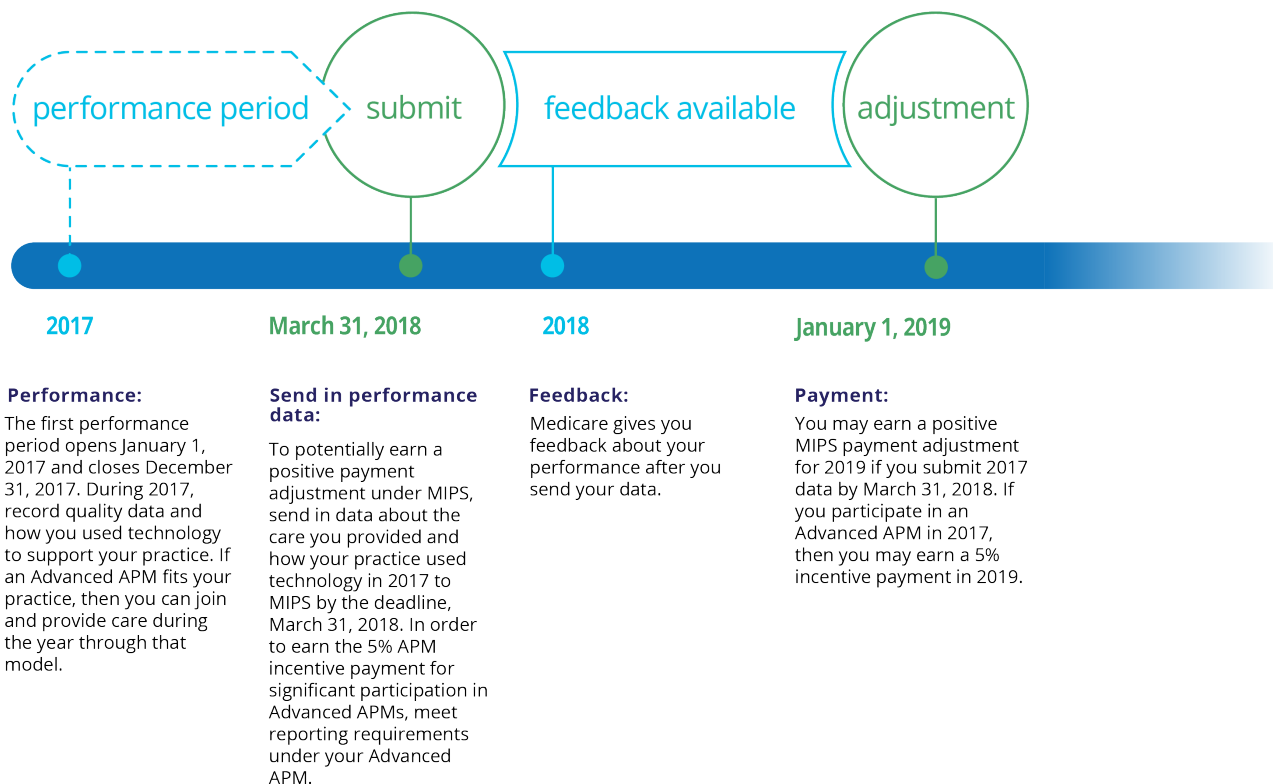
The CMS Innovation Center bears primary responsibility for development of policies and operations to implement the APM incentive provisions of MACRA through the Quality Payment Program. The CMS Innovation Center fulfills this role because it is best positioned to not only design new models, but also to implement model tests, identify challenges, modify the design and implementation of a model, and make refinements to the duration and scope of a model based on the model's evaluation, including patient and health care provider feedback.

For performance years from 2019-2024, eligible clinicians may earn a five percent incentive payment and be excluded from MIPS reporting and payment adjustments by going further in improving patient care and taking on risk through a defined level of participation in an Advanced APM. Specifically, eligible clinicians may earn a five percent incentive payment in 2019 for Advanced APM participation in 2017 if they receive at least 25 percent of their Medicare Part B payments, or see at least 20 percent of their Medicare patients, through an Advanced APM. Eligible clinicians who meet the patient or payment count threshold will be considered Qualifying APM Participants (QPs). The incentive payment is five percent of the estimated aggregate payment amounts for Medicare Part B covered professional services furnished by the QP in the year preceding the payment year. Because the patient and payment count thresholds for determining QPs are adjusted over time, please refer to the calendar year (CY) 2017 Quality Payment Program Final Rule with Comment Period<sup>6</sup> for details about QP determinations beyond payment year 2019. The MIPS participation timeline is illustrated in Figure 1, and the Qualifying APM Participant (QP) performance period and APM incentive payment timeline in Figure 2.

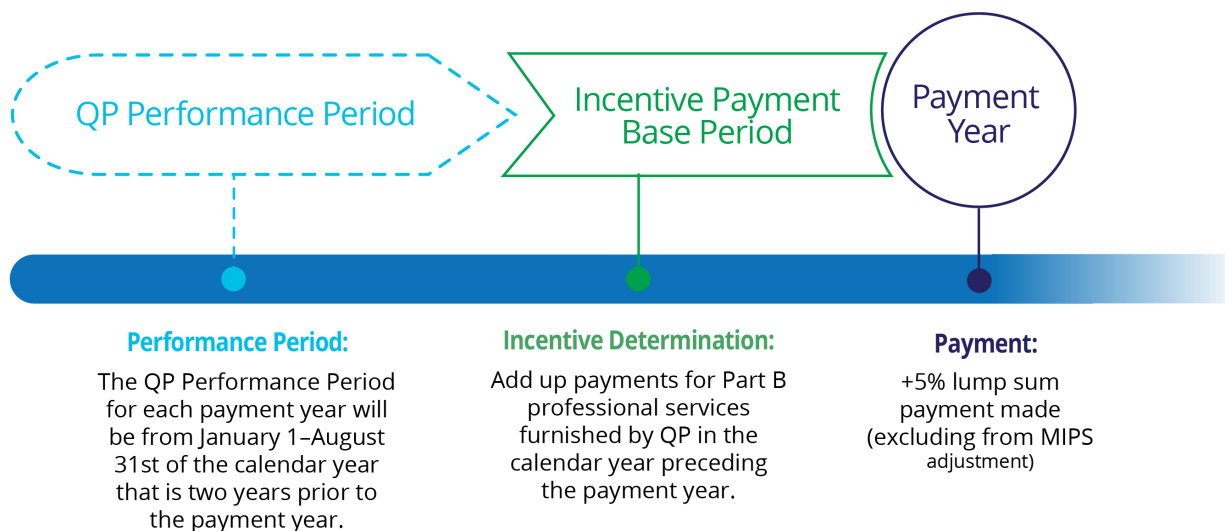
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<sup>6</sup> CY 2017 Quality Payment Program Final Rule with Comment Period:  
<https://www.gpo.gov/fdsys/pkg/FR-2016-11-04/pdf/2016-25240.pdf>

**Figure 1. Merit-based Incentive Payment System (MIPS) Timeline**



**Figure 2. Qualifying APM Participant (QP) Performance Period and Advanced APM Incentive Payment Timeline**





Under the Quality Payment Program, CMS began measuring performance for doctors and other clinicians through MIPS in January 2017, with MIPS payment adjustments beginning in 2019. Beginning in performance year 2017, CMS also began assessing the level of participation in Advanced APMs to identify eligible clinicians who qualify for the APM incentive payment for 2019. In addition, beginning in performance year 2019 for payment year 2021, eligible clinicians may qualify for APM incentive payments that are based in part on participation in Other Payer Advanced APMs, which will be developed by non-Medicare payers such as private insurers or state Medicaid programs, and recognized by CMS.

### Physician-Focused Payment Model Technical Advisory Committee

Section 101(e)(1) of MACRA established the Physician-Focused Payment Model Technical Advisory Committee (PTAC)<sup>7</sup> to review and assess proposals for new physician-focused payment models (PFPMs) submitted by individuals and stakeholders, and to make comments and recommendations to the Secretary of the Department of Health and Human Services (HHS) regarding whether the proposals meet the PFPM criteria established by the Secretary. CMS established PFPM criteria in 2017 for use by the PTAC in its review of proposed models (see Table 2).

The PTAC is a federal advisory committee whose members are appointed by the Comptroller General. CMS believes that, in its advisory role, the PTAC will assist HHS in improving the process for model development. HHS anticipates that the availability of the PTAC process will encourage and facilitate the development of models that have a high likelihood of being implemented and represent the diversity of physicians across the country.

**Table 2. Physician-Focused Payment Model (PFPM) Criteria<sup>8</sup>**

Categories	The Secretary seeks PFPMs that:
<b>Incentives:</b> Pay for higher-value care	<b>Value over volume:</b> Provide incentives to practitioners to deliver high quality health care.
	<b>Flexibility:</b> Provide the flexibility needed for practitioners to deliver high quality health care.

