Critical Policy Updates for ACOs

Agenda

1. Welcome
2. Presentation:
   - Congress
   - COVID-19
   - ACO Results
   - NAACOS Advocacy Priorities
   - Proposed 2022 Medicare Physician Fee Schedule (PFS) rule
   - Innovation Center Models
3. Audience Q&A

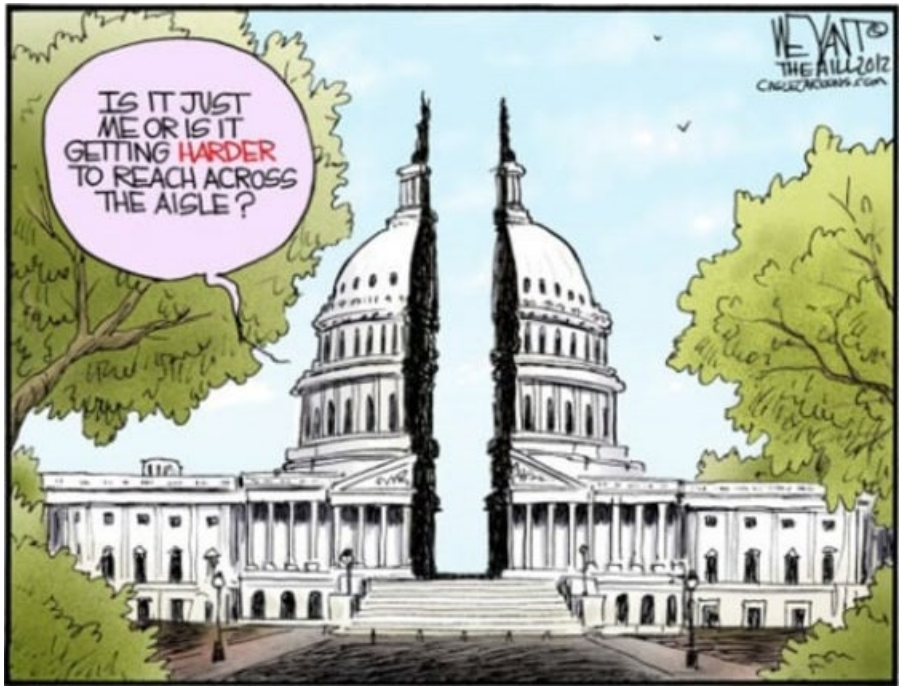
Speakers

	**Allison Brennan** Senior Vice President of Government Affairs NAACOS
	**David Pittman** Senior Policy Advisor NAACOS
	**Jennifer Gasperini** Director of Regulatory and Quality Affairs NAACOS

Congress

Congress

- Partisanship is incredibly high in Washington
  - The House is divided with 220 Democrats to 212 Republicans with 3 vacancies
  - The Senate is split 50-50 with VP Kamala Harris casting the tie-breaking vote
- Democrats are using wonky budget procedures to pass big pieces of legislation



Congress

What to look for from Congress…

- Build Back Better Act
  - $3.5 trillion budget reconciliation bill that aims to expand Medicare benefits on vision, hearing and dental, expand ACA and Medicaid coverage, provide paid family leave, address healthcare workforce issues, among many other issues
  - Paid for mostly through changes in the tax code
  - Drug pricing is also on the table as a pay-for
- Infrastructure/jobs creation package
  - Would cost about $1 trillion
  - Democrats want to pass this separately from reconciliation bill
- Preventing automatic cuts in Medicare spending
- Debt ceiling increase
- Bipartisan health package???