<sup>7</sup> Physician-focused Payment Technical Advisory Committee: <https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee>

<sup>8</sup> Quality Payment Program Final Rule: <https://www.federalregister.gov/documents/2016/11/04/2016-25240/medicare-program-merit-based-incentive-payment-system-mips-and-alternative-payment-model-apm>

Categories	The Secretary seeks PFPMs that:
	<p><b>Quality and Cost:</b> Are anticipated to improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost.</p> <p><b>Payment Methodology:</b> Pay APM Entities with a payment methodology designed to achieve the goals of the PFPM criteria. Addresses in detail through this methodology how Medicare and other payers, if applicable, pay APM Entities, how the payment methodology differs from current payment methodologies, and why the Physician-Focused Payment Model cannot be tested under current payment methodologies.</p> <p><b>Scope:</b> Aim to broaden or expand the CMS APM portfolio by addressing in a new way or by addressing an issue in payment policy in a new way or APM Entities whose opportunities to participate in APMs have been limited.</p> <p><b>Ability to be evaluated:</b> Have evaluable goals for quality of care, cost, and any other goals of the PFPM.</p>
<p><b>Care Delivery Improvements:</b> Promote better care coordination, protect patient safety, and encourage patient engagement</p>	<p><b>Integration and Care Coordination:</b> Encourage greater integration and care coordination among practitioners and across settings where multiple practitioners or settings are relevant to delivering care to the population treated under the PFPM.</p> <p><b>Patient Choice:</b> Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.</p> <p><b>Patient Safety:</b> Aim to maintain or improve standards of patient safety.</p>
<p><b>Information Enhancements:</b> Improving the availability of information to guide decision-making</p>	<p><b>Health Information Technology:</b> Encourage use of health information technology to inform care.</p>

After the PTAC submits its comments and recommendation to the Secretary, the Secretary will post a detailed response on the CMS website. Without being able to predict the volume, quality, or appropriateness of the proposed PFPMs that the PTAC will make comments and recommendations on, CMS is not in a position to propose a commitment to test all such models. If the Secretary decides to implement a proposed PFPM, it may then go through the CMS developmental process for APMs, including design changes as necessary, public announcement, and a request for applications. The decision by CMS to test a model

recommended by the PTAC will not require stakeholders to submit a second proposal to CMS. Proposed PFPMs that the PTAC recommends to the Secretary but that are not immediately tested by CMS may be considered for testing at a later time. CMS might continue to test PFPMs that are developed within CMS but believes that the PTAC process will be instrumental to achieving our goal of developing a broader array of PFPMs.

## How the CMS Innovation Center Assesses Ideas for New Models

In developing your idea for an APM, it may be helpful to consider the CMS Innovation Center’s approach to model design. The CMS Innovation Center has a number of factors and relevant questions for assessing ideas for new payment and service delivery models being tested under section 1115A.

### Model Design Factors

A summary of factors and questions to be addressed when designing a model is provided in Table 3.

**Table 3. CMS Model Design Factors**

Factor	Question to be Addressed
1. Alignment with key CMS and HHS goals	Does the model design align with the Department’s goals, such as the <a href="#">CMS Quality Strategy</a> and implementation of the Medicare Access and CHIP Reauthorization Act of 2015 ( <a href="#">MACRA</a> )?
2. Extent of clinical transformation in model design	Do we expect the magnitude and types of changes in care delivery in the model test to be significant improvements over current practice?
3. Strength of evidence base	What data or prior experience (of CMS or other payers) supports the intervention proposed in the model design?
4. Scale of the model design	What is the number and/or percent of beneficiaries and practitioners included in the model design?
5. Demographic, clinical, and geographic diversity	A. Does the model design target key diverse patient and practitioner populations that CMS has yet to engage in other models, or geographic regions with previously low participation in CMS models? B. Does the model design address a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures?
6. Alignment with other payers and CMS programs	To what extent can the model design leverage investments that: <ul style="list-style-type: none"> <li>• Other health care payers are making in payment and delivery system reform; or</li> <li>• CMS has made in its other initiatives?</li> </ul>

Factor	Question to be Addressed
7. Potential for quality improvement	<p>To what extent can we expect the model design to result in improved clinical quality or patient experience of care, including but not limited to:</p> <ul style="list-style-type: none"> <li>• Making the care experience reflect patients' goals and preferences;</li> <li>• Better coordinating care;</li> <li>• Producing better health outcomes; and</li> <li>• Reducing disparities in health care quality experienced by vulnerable populations?</li> </ul>
8. Potential for cost savings	What amount of savings will the model design generate for Medicare, Medicaid, and/or CHIP?
9. Size of investment required for CMS*	What are the likely costs to CMS to design and test the model design?
10. Probability of model success	What is the nature and magnitude of risks/barriers to success of the model design?
11. Economic impact*	What is the likely return that CMS will see for its time and resource investments in the model design?
12. Overlap with current and anticipated models	To what degree is the intervention in the model design unique from that implemented in other model tests?
13. Evaluative feasibility	Will CMS be able to design an appropriate model evaluation, collect data, and analyze results to make reasonable conclusions about the model design's performance?
14. Stakeholder interest and acceptance	Will there be enough stakeholder interest in the model design to get to the desired/necessary levels of participation?
15. Operational feasibility for participants	How feasible will it be for participants to access or prepare and build the infrastructure (e.g., health IT tools) needed to do what is expected under the model design?
16. Operational feasibility for CMS*	<p>A. How feasible will it be for CMS to prepare and build the systems, processes, and other infrastructure necessary to test the model design within existing time and resource constraints?</p> <p>B. Will CMS be able to appropriately monitor the model design and the activities of its participants to assess compliance and promote program integrity?</p>
17. Effects on coverage and benefits	Does the model design raise concerns about limits on coverage or provision of covered benefits for beneficiaries?
18. CMS's waiver authority*	Could the model be tested under existing law, and if not, is CMS authorized to waive any laws or regulations as may be necessary solely for purposes of testing the model design?

Factor	Question to be Addressed
19. Ability of other payers to test the model	Are there other government or private entities that could test the model design as effectively as CMS?
20. Scalability*	Will CMS have appropriate legal authority to expand the duration or scope of the model design if such expansion is expected to either reduce spending without reducing the quality of care or improve the quality of care without increasing spending? Will there be health IT and data infrastructure to support broad participation among eligible providers?

*\*Factors CMS would not expect stakeholders to focus on in designing APMs*



## Model Evaluability

There is no universal approach for designing, testing, and evaluating payment and service delivery models. Each model tested by the CMS Innovation Center is unique in its goals, and thus in its design as well. Every model tested under the Innovation Center's authority has an independent evaluation that includes an analysis of the quality of care furnished under the model and the changes in spending resulting from the model. Decisions made regarding the features and design of a model also influence the design and structure of the evaluation and CMS's ability to determine whether the results obtained from the evaluation are valid and replicable.

The model design factors presented in Figure 2 significantly influence the evaluability of models, providing the basis for demonstrating improvements in the quality of care and reductions in program spending.

The approach to each model's evaluation must be tailored to the particular features of the model design in order to accurately identify and understand the model's impacts. While many evaluations share similar components, the unique way in which models operationalize key design and implementation features must be critically considered and addressed in order to implement a successful evaluation. Each evaluation is built upon a foundational understanding of

### Figure 3. CMS Model Evaluability Factors


**Model eligibility:** Identifying the beneficiaries that are eligible to be served by the model is part of the initial model design. The determination of how to identify those individuals has implications for both CMS's ability to detect a model's impact and to generalize the results obtained from the model test to a broader population.

**Assignment strategy:** Once the intervention is defined and eligibility criteria are established, it must be determined how to implement the model. The decision to use random assignment (i.e., assigning beneficiaries within a participating provider) rather than utilize a non-randomized design substantially impacts the results and our ability to identify and control for differences between the treatment and comparison groups.

**Model scope:** Prior to launching a model test, it is necessary to determine the model scope needed to generate a reliable test of the model's impact. This includes identifying the key outcomes of interest, truly understanding the target population, and determining the extent to which CMS can expect to drive the outcomes of interest with the model's interventions.

**Statistical power:** The statistical power of the model represents the chance that the evaluation will be able to detect an effect, if an effect exists. In general, the greater the number of beneficiaries and health care providers in the model and the less the correlation between the outcomes and individual providers, the greater the statistical power.

**Power calculations:** Power calculations determine the minimum sample size needed to detect a reasonable effect, increase the likelihood of identifying an effect, if indeed one exists, and enable CMS to scale successful models wisely. These calculations consider a variety of factors including type and magnitude of differences within the target population and the expected impact of the model on the outcome measure. Power calculations also directly and indirectly impact the other factors we highlight above as influences on the evaluability of the model.



the individual model and leverages available quantitative and qualitative data to provide policymakers with valuable evidence to inform their decision to potentially expand the model.

### **Timeline for Alternative Payment Model Implementation**

Alternative Payment Models (APMs) generally take the CMS Innovation Center 18 months to design and launch, although this period of time may vary significantly in length. To design model tests of APMs, the CMS Innovation Center addresses each of the model design factors previously described in this toolkit. For example, to maintain a rigorous evaluation of model outcomes, CMS needs to build the necessary model infrastructure for such functions as quality measurement, financial calculations, and payment disbursements, and to coordinate with other payers if they are included in the model's design. The specifics of a model will determine how long it takes to develop and implement.

#### **Models may take longer to design or begin testing if they:**

- Require changes to the Medicare payment processing system, because those changes typically can take nine months to one year;
- Are unique or include broader changes, because more time is needed to design and implement model tests based on designs CMS has less experience with;
- Include payment policy waivers or fraud and abuse waivers;
- Require a new data registry or other infrastructure; or
- Include other payers, because CMS may need to coordinate with payers, enter into legal agreements or Memoranda of Understanding with those payers, or give them time to prepare for participation, including time for payers to connect with participants' health care providers about taking part in the model test.

#### **Models may take less time to develop if they:**

- Are built on existing models, because a new model may be able to leverage some of the infrastructure and best practices from the existing model; or
- Leverage existing infrastructure for collecting quality measures.

Apart from these factors, there are certain activities that must be planned for in all model testing. Time is needed for CMS to draft applications, inform eligible individuals and entities of the opportunity to participate in a new model, and solicit completed applications. Entities need time to complete applications and CMS needs time to review applications and prepare participation agreements for entities to sign. Entities need time to review these participation agreements and to begin planning for participation in the model. In addition, models generally require contract support, and the model development timeline has to include the time needed for bidding and awarding contracts for these support services.