Value in Health Care Act of 2021

- NAACOS is working to pass key ACO legislation as part of its ongoing work with Congress

Value in Health Care Act (H.R. 4587)

- The "Value Act" was introduced in the House of Representatives on July 20
- Bill text is available here and a summary available here
- The bill supports ACOs and the shift to value-based care and payment
- Sponsors include Reps. Peter Welch (D-Vt.), Suzan DelBene (D-Wash.), Darin LaHood (R-Ill.), and Brad Wenstrup (R-Ohio)
- Sen. Sheldon Whitehouse (D-R.I.) is the Senate champion
- An Independent analysis shows the Value Act would save $280 million over 10 years
- 14 leading national healthcare stakeholder organizations sent a letter and issued a press release in support of the bill

Value in Health Care Act of 2021

- Encourages participation in the Medicare Shared Savings Program by:
  - Increasing shared savings rates
  - Modifying risk adjustment
  - Eliminating high-low revenue distinction
  - Providing more time before risk is required
  - Removing ACO patients from regional population in benchmarks
- Provides advanced funding to ACOs
- Improves Advanced APM incentives and fixes “QP” thresholds
  - Extends the Advanced APM bonus for six additional years
  - Maintains the QP payment threshold at 50% through performance year 2022 (payment year 2024) with small annual increases thereafter
- Requires study on overlap in value-based care programs
- Calls for GAO study on racial health disparities for ACOs compared to FFS

Value Act Supporters

‘Rural Glitch’ Bill

The Accountable Care In Rural America Act (H.R. 3746)

- Removes ACO-assigned benes from regional adjustment in benchmarking
- Reintroduced in the House in June
- Sponsored by Reps. DelBene (D-Wash.), Bera (D-Calif.), Arrington (R-Texas), Kelly (R-Pa.), O’Halleran (D-Ariz.), Sewell (D-Ala.), Dunn (R-Fla.), and Gooden (R-Texas)
- Sen. Cortez-Masto (D-Nev.) is the Senate champion
- One-page summary of the “Rural Glitch” issue
- NAACOS and 12 other leading national healthcare organizations sent a letter and issued a press release in support of the bill

Grassroots Engagement

- It's important for Congress and CMS to hear directly from you
- In the last year, we've set up grassroots engagements on:
  - Value Act and other bills
  - ACO quality changes
  - Advanced APM bonuses
- **To take part, visit NAACOS.com/Take-Action**
- NAACOS also operates a Political Action Committee