## **How to Share Your Idea with the CMS Innovation Center**

In addition to ideas for new Alternative Payment Models (APMs), the CMS Innovation Center may be interested in your idea if it could be tested within an existing or future APM. An example of this is the Shared Decision Making Model (SDM), which will be tested within the structure of the Shared Savings Program or Next Generation Accountable Care Organization (ACO) Model by those ACOs that applied and were selected to participate in the Model. This Model will build upon the practice redesign strategies that the ACO has already implemented. The SDM engages patients to be partners in health care decisions, enabling patients to choose treatment options in accord with their wishes and making them more likely to adhere to their treatment plans, and as a result reducing the number of volume-based procedures and increasing the possibility of shared savings for the ACOs. More information on this model can be found here: <https://innovation.cms.gov/initiatives/Beneficiary-Engagement-SDM/index.html>.

Information about how to share your ideas with the CMS Innovation Center is available here: <https://innovation.cms.gov/Share-Your-Ideas/index.html>.



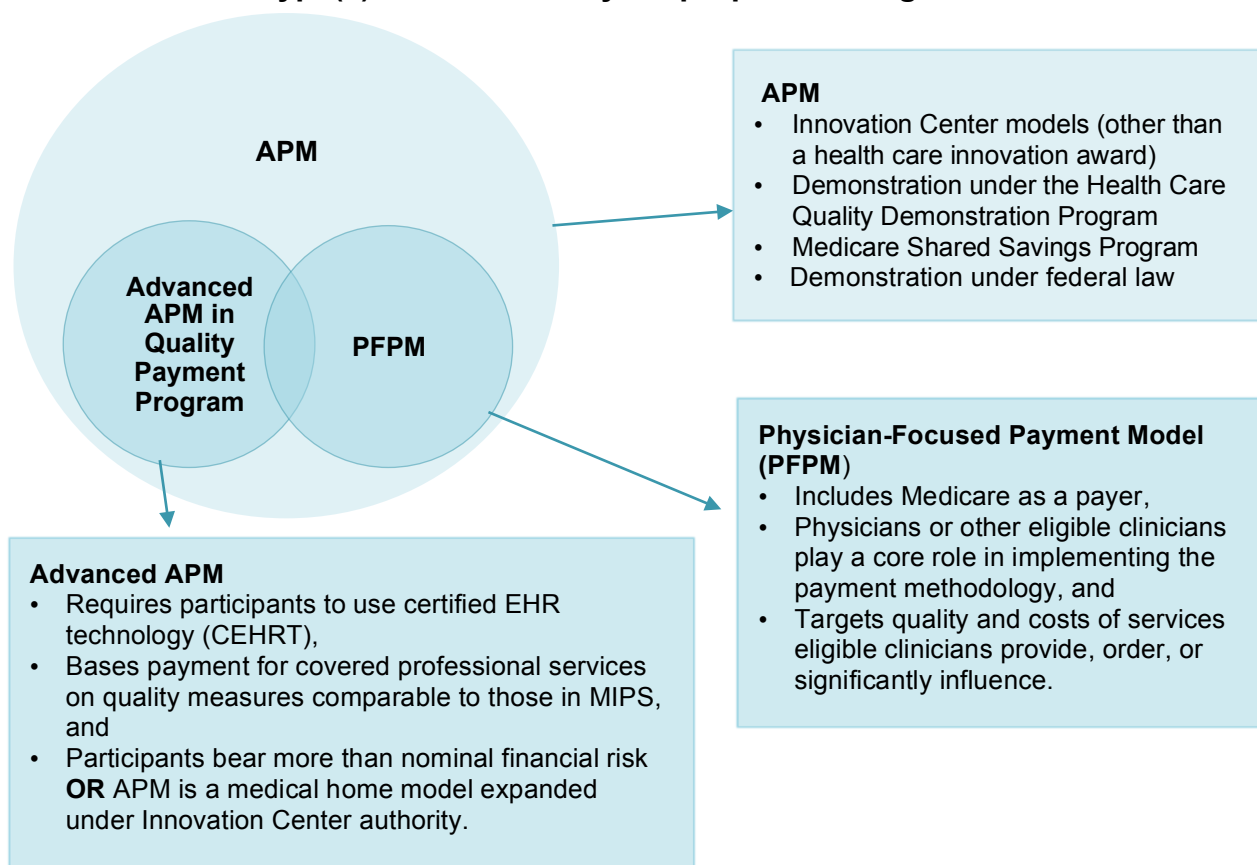
## Alternative Payment Model Design Elements

As described in the previous section, there are a number of factors that are taken into consideration by the CMS Innovation Center in the selection of models for testing. Based on these factors, this section provides an overview of seven key elements to take into account in designing an Alternative Payment Model (APM) for CMS's consideration:

1. What type(s) of APM would your proposed design be?
2. How would your APM design result in clinical practice transformation?
3. What is the rationale for your APM design?
4. What is the proposed scale of your APM design?
5. How would your APM design align with other payers and other CMS programs?
6. How would improvements in clinical quality or patient experience of care be measured under your APM design?
7. How easy would it be for health care providers to participate in your APM design?

The CMS APM Design Worksheet is provided in the Appendix to aid stakeholders in developing their ideas and addressing these key elements.

## Element 1. What type(s) of APM would your proposed design be?



### Examples of existing APMs:

#### [Next Generation Accountable Care Organizations \(ACO\)](#)

Next Generation 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. The Next Generation ACO Model is tested under 1115A and is therefore an APM.

#### [Independence at Home \(IAH\) Demonstration](#)

IAH tests whether home-based primary care can reduce the need for hospitalization, improve patient and caregiver satisfaction, and lead to better health and lower costs to Medicare. The IAH Demonstration is a demonstration under federal law and is therefore an APM.

#### [Comprehensive End Stage Renal Disease \(ESRD\) Care](#)

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. The Comprehensive ESRD Care model is tested under 1115A and is therefore an APM.



**Element 2. How would your APM design result in clinical practice transformation?**

Clinical Practice Transformation Component	Examples of Clinical Practice Transformation from Existing APMs		
	<u>Oncology Care Model (OCM)</u>	<u>Comprehensive Primary Care Plus (CPC+)</u>	<u>Million Hearts Cardiovascular Disease Risk Reduction (MH) Model</u>
Includes specific changes in how clinical care is delivered	Participating practices provide enhanced services to Medicare beneficiaries such as documenting a care plan, patient navigation, and treatment of beneficiaries with therapies in accordance with nationally recognized clinical guidelines.	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.	Employs a randomized controlled design that seeks to bridge a gap in cardiovascular care by providing targeted incentives for health care practitioners to engage in beneficiary (cardiovascular disease) CVD risk calculation and population-level risk management. Instead of focusing on the individual components of risk, participating organizations will engage in risk stratification across a beneficiary panel to identify those at highest risk for atherosclerotic cardiovascular disease (ASCVD).
Tests difference in payment, effect of paying for value over volume	Participating practices are eligible to receive a performance-based incentive payment based on financial and quality performance during a six-month episode of care, which begins upon chemotherapy administration to cancer patients.	Practices receive a care management fee plus performance-based incentive payments based on utilization and quality/experience components plus visit and non-visit based payments.	Practices randomized to the intervention group will receive a risk stratification payment, cardiovascular management payment, and a performance-based incentive based on the ASCVD risk reduction across beneficiaries in their high-risk cohort. Control group practices receive a data reporting payment.

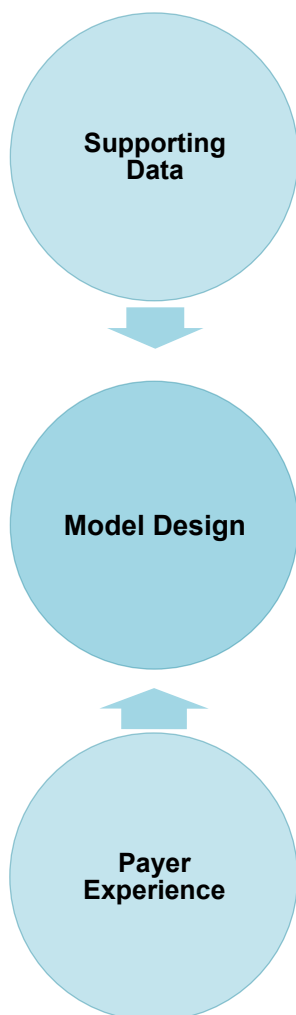
Clinical Practice Transformation Component	Examples of Clinical Practice Transformation from Existing APMs		
	<u>Oncology Care Model (OCM)</u>	<u>Comprehensive Primary Care Plus (CPC+)</u>	<u>Million Hearts Cardiovascular Disease Risk Reduction (MH) Model</u>
Describes amount of any new payments proposed	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 the opportunity to earn a performance-based payment incentivizes practices to lower the total cost of care and improve care for beneficiaries during such episodes.	Per-beneficiary per month (PBPM) care management fee: <b>Track 1:</b> \$15 (average) <b>Track 2:</b> \$28 (average) \$100 (complex)	<i>Intervention Group</i> One time per-beneficiary risk stratification payment- \$10  Cardiovascular management reporting period- \$10 per-beneficiary per month (PBPM) during Year 1 of model data collection  Risk reduction performance-based payment- between \$0-10 PBPM depending on risk reduction among high risk beneficiaries  <i>Control Group</i> Annual per-beneficiary reporting payment- \$20
Payment methodology	The two additional forms of payment are the per-beneficiary Monthly Enhanced Oncology Services (MEOS) payment to participating practices for the duration of an episode of care and the potential for a performance-based payment to participating practices based on their performance during such episodes.	(1) Care management fee: risk-adjusted for each practice to account for the intensity of care management services required for the practice's specific population.  (2) Performance-based incentive payment: prospectively pay and retrospectively reconcile a performance-based incentive based on how well the practices performs on patient experience measures, clinical quality measures, and utilization measures that	Intervention group practices are incentivized to stratify their Medicare FFS beneficiaries based on ASCVD risk and to prevent first-time heart attacks and strokes through lowering the ASCVD risk of their high-risk beneficiary population.

Clinical Practice Transformation Component	Examples of Clinical Practice Transformation from Existing APMs		
	<u>Oncology Care Model (OCM)</u>	<u>Comprehensive Primary Care Plus (CPC+)</u>	<u>Million Hearts Cardiovascular Disease Risk Reduction (MH) Model</u>
		drive total cost of care.  (3) Payment under Medicare Physician Fee Schedule (PFS): For Track 2 practices, a portion of fee-for-service (FFS) payments goes into Comprehensive Primary Care Payments, which are paid in a lump sum, quarterly, absent a claim.	

### Element 3. What is the rationale for your APM design?

#### Show Your Evidence

The APM should identify an intervention and what data or prior experience (of CMS or other payers) supports the intervention of the PFPM APM.



#### Examples from existing APMs:

##### [Comprehensive Care for Joint Replacement \(CJR\)](#)

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.

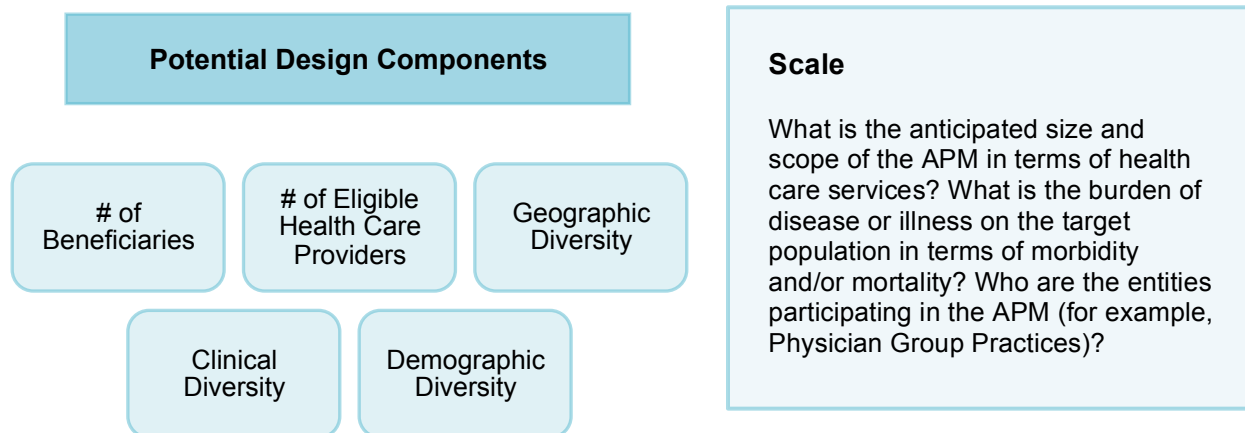
##### [Next Generation Accountable Care Organization \(ACO\)](#)

The payment model tested in the Next Generation ACO Model is a financial model with long-term sustainability and a shared savings payment policy with higher levels of shared savings and risk for Next Generation ACOs than levels in the Medicare Shared Savings Program. ACOs have a choice between four payment mechanisms, including three alternate payment mechanisms that offer Next Generation ACOs the opportunity for stable and predictable cash flow and facilitate investment in infrastructure and care coordination. These models of payments are flexible to accommodate the specific organizational and market conditions in which Next Generation ACOs work.

##### [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 currently offers three different models for types of care provided to Medicare beneficiaries who have been hospitalized.

#### Element 4. What is the proposed scale of your APM design?



#### Examples from existing APMs:

##### [Comprehensive ESRD Care \(CEC\)](#)

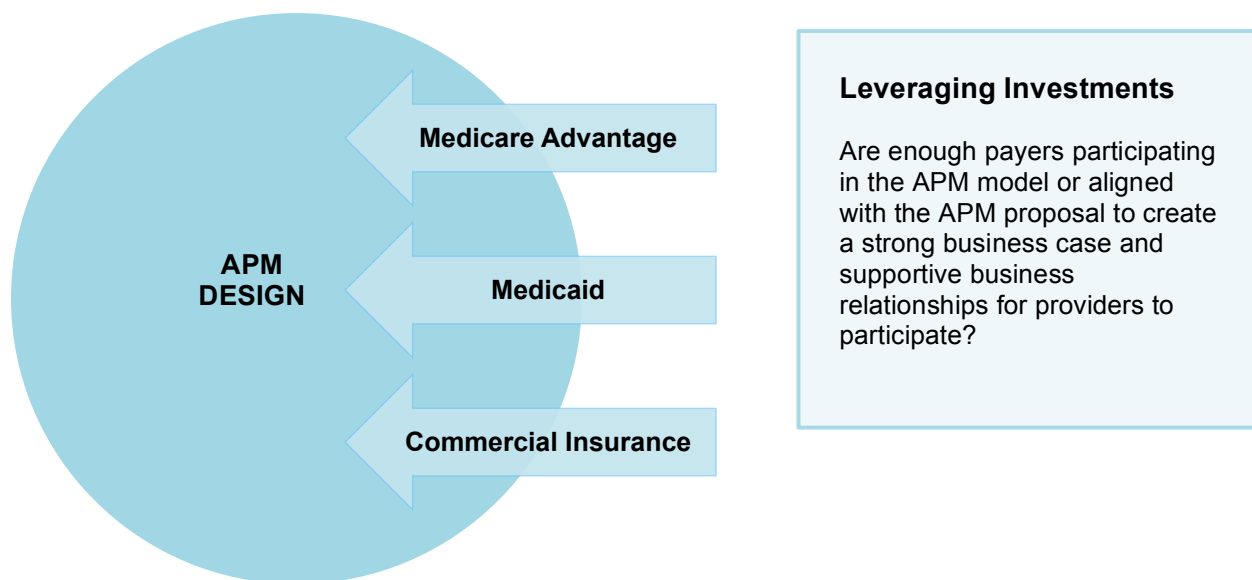
More than 600,000 Americans have end stage renal disease (ESRD) and require life sustaining dialysis treatments several times per week. Many beneficiaries with ESRD suffer from poorer health outcomes, often the result of underlying disease complications and multiple co-morbidities. These can lead to high rates of hospital admissions 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.

##### [Next Generation ACO Model](#)

The Next Generation ACO Model is designed for health care organizations and providers that are already experienced in coordinating care for patients across care settings. Beneficiaries are aligned to Next Generation ACOs through the plurality of qualified evaluation and management services furnished by Next Generation Participants. Next Generation ACOs are required to maintain aligned populations of at least 10,000 Medicare FFS beneficiaries, and, as of 2017, 44 Next Generation ACOs headquartered in 20 states are caring for over 1 million beneficiaries. Most Medicare-enrolled providers and suppliers (excepting a limited subset of prohibited participants) may serve as Participants and/or Preferred Providers for Next Generation ACOs. In 2017 there are over 40,000 unique physicians and non-physician practitioners serving as Next Generation Participants, and numerous other entities serving as Participants and Preferred Providers.



## Element 5. How would your APM design align with other payers and other CMS programs?



### Examples from existing APMs:

#### [State Innovation Model \(SIM\) Initiative](#)

The 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.

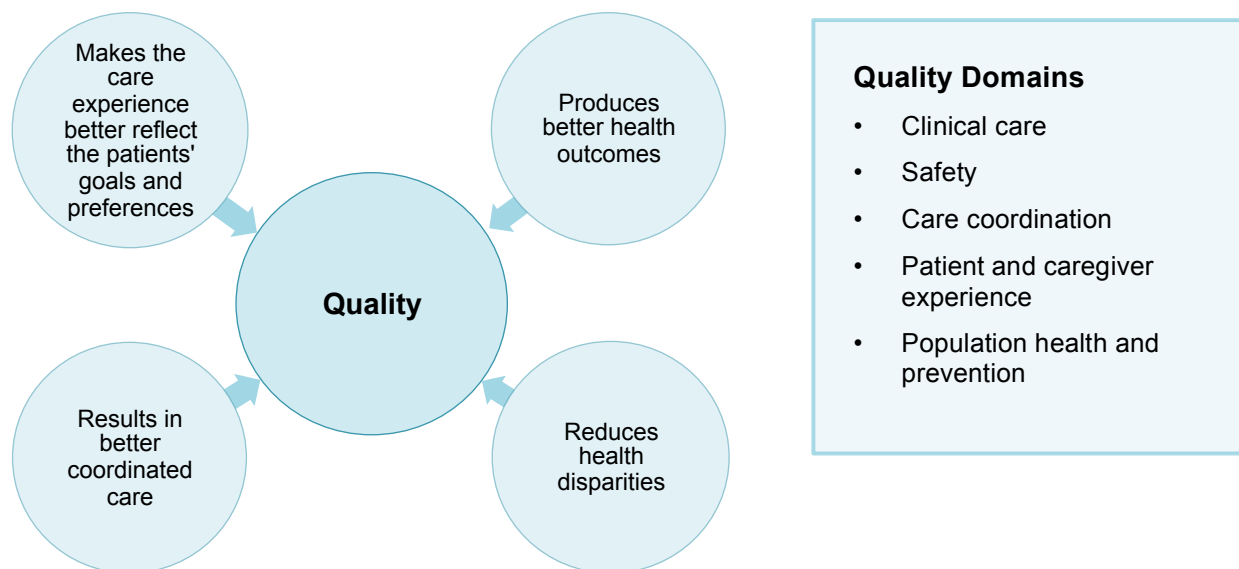
#### [Comprehensive Primary Care Plus \(CPC+\)](#)

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.

#### [Million Hearts Cardiovascular Disease Risk Reduction \(MH\) Model](#)

The MH Model is part of the federal Million Hearts® Initiative, a broad national initiative co-led by CMS and CDC to prevent one million heart attacks and strokes within five years through the management of the "ABCS"—aspirin therapy, blood pressure control, cholesterol management and smoking cessation. Million Hearts® brings together communities, public and private health systems, nonprofit organizations, federal agencies, and private-sector partners from across the country to fight heart disease and stroke.