COVID-19

COVID-19 & ACOs

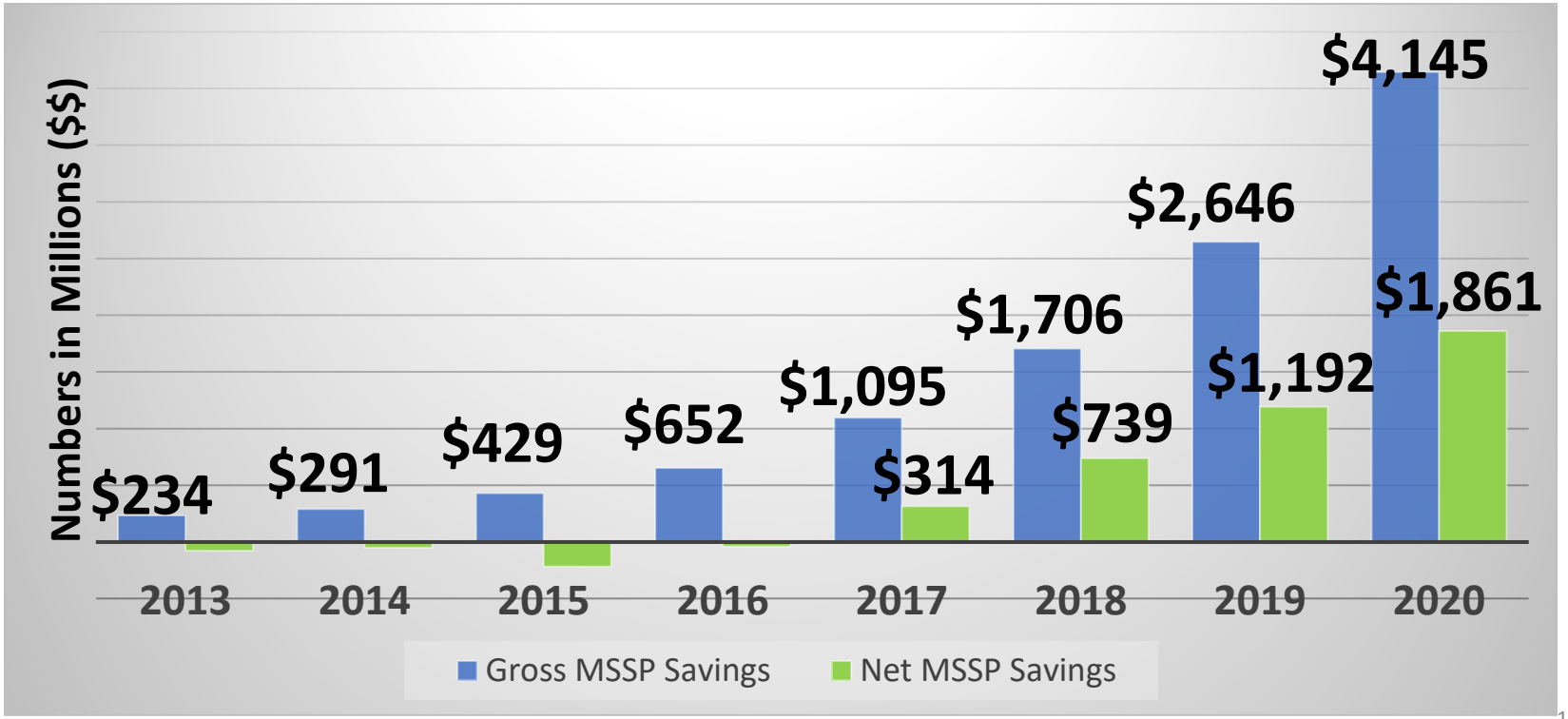
- The length of HHS's COVID-19 Public Health Emergency is uncertain
  - Currently goes through Oct. 18
  - Expected to be renewed through the rest of this year
- What does that mean for ACOs?
  - Shared losses for MSSP ACOs will be reduced based on the proportion of months that are covered by the public health emergency
  - Enforcement discretion around beneficiary notifications
  - Lots of other Medicare flexibilities
  - More detail in this FAQ document from CMS
- Congress must act to extend telehealth flexibilities beyond the PHE
  - Lots of interest and activity around that but $$ makes it difficult
  - Telehealth FAQ to assist ACOs using telehealth services
- More resources and help on NAACOS's standalone COVID-19 page
  - COVID-19 and ACOs fact sheet

ACO Results

MSSP 2020 Results

- CMS in August published results of MSSP ACOs' performance in 2020
- It was the program's best year to date, even in a pandemic
  - $4.1 billion in gross savings and $1.9 billion in net savings
  - ACOs earned $2.3 billion in shared savings payments
  - Average quality score of 97.8% and 60 ACOs earned a perfect score of 100
- Since 2012, ACOs have saved Medicare $12.6 billion in gross savings and $4.4 billion in net savings
- We issued a press release and this summary of the results
  - NAACOS encourages ACOs to do the same
- We use these positive results in our advocacy with policymakers
- **NAACOS congratulates ACOs on their hard work and positive results!**