## Element 6. How is improvement in clinical quality or patient experience of care measured under your APM design?



### Examples from existing APMs:

#### [Medicare Shared Savings Program](#) and [Next Generation Accountable Care Organization \(ACO\)](#)

The Medicare Shared Savings Program and the Next Generation 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.

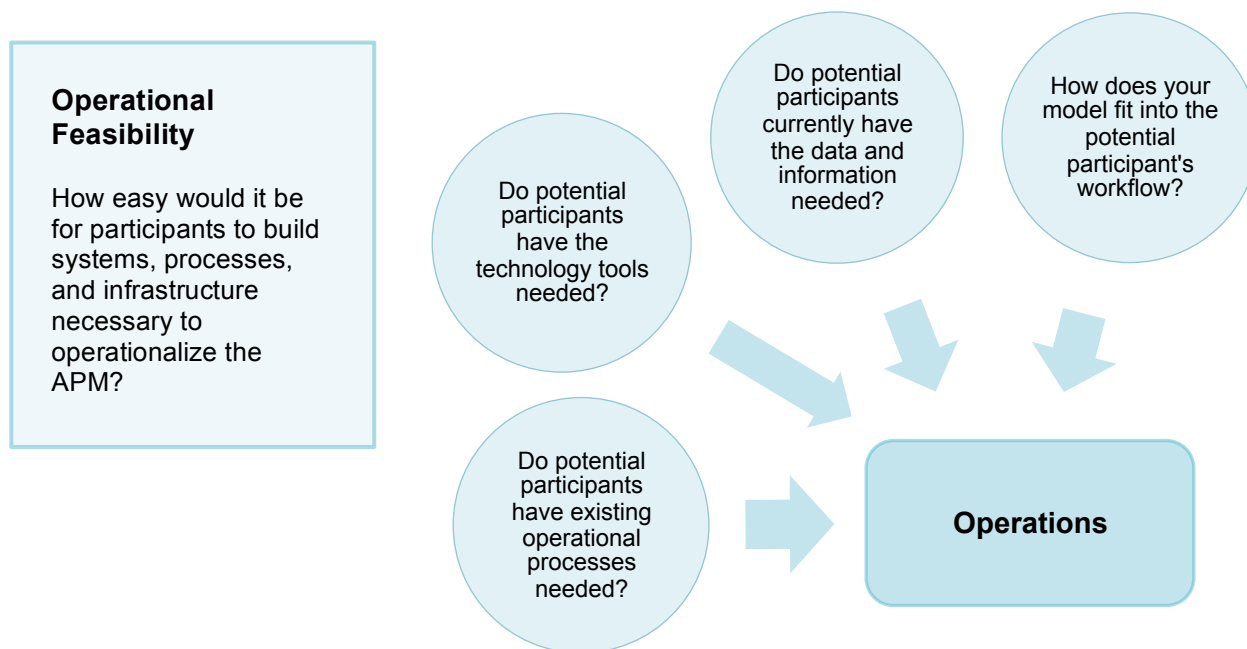
#### [Independence at Home \(IAH\) Demonstration](#)

Selected primary care practices provide home-based primary care to targeted chronically ill beneficiaries. Participating practices make in-home visits tailored to an individual patient's needs and coordinate their care. CMS tracks the beneficiary's care experience through quality measures (e.g., follow up contact within 48 hours of a hospital admissions, hospital discharge, and emergency department visit; medication reconciliation; annual documentation of patient preferences; all-cause hospital readmissions within 30 days; hospital admissions for Ambulatory Care Sensitive Conditions; and Emergency department visits for Ambulatory Care Sensitive Conditions). Practices that succeed in meeting these quality measures while generating Medicare savings have an opportunity to receive incentive payments after meeting a minimum savings requirement.

#### [Million Hearts Cardiovascular Disease Risk Reduction \(MH\) Model](#)

The MH Model is part of CMS's broader strategy to improve the health care system by paying practitioners for what works, unlocking health care data, and finding new ways to coordinate and integrate care to improve quality. It requires participating practices to use team-based care and shared decision-making when creating a care plan to reduce the ASCVD risk scores of high-risk beneficiaries, and encourages the same standard of care for medium and low-risk beneficiaries. This model will test if team-based care and shared decision-making are effective tools, along with incentives, to promote preventative health care.

## Element 7. How easy would it be for health care providers to participate in your APM design?



### Examples from existing APMs:

#### [Next Generation Accountable Care Organization \(ACO\)](#)

The Next Generation 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 Next Generation ACOs require data and information from CMS.

#### [Independence at Home \(IAH\) Demonstration](#)

As part of their application to participate, the practices were required to demonstrate experience providing home-based primary care to high-cost chronically ill beneficiaries. Participating practices include primary care practices and other multidisciplinary teams. This APM fit in to the workflow because of the experience providing home-based services and the existing operational processes were in place, however, the practices required data and information from CMS.

## Opportunities for Innovations that are not Alternative Payment Models

The focus of this toolkit is on designing Alternative Payment Models (APMs). However, there may be many ideas that would change current payment or service delivery structures or create new ones or could be a valuable driver of improvement in the health care system, but do not have all of the elements of an APM. This section of the toolkit addresses a few additional avenues beyond APM design that you may wish to consider for testing your idea for health care innovation.

### What if my idea is for care redesign?

You could approach an Accountable Care Organization (ACO) or other entity participating in an APM. These entities may be interested in incorporating your idea to see if it can help improve quality of care or reduce costs. Some information about current APMs and their participants is available here:

<https://innovation.cms.gov/initiatives/index.html#views=models>

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharesavingsprogram/index.html?redirect=/sharesavingsprogram>

### What if my idea is a new quality measure?

The [National Quality Forum](#) (NQF) has evaluation criteria for quality measures you can review to see if your idea would meet some or all of the criteria. The Measure Evaluation Criteria are here: <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=83123>.

NQF has an open submission process for measure developers. More information is available here: [http://www.qualityforum.org/Measuring\\_Performance/Submitting\\_Standards.aspx](http://www.qualityforum.org/Measuring_Performance/Submitting_Standards.aspx).

If you believe your measure will meet criteria, you may want to go to a specialty society, academic medical institution, or other entity to request funding for the development of your measure. In addition, to aid in the development of quality measures, agencies from the Department of Health and Human Services (HHS) often solicit stakeholder input in the form of calls for quality measures and grant funding. Specifically, CMS invites clinicians and organizations each year to submit quality measure candidates through its [Annual Call for Measures and Activities for MIPS](#). These measures are then reviewed and evaluated by CMS for potential adoption.

There may be funding opportunities available through the Agency for Healthcare Research and Quality (AHRQ) to develop measures. Information about funding and grant opportunities from AHRQ can be found here: <https://www.ahrq.gov/funding/index.html>.

## **What if my idea is a software or technology solution?**

If you have a technology solution designed to help clinicians achieve cost and quality goals, you could partner directly with clinicians participating in APMs, such as clinicians in Medicare Shared Savings Program ACOs. By understanding the unique needs of specific APMs, you can better understand the needs of clinicians participating in these models and discover which providers will find your solution most appropriate for their needs.

APMs being tested by the CMS Innovation Center may also offer special opportunities for vendor collaboration around a model. For instance, practices participating in Track 2 of the Comprehensive Primary Care Plus Initiative (CPC+) are working with a wide range of health IT vendors to develop specific capabilities that support the goals of the model; while collaborating vendors are not direct participants, they work closely with both the CMS Innovation Center and practices over the life of the model. For more information about CPC+, see: <https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus>.

If you have an idea for software or technology solution that is still in an early stage of development, you may also be interested in health IT developer contests offered by HHS that reward new innovation. Learn more about ONC challenges at <https://www.healthit.gov/policy-researchers-implementers/health-it-prizes-challenges> .



## Frequently Asked Questions

Below are common questions you may have as you consider designing an Alternative Payment Model (APM). If you have a question that is not listed, you may submit it at [QPP@cms.hhs.gov](mailto:QPP@cms.hhs.gov).

### Transforming the Health Care Delivery System

**Q1.** What is The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)?

**A1.** MACRA was legislation enacted in 2015. In addition to other provisions, MACRA ended the Sustainable Growth Rate formula for Medicare physician fee schedule payment updates; established the Physician-Focused Payment Model Technical Advisory Committee; consolidated multiple physician fee schedule value and quality programs into a single aligned system called the Merit-based Incentive Payment System (MIPS); and provided incentives for sufficient participation in Advanced Alternative Payment Models (Advanced APMs). MIPS and Advanced APMs together form the two paths of the Quality Payment Program.

**Q2.** What is the LAN?

**A2.** The [Health Care Payment Learning and Action Network \(LAN\)](#) provides a mechanism for public and private payers, purchasers, health care providers, consumers, and states to align and increase development of alternative payment models that improve the quality and value of health care.


### Quality Payment Program

**Q3.** What is the Quality Payment Program?

**A3.** The [Quality Payment Program](#) aims to improve health outcomes, promote smarter spending, minimize burden of participation, and provide fairness and transparency in operations through MIPS and incentive payments for sufficient participation in Advanced APMs. MIPS eligible clinicians earn a performance-based payment adjustment. Clinician participation in an Advanced APM may earn an eligible clinician an incentive payment for achieving threshold levels of participation in an innovative payment model. Eligible clinicians who earn this incentive may be exempt from MIPS reporting and requirements or payment adjustments.

**Q4.** Is there a summary of the Quality Payment Program regulation available?

**A4.** Yes. The [executive summary of the final rule](#) provides a summary of the calendar year (CY) 2017 Quality Payment Program final rule with comment period. Among other things, that rule established incentives for participation in Advanced APMs, supporting the goals of transitioning from fee-for-service (FFS) payments to payments for quality and value, including approaches that focus on putting patients first. It also includes definitions of Qualifying APM Participants (QPs) in Advanced APMs and outlines the criteria for use by the Physician-Focused Payment



Model Technical Advisory Committee (PTAC) in making comments and recommendations to the Secretary on physician-focused payment models (PFPMs), and implements the MIPS.

**Q5.** What is an APM?

**A5.** An APM is defined by MACRA as a CMS Innovation Center Model (other than a Health Care Innovation Award); a Demonstration under the Health Care Quality Demonstration Program; the Medicare Shared Savings Program; or a Demonstration required under federal law.

**Q6.** What is an Advanced APM?

**A6.** An Advanced APM is an APM that requires participants to use Certified EHR Technology, bases payment for covered professional services on quality measures comparable to those in MIPS, and either requires participant entities to bear more than nominal financial risk **OR** is an APM that is a medical home model expanded under CMS Innovation Center authority.

**Q7.** How can I (as a health care provider) participate in an Advanced APM?

**A7.** An Eligible Clinician can participate in an Advanced APM:

- By joining a practice or organization that is already a participant in an existing Advanced APM;
- By applying to become a participant in an Advanced APM that has been announced, but not yet awarded;
- By developing an APM that meets the criteria for Advanced APM status and sharing your idea with the CMS Innovation Center through the following link on our website: <https://innovation.cms.gov/Share-Your-Ideas/index.html>. If your idea could be tested within an existing or future APM, the CMS Innovation Center might develop and announce it as a model test; or
- By proposing through the Physician-Focused Payment Model Technical Advisory Committee (PTAC) an APM that (1) Meets the criteria for an Advanced APM; (2) Is recommended for testing by both the PTAC and HHS; and (3) Is announced for testing as an Advanced APM by the CMS Innovation Center.

**Q8.** What is the role of the CMS Innovation Center in implementing the Quality Payment Program?

**A8.** The CMS Innovation Center plays a critical role in implementing the Quality Payment Program, which Congress created as part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The CMS Innovation Center works in consultation with clinicians and others to increase the number and variety of models available to ensure that a wide range of clinicians, including those in small practices and rural areas, have the option to participate.

**Q9.** Which models currently being tested by the CMS Innovation Center are Advanced APMs?

**A9.** In 2017, the CMS Innovation Center is testing the following Advanced APMs:

- [Comprehensive ESRD Care \(CEC\) - Two-Sided Risk](#)
- [Comprehensive Primary Care Plus \(CPC+\)](#)
- [Next Generation ACO Model](#)
- [Shared Savings Program - Track 2](#)
- [Shared Savings Program - Track 3](#)
- [Oncology Care Model \(OCM\) - Two-Sided Risk](#)
- [Comprehensive Care for Joint Replacement \(CJR\) Payment Model \(Track 1- CEHRT\)](#)

A comprehensive list of APMs and Advanced APMs can be found here: <https://qpp.cms.gov>.

**Q10.** What is a Physician-Focused Payment Model (PFPM)?

**A10.** The definition of PFPM is an APM: (1) In which Medicare is a payer; (2) in which eligible clinicians that are eligible professionals as defined in [section 1848\(k\)\(3\)\(B\) of the Act](#) are participants and play a core role in implementing the APM's payment methodology, and (3) which targets the quality and costs of services that eligible clinicians participating in the APM provide, order, or can significantly influence. PFPMs must give eligible clinicians a core role in implementing the payment methodology. The definition of PFPMs includes models that include any eligible clinicians that meet the requirements of [section 1848\(k\)\(3\)\(B\) of the Social Security Act](#).

**Q11.** Can PFPMs involve both Medicare and other payers?

**A11.** Yes. Other payers in addition to Medicare, such as Medicaid or private payers, may be included.

**Q12.** Does the definition of a PFPM include models that do not include physicians or physician group practices, but include other clinicians as participants?

**A12.** The definition of a PFPM includes any eligible clinicians that fall under the definition in [section 1848\(k\)\(3\)\(B\) of the Social Security Act](#).

**Q13.** What other clinicians qualify to participate as “eligible clinicians?”

**A13.** The list of eligible clinicians for purposes of determining Qualifying APM Participants is defined in [section 1833\(z\)\(3\)\(B\) of the Act](#) and includes: physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, registered dietitians or nutrition professionals, physical or occupational therapists, qualified speech-language pathologists, and qualified audiologists.

**Q14.** How is “physician” defined by CMS?

**A14.** Physician means doctor of medicine, doctor of osteopathy (including osteopathic practitioner), doctor of dental surgery, doctor of dental medicine, doctor of podiatric medicine, or doctor of optometry, and with respect to certain specified treatment, a doctor of chiropractic legally authorized to practice by a State in which he/she performs this function.

## Physician-Focused Payment Model Technical Advisory Committee (PTAC)

**Q15.** What is the role and composition of PTAC?

**A15.** Section 101 (e)(1) of MACRA created the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to make comments and recommendations to the Secretary of the Department of Health and Human Services on proposals for PFPMs submitted by individuals and stakeholder entities. Please see <https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee> for its charter, bylaws and current members.

**Q16.** Will CMS test all PFPMs recommended by the PTAC?

**A16.** CMS believes the PTAC will be a valuable resource in developing new APMs. While CMS cannot provide assurance that it will pursue any particular model, CMS is committed to giving all models recommended by the PTAC a thorough and thoughtful review.

**Q17.** What happens after a PFFM proposal is selected for implementation by CMS?

**A17.** If a PFFM proposal is selected for implementation by CMS, it may go through the CMS developmental process for APMs, which may include design changes as necessary, public announcement, and a request for applications. The decision to test a model recommended by the PTAC will not require stakeholders to submit a second proposal to CMS.

Proposed PFPMs that meet all of the PFFM criteria and are recommended by the PTAC may need less time to go through the CMS development process; however, we cannot guarantee that the development process would be shortened or estimate by how much it would be shortened. Each APM is unique and these processes depend on many variables including the nature of the PFFM's design.


**Q18.** Is there opportunity for public input into the design of PFFM proposals submitted to the PTAC?

**A18.** Yes. The PTAC has made public information regarding its process for its review of PFFM proposals, and information about this process can be found at <https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee>.

## Health Information Technology (Health IT)

**Q19.** Where is there information on health IT?

**A19.** General information on how providers can successfully adopt and use health IT can be found at [www.healthit.gov](http://www.healthit.gov). A key resource for providers would be [ONC's Health IT Playbook](#), which provides actionable steps for addressing many of the challenges providers face with health IT and quality improvement. The online tool offers health care providers guidance on how to implement and use health IT to advance care information and delivery.



Valuable resources and information are also available through the [eCQI Resource Center](#), a joint effort by CMS and ONC to bring together stakeholders from across the eCQI community and provide a centralized location for news, information, tools and standards related to eCQI and electronic clinical quality measures (eCQMs).

**Q20.** Is there support for states in regard to health IT?

**A20.** Yes. The State Innovation Models (SIM) Initiative provides financial and technical support to states to design and test innovative, state-based, multi-payer health care delivery and payment system reform. The [ONC SIM Health IT Resource Center](#) provides resources that can be leveraged to support health IT innovation in care delivery and payment systems.

One key resource is the [Health IT-Enabled Quality Measurement Strategic Implementation Guide](#), which provides guidance for the development and execution of a statewide multi-stakeholder health-IT enabled quality measure strategy. The guidance addresses targeted implementation of priority-use cases producing early successes within the context of designing for an advanced quality improvement ecosystem and implementation of value-based payment.





## Resources

[Center for Medicare and Medicaid Innovation \(CMS Innovation Center\)](#)

[CMS Acronyms](#)

[CMS Data](#)

[Health Care Payment Learning & Action Network](#)

[Innovator's Guide to Navigating Medicare](#)

[Medicare Access and CHIP Reauthorization Act of 2015 \(MACRA\)](#)

[MACRA Speaker Engagement Requests](#)

[Medicare Claims Processing Manual](#)

[Medicare National Coverage Determinations Manual](#)

[Medicare Shared Savings Program](#)

[Office of the National Coordinator for Health IT](#)

[Physician-Focused Payment Model Technical Advisory Committee](#)

[\(PTAC\) Quality Payment Program](#)

[Quality Payment Program Final Rule](#)

## Glossary of Acronyms

ACO	Accountable Care Organization
AHRQ	Agency for Healthcare Research and Quality
APM	Alternative Payment Model
CEHRT	Certified EHR technology
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CJR	Comprehensive Care for Joint Replacement
CQM	Clinical Quality Measure
eCQM	electronic Clinical Quality Measure
EHR	Electronic Health Record
EP	Eligible Professionals
ESRD	End-Stage Renal Disease
FFS	Fee-for-Service
HIPAA	Health Insurance Portability and Accountability Act of 1996
HPSA	Health Professional Shortage Area
HHS	Department of Health & Human Services
HIT	Health Information Technology
HRSA	Health Resources and Services Administration
IT	Information Technology
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MIPS	Merit-based Incentive Payment System
NPI	National Provider Identifier
OCM	Oncology Care Model
PFFPM	Physician-Focused Payment Model
PFS	Physician Fee Schedule
PQRS	Physician Quality Reporting System
PTAC	Physician-Focused Payment Model Technical Advisory Committee
QP	Qualifying APM Participant
TCPI	Transforming Clinical Practice Initiative
TIN	Tax Identification Number
VM	Physician Value-based Payment Modifier

## Glossary of Quality Payment Program Defined Terms

The following are terms and definitions set forth in the Quality Payment Program regulation [§ 414.1305](#). While some of the terms may not be used in the APM Toolkit, we believe this broad list is helpful given its relevance to designing new APMs. The Quality Payment Program enables implementation of the APM incentive provisions in MACRA. Individuals and organizations designing new APMs should be aware of how the program is designed to accelerate the adoption of new APMs by building on existing efforts to tie payment to quality and improvements in care delivery, as well as modernizing the way Medicare pays clinicians.