Gross and Net MSSP Savings



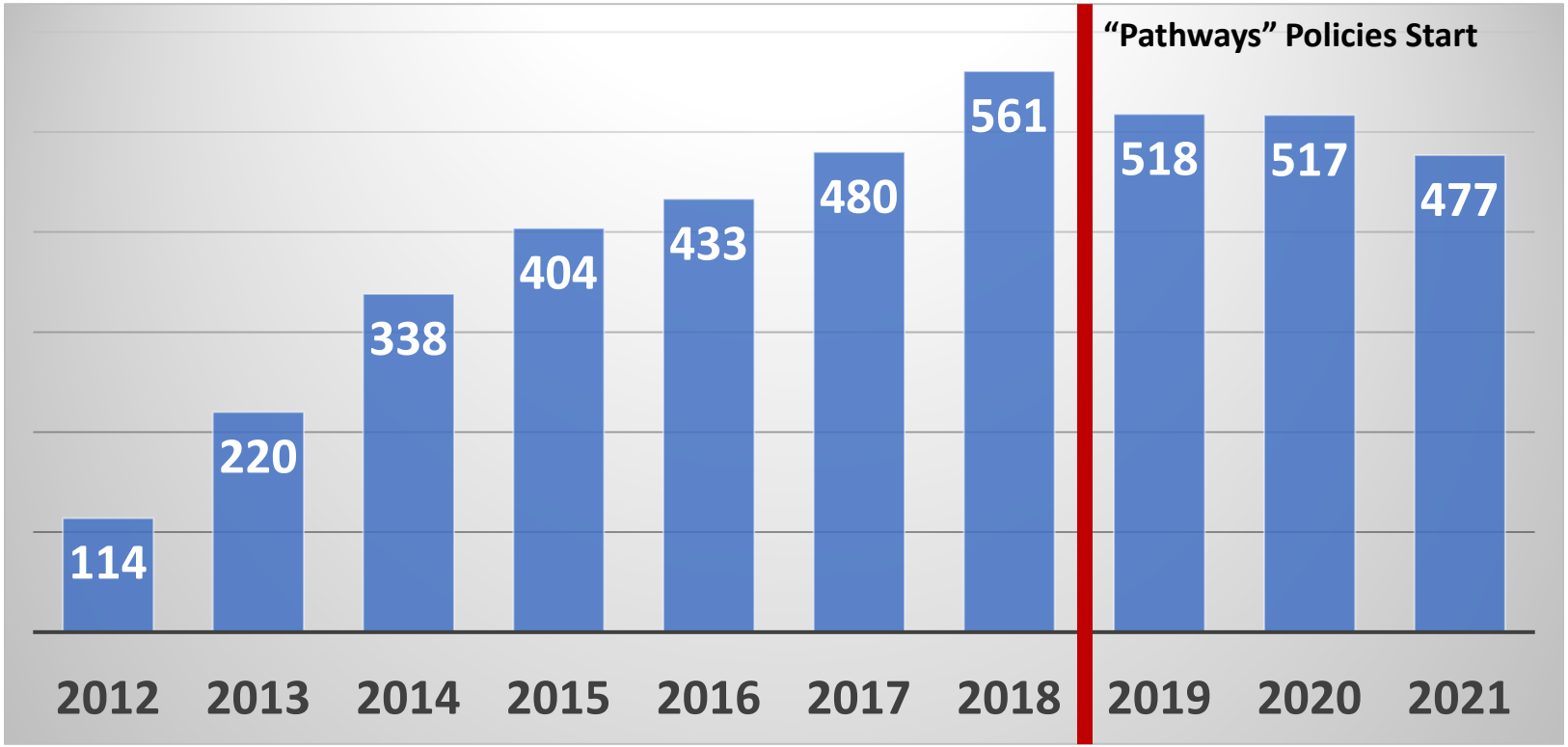
NAACOS Advocacy Priorities

NAACOS Advocacy Priorities

To support the ACO movement and recalibrate the value transition to center on/support healthcare providers, NAACOS recommends HHS:

- Set a national goal to have a majority of traditional Medicare beneficiaries in an ACO by 2025
- Strengthen incentives to attract new ACOs and retain existing ones
- Deprioritize the rush to risk and build a population health infrastructure
- Address overlap of competing payment models to prioritize total cost of care models
- Provide meaningful funding to build infrastructure necessary to spur innovation and value through expanded advanced payments and grants