### **Additional performance threshold:**

The numerical threshold for a Merit-based Incentive Payment System (MIPS) payment year against which the final scores of MIPS eligible clinicians are compared to determine the additional MIPS payment adjustment factors for exceptional performance.

### **Advanced Alternative Payment Model (Advanced APM):**

An APM that CMS determines meets the criteria set forth in [42 CFR § 414.1415](#).

### **Advanced APM Entity:**

An APM Entity that participates in an Advanced APM or Other Payer Advanced APM.

### **Affiliated practitioner:**

An eligible clinician identified by a unique APM participant identifier on a CMS-maintained list who has a contractual relationship with the Advanced APM Entity for the purposes of supporting the Advanced APM Entity's quality or cost goals under the Advanced APM.

### **Affiliated practitioner list:**

The list of Affiliated Practitioners of an APM Entity that is compiled from a CMS-maintained list.

### **Alternative Payment Model (APM):**

1. A model under [section 1115A of the Social Security Act](#) (other than a health care innovation award);
2. The shared savings program under [section 1899 of the Act](#);
3. A demonstration under [section 1866C of the Act](#); or
4. A demonstration required by Federal law.

### **APM Entity:**

An entity that participates in an APM or payment arrangement with a non-Medicare payer through a direct agreement or through Federal or State law or regulation.

### **APM Entity group:**

The group of eligible clinicians participating in an APM Entity, as identified by a combination of the APM identifier, APM Entity identifier, Taxpayer Identification Number (TIN), and National Provider Identifier (NPI) for each participating eligible clinician.

### **APM Incentive Payment:**

The lump sum incentive payment for a year paid to an eligible clinician who is a QP for the year from 2019 through 2024.

### **Attestation:**

A secure mechanism, specified by CMS, with respect to a particular performance period, whereby a MIPS eligible clinician or group may submit the required data for the advancing care information or the improvement activities performance categories of MIPS in a manner specified by CMS.

### **Attributed beneficiary:**

A beneficiary attributed to the Advanced APM Entity under the terms of the Advanced APM or Other Payer Advanced APM and listed as an attributed beneficiary on the latest available list of attributed beneficiaries at the time of a QP determination.

*Attribution-eligible beneficiary* refers to any beneficiary who during the QP Performance Period:

1. Is not enrolled in Medicare Advantage or a Medicare cost plan;
2. Does not have Medicare as a secondary payer;
3. Is enrolled in both Medicare Parts A and B;
4. Is at least 18 years of age;
5. Is a United States resident; and
6. Has a minimum of one claim for evaluation and management services furnished by an eligible clinician who is in the APM Entity for any period during the QP Performance Period or, for an Advanced APM that does not base attribution on evaluation and management services and for which attributed beneficiaries are not a subset of the attribution-eligible beneficiary population based on the requirement to have at least one claim for evaluation and management services furnished by an eligible clinician who is in the APM Entity for any period during the QP Performance Period, the attribution basis determined by CMS based upon the methodology the Advanced APM uses for attribution, which may include a combination of evaluation and management and/or other services.

### **Certified Electronic Health Record Technology (CEHRT) means the following:**

(1) For any calendar year before 2018, EHR technology (which could include multiple technologies) certified under the ONC Health IT Certification Program that meets one of the following:

(i) The 2014 Edition Base EHR definition (as defined at [45 CFR 170.102](#)) and that has been certified to the certification criteria that are necessary to report on applicable objectives and measures specified for the MIPS advancing care information performance category, including the applicable measure calculation certification criterion at [45 CFR 170.314\(g\)\(1\)](#) or (2) for all certification criteria that support an objective with a percentage-based measure.

(ii) Details about the certification criteria are at [45 CFR 170.314](#) and [45 CFR 170.315](#).

(2) For 2018 and subsequent years, EHR technology (which could include multiple technologies) certified under the ONC Health IT Certification Program that meets the 2015 Edition Base EHR definition (as defined at [45 CFR 170.102](#)) and has been certified to meet the 2015 Edition health IT certification criteria—

(i) As described at [45 CFR 170.315\(a\)\(12\)](#) (family health history) and [45 CFR 170.315\(e\)\(3\)](#) (patient health information capture); and

(ii) Reports as necessary on applicable objectives and measures specified for the MIPS advancing care information performance category including the following:

(A) The applicable measure calculation certification criterion at [45 CFR 170.315\(g\)\(1\)](#) or (2) for all certification criteria that support an objective with a percentage-based measure; and

(B) Clinical quality measure certification criteria that support the calculation and reporting of clinical quality measures at [45 CFR 170.315\(c\)\(2\)](#) and (c)(3)(i) and (ii) and optionally (c)(4), and can be electronically accepted by CMS.

**CMS-approved survey vendor:**

A survey vendor that is approved by CMS for a particular performance period to administer the CAHPS for MIPS survey and to transmit survey measures data to CMS.

**CMS Web Interface:**

A web product developed by CMS that is used by groups that have elected to utilize the CMS Web Interface to submit data on the MIPS measures and activities.

**Covered professional services:**

*As defined in section [1848\(k\)\(3\)\(A\) of the Act](#).*

Eligible clinician:

An “eligible professional” as defined in section [1848\(k\)\(3\) of the Act](#), as identified by a unique TIN and NPI combination and, includes any of the following:

1. A physician.
2. A practitioner described in section [1842\(b\)\(18\)\(C\) of the Act](#).



3. A physical or occupational therapist or a qualified speech-language pathologist.
4. A qualified audiologist (as defined in section [1861\(II\)\(3\)\(B\) of the Act](#)).

**Episode payment model:**

An APM or other payer arrangement designed to improve the efficiency and quality of care for an episode of care by bundling payment for services furnished to an individual over a defined period of time for a specific clinical condition or conditions.

**Estimated aggregate payment amounts:**

The total payments to a QP for Medicare Part B covered professional services for the incentive payment base period, estimated by CMS as described in [42 CFR § 414.1450\(b\)](#).

**Final score:**

A composite assessment (using a scoring scale of 0 to 100) for each MIPS eligible clinician for a performance period determined using the methodology for assessing the total performance of a MIPS eligible clinician according to performance standards for applicable measures and activities for each performance category. The final score is the sum of each of the products of each performance category score and each performance category's assigned weight, multiplied by 100.

**Group:**

Two or more eligible clinicians (including at least one MIPS eligible clinician), represented by a single Taxpayer Identification Number (TIN) as identified by their individual National Provider Identifier (NPI), who have reassigned their billing rights to the TIN.

**Health Professional Shortage Areas (HPSA):**

Areas as designated under [section 332\(a\)\(1\)\(A\) of the Public Health Service Act](#).

**High priority measure:**

An outcome, appropriate use, patient safety, efficiency, patient experience, or care coordination quality measure.

**Hospital-based MIPS eligible clinician:**

A MIPS-eligible clinician who furnishes 75 percent or more of his or her covered professional services in sites of service identified by the Place of Service codes used in the HIPAA standard transaction as an inpatient hospital, on-campus outpatient hospital, or emergency room setting based on claims for a period prior to the performance period as specified by CMS.

**Improvement activities:**

An activity that relevant MIPS eligible clinicians, organizations, and other relevant stakeholders identify as improving clinical practice or care delivery and that the Secretary determines, when effectively executed, is likely to result in improved outcomes.

**Incentive payment base period:**

The calendar year prior to the year in which CMS disburses the APM incentive payment.

**Low-volume threshold:**

An individual MIPS-eligible clinician or group who, during the low-volume threshold determination period, have Medicare Part B allowed charges less than or equal to \$30,000 or provide care for 100 or fewer Part B-enrolled Medicare beneficiaries.

**Meaningful EHR user for MIPS:**

A MIPS-eligible clinician who possesses certified EHR technology (CEHRT), uses the functionality of CEHRT, and reports on applicable objectives and measures specified for the advancing care information performance category for a performance period in the form and manner specified by CMS, supports information exchange and the prevention of health information blocking, and engages in activities related to supporting providers with the performance of CEHRT.

**Measure benchmark:**

The level of performance that the MIPS eligible clinician is assessed on for a specific performance of period at the measures and activities level.

**Medicaid APM:**

A payment arrangement authorized by a State Medicaid program that meets the criteria for an Other Payer Advanced APM under [42 CFR § 414.1420\(a\)](#).

**Medical Home Model:**

An APM under [section 1115A of the Social Security Act](#) that is determined by CMS to have the following characteristics:

- (1) The APM has a primary care focus with participants that primarily include primary care practices or multispecialty practices that include primary care physicians and practitioners and offer primary care services. For the purposes of this provision, primary care focus means the inclusion of specific design elements related to eligible clinicians practicing under one or more of the following Physician Specialty Codes: 01 General Practice; 08 Family Medicine; 11 Internal Medicine; 16 Obstetrics and Gynecology; 37 Pediatric Medicine; 38 Geriatric Medicine; 50 Nurse Practitioner; 89 Clinical Nurse Specialist; and 97 Physician Assistant;
- (2) Empanelment of each patient to a primary clinician; and
- (3) At least four of the following:
  - (i) Planned coordination of chronic and preventive care.
  - (ii) Patient access and continuity of care.

- (iii) Risk-stratified care management.
- (iv) Coordination of care across the medical neighborhood.
- (v) Patient and caregiver engagement.
- (vi) Shared decision-making.
- (vii) Payment arrangements in addition to, or substituting for, fee-for-service payments (for example, shared savings or population-based payments).

**Medicaid Medical Home Model:**

A payment arrangement under title XIX that CMS determines to have the following characteristics:

1. The payment arrangement has a primary care focus with participants that primarily include primary care practices or multispecialty practices that include primary care physicians and practitioners and offer primary care services. For the purposes of this provision, primary care focus means the inclusion of specific design elements related to eligible clinicians practicing under one or more of the following Physician Specialty Codes: 01 General Practice; 08 Family Medicine; 11 Internal Medicine; 16 Obstetrics and Gynecology; 37 Pediatric Medicine; 38 Geriatric Medicine; 50 Nurse Practitioner; 89 Clinical Nurse Specialist; and 97 Physician Assistant;
2. Empanelment of each patient to a primary clinician; and
3. At least four of the following:
  - (i) Planned coordination of chronic and preventive care.
  - (ii) Patient access and continuity.
  - (iii) Risk-stratified care management.
  - (iv) Coordination of care across the medical neighborhood.
  - (v) Patient and caregiver engagement.
  - (vi) Shared decision-making.
  - (vii) Payment arrangements in addition to, or substituting for, fee-for-service payments (for example, shared savings or population-based payments).

**Merit-based Incentive Payment System (MIPS):**

The program required by [section 1848\(q\) of the Social Security Act](#).

**MIPS APM:**

An APM that meets the criteria specified under [42 CFR § 414.1370\(b\)](#).

*MIPS eligible clinician* as identified by a unique billing TIN and NPI combination used to assess performance, means any of the following (excluding those identified at [42 CFR § 414.1310\(b\)](#)):

- (1) A physician as defined in [section 1861\(r\) of the Social Security Act](#).
- (2) A physician assistant, a nurse practitioner, and clinical nurse specialist as such terms are defined in [section 1861\(aa\)\(5\) of the Social Security Act](#).
- (3) A certified registered nurse anesthetist as defined in section 1861(bb)(2) of the Social Security Act.
- (4) A group that includes such clinicians.

**MIPS payment year:**

A calendar year in which the MIPS payment adjustment factor, and if applicable the additional MIPS payment adjustment factor, are applied to Medicare Part B payments.

**New Medicare-Enrolled MIPS eligible clinician:**

An eligible clinician who first becomes a Medicare-enrolled eligible clinician within the Provider Enrollment, Chain and Ownership System (PECOS) during the performance period for a year and had not previously submitted claims under Medicare as an individual, an entity, or a part of a physician group or under a different billing number or tax identifier.

**Non-patient facing MIPS eligible clinician:**

An individual MIPS eligible clinician that bills 100 or fewer patient-facing encounters (including Medicare telehealth services defined in section 1834(m) of the Act) during the non-patient facing determination period, or a group, provided that more than 75 percent of the NPIs billing under the group's TIN meet the definition of a non-patient facing individual MIPS eligible clinician during the non-patient facing determination period.

**Other Payer Advanced APM:**

A payment arrangement that meets the criteria set forth in [42 CFR § 414.1420](#).

**Other payer arrangement:**

A payment arrangement with any payer that is not an APM.

**Partial Qualifying APM Participant (Partial QP):**

An eligible clinician determined by CMS to have met the relevant Partial QP threshold under [42 CFR § 414.1430\(a\)\(2\)](#) and (4) and (b)(2) and (4) for a year.

**Partial QP patient count threshold:**

The minimum threshold score specified in [42 CFR § 414.1430\(a\)\(4\)](#) and (b)(4) that an eligible clinician must attain through a patient count methodology described in [42 CFR §§ 414.1435\(b\)](#) and [414.1440\(c\)](#) to become a Partial QP for a year.

### **Partial QP payment amount threshold:**

The minimum threshold score specified in [42 CFR § 414.1430\(a\)\(2\)](#) and (b)(2) that an eligible clinician must attain through a payment amount methodology described [42 CFR §§ 414.1435\(a\)](#) and [414.1440\(b\)](#) to become a Partial QP for a year.

*Participation List* means the list of participants in an APM Entity that is compiled from a CMS-maintained list.

### **Participation List:**

The list of participants in an APM Entity that is compiled from a CMS-maintained list.

### **Performance category score:**

The assessment of each MIPS eligible clinician's performance on the applicable measures and activities for a performance category for a performance period based on the performance standards for those measures and activities.

### **Performance standards:**

The level of performance and methodology that the MIPS eligible clinician is assessed on for a MIPS performance period at the measures and activities level for all MIPS performance categories.

### **Performance threshold:**

The numerical threshold for a MIPS payment year against which the final scores of MIPS eligible clinicians are compared to determine the MIPS payment adjustment factors.

### **QP patient count threshold:**

The minimum threshold score specified in [42 CFR § 414.1430\(a\)\(3\)](#) and (b)(3) that an eligible clinician must attain through a patient count methodology described in [§§ 414.1435\(b\)](#) and [414.1440\(c\)](#) to become a QP for a year.

### **QP payment amount threshold:**

The minimum threshold score specified in [42 CFR § 414.1430\(a\)\(1\)](#) and (b)(1) that an eligible clinician must attain through the payment amount methodology described in [§§ 414.1435\(a\)](#) and [414.1440\(b\)](#) to become a QP for a year.

### **QP Performance Period:**

The time period that CMS will use to assess the level of participation by an eligible clinician in Advanced APMs and Other Payer Advanced APMs for purposes of making a QP determination for the eligible clinician for the year as specified in [42 CFR § 414.1425](#). The QP Performance Period begins on January 1 and ends on August 31 of the calendar year that is 2 years prior to the payment year.





**Qualified Clinical Data Registry (QCDR):**

A CMS-approved entity that has self-nominated and successfully completed a qualification process to determine whether the entity may collect medical or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients.

**Qualified registry:**

A medical registry, a maintenance of certification program operated by a specialty body of the American Board of Medical Specialties or other data intermediary that, with respect to a particular performance period, has self-nominated and successfully completed a vetting process (as specified by CMS) to demonstrate its compliance with the MIPS qualification requirements specified by CMS for that performance period. The registry must have the requisite legal authority to submit MIPS data (as specified by CMS) on behalf of a MIPS eligible clinician or group to CMS.

**Qualifying APM Participant (QP):**

An eligible clinician determined by CMS to have met or exceeded the relevant QP payment amount or QP patient count threshold under [42 CFR § 414.1430\(a\)\(1\)](#), (a)(3), (b)(1), or (b)(3) for a year based on participation in an Advanced APM Entity.

**Rural areas:**

Clinicians in zip codes designated as rural, using the most recent HRSA Area Health Resource File data set available.

**Small practices:**

Practices consisting of 15 or fewer clinicians and solo practitioners.

**Threshold Score:**

The percentage value that CMS determines for an eligible clinician based on the calculations described in [42 CFR § 414.1435](#) or [§ 414.1440](#).

**Topped out non-process measure:**

A measure where the Truncated Coefficient of Variation is less than 0.10 and the 75th and 90th percentiles are within 2 standard errors.

**Topped out process measure:**

A measure with a median performance rate of 95 percent or higher.



## **Appendix: CMS Alternative Payment Model Design Worksheet**

The CMS Alternative Payment Model Design Worksheet (APM Design Worksheet) is a tool to aid stakeholders in developing their ideas for new model designs. Completion of the APM Design Worksheet is not a requirement for proposing a new payment model design to CMS.

The APM Design Worksheet includes key questions to consider within the following seven topic areas:

1. APM Type,
2. Clinical Practice Transformation,
3. Rationale and Evidence,
4. Scale and Scalability: Participants,
5. Alignment,
6. Quality Improvement, and
7. Participation: Operational Feasibility.

## CMS Alternative Payment Model Design Worksheet

Design Element	Item	Key Question to Address
1. APM Type	<input type="checkbox"/>	Would your model design be an APM or an Advanced APM? Would it also be considered a PFPM?
	<input type="checkbox"/>	Is it a shared savings model? Does it create shared risk?
	<input type="checkbox"/>	Which type or types of payment does your model design create (episode-based, capitated, population-based, or other)?
	<input type="checkbox"/>	What is the proposed methodology for the calculation of these payment types?
	<input type="checkbox"/>	Does your model mitigate the risk of increased expenditures under the applicable programs (Medicare, Medicaid, or CHIP), for example by ensuring a balance between guaranteed payment and performance-based payment?
2. Clinical Practice Transformation	<input type="checkbox"/>	Which medical condition(s) does your model design seek to address?
	<input type="checkbox"/>	How does the intervention identified in your model design differ from current practice in the care of your target patient population?
	<input type="checkbox"/>	Does the intervention identified in your model design represent a process improvement, improvement on current practices, or a means to fill a gap in care?
3. Rationale and Evidence	<input type="checkbox"/>	Is there a significant evidence base to support the viability of your proposed intervention or interventions?
4. Scale and Scalability: Participants	<input type="checkbox"/>	Which health care provider types will be eligible to participate in your model?
	<input type="checkbox"/>	Which beneficiary population(s) will your model address?
	<input type="checkbox"/>	How large does your model design need to be in order to yield actionable evidence in reduction of cost or improved quality of care for beneficiaries?
	<input type="checkbox"/>	How could the success of the intervention or interventions in your model design be evaluated? What challenges might be encountered with the evaluation?
5. Alignment	<input type="checkbox"/>	How would your model design promote participation in APMs by broadening and expanding CMS's portfolio of APMs in areas such as geographic location, specialty, condition, and illness?
	<input type="checkbox"/>	Does your model design fill any known gaps in the CMS portfolio?
	<input type="checkbox"/>	Does your model design align with the models or programs being run by other payers?
6. Quality Improvement	<input type="checkbox"/>	Which specific quality measures do you recommend for use in your model design?
	<input type="checkbox"/>	How are the incentives created by your model design expected to improve care quality?
	<input type="checkbox"/>	How could your model design adapt to account for changing technology, including new drug therapies?
7. Participation: Operational Feasibility	<input type="checkbox"/>	Does your model design align with existing CMS initiatives? Can existing infrastructure be leveraged to support your model design?
	<input type="checkbox"/>	Would participants need to make significant investments or changes to be able to participate in your model design?
	<input type="checkbox"/>	Does your model design include participant eligibility requirements, a beneficiary assignment or alignment strategy, and a strategy to manage overlap with any co-occurring initiatives?