Total MSSP ACOs



Advocacy priorities

- NAACOS advocates on behalf of ACOs with Congress and the Administration.
- In addition to the Congressional priorities discussed earlier, we focus on educating lawmakers and staff about the work of ACOs.
- NAACOS also regularly meets with leaders and staff from CMS and HHS.
- Recent priorities include:
  - Reversing the trend of declining MSSP participation
  - Delaying and modifying the MSSP quality overhaul
  - Fixing key benchmarking and risk adjustment issues
  - Making improvements to the Direct Contracting Model
  - Fixing issues of APM overlap to prioritize ACOs

Enhanced Plus

NAACOS is advocating to create an "Enhanced Plus" option in MSSP

- Permanent option featuring full risk and capitation with details including:
  - 100% shared savings and loss rates
  - Participation at TIN-NPI level
  - Options for capitated payments, including partial and full capitation and the ability to negotiate downstream value-based payment arrangements
  - Benchmarking: Rolling historical baseline based on 3 years, w/regional component starting at 50% and increasing gradually to 70%. Apply a regional-only benchmarking trend. Do not use a MSR or MLR and instead apply a 1.5% discount.
  - Offer advanced waivers, including these and more:
    - Post Discharge Home Visit Waiver
    - Care Management Home Visit Waiver
    - Ability to Tailor Cost Sharing Support for Part B Services

Proposed 2022 Medicare PFS Rule

Overview

- CMS released the proposed 2022 Medicare Physician Fee Schedule (MPFS) rule
  - MPFS factsheet and QPP factsheet
  - Access NAACOS's in-depth analysis of the rule here
- This annual regulation includes PFS payment updates, changes to Medicare Part B policies and changes to the MSSP
- The Medicare Access and CHIP Reauthorization Act (MACRA) included a 0% update to the Conversion Factor (CF) for 2022
  - 2022 CF: $33.58, which is 3.75% lower than the 2021 CF of $34.89
- Minor payment shifts among specialties (see Table 123 on page 39531)
- CMS is reviewing comments submitted to the agency, including NAACOS's letter and will release a final rule around Nov. 1

Quality Payment Program

- MACRA strengthened the shift to value, but more must be done!
- Performance Year (PY) 2022 corresponds to 2024 payment adjustments
- PY 2022 is the final year for:
  - 5% Advanced APM bonuses
  - Additional funding for ECs that meet/exceed the MIPS exceptional performance threshold, which will significantly decrease max. bonuses
- Starting with PY 2024, ECs in Advanced APMs that meet the Qualifying APM Participant (QP) thresholds will earn automatic annual updates of 0.75% compared to ECs in MIPS that will get 0.25% updates plus MIPS bonuses/penalties.
- For more information on the QPP, refer to NAACOS's ACO Guide to MACRA

2022 MIPS Proposals

- 2022 performance year is the first year CMS is required to begin establishing MIPS thresholds based on actual MIPS performance – max penalty of -9%
- CMS proposes to raise the MIPS thresholds for the 2022 performance year
  - 75 points= performance threshold (increase of 15 points)
  - 89 points = exceptional performance threshold (increase of 4 points)
- CMS projects MIPS adjustments of up to 14%, while also anticipating much lower bonuses due to high performance in the MIPS program overall
- CMS does not propose changes to the way ACOs are scored in MIPS in 2022

Proposed Quality Changes

- In the 2021 MPFS rule, CMS finalized policies to align MSSP ACO quality requirements with the MIPS approach to quality assessments under a new quality assessment structure called the APM Performance Pathway (APP)
  - The APP changed the way ACOs are evaluated on quality effective in 2021 and required ACOs to move to electronic clinical quality measure (eCQM) reporting by 2022, also reducing the measure set to 3 clinical measures + CAHPS and admin. claims measures
  - Learn more about these req's in our NAACOS resource

2020 MSSP ACO Quality	2021 MSSP ACO Quality
Domain-based scoring approach; Web Interface reporting for all; Minimum performance standard is established based on Web Interface reporters; Shared savings rate varies based on final quality score	APP scoring approach; Web Interface or eCQM reporting; Minimum performance standard is established based on MIPS quality performance category scores for all MIPS reporters; All exceeding the min. standard receive max shared savings rate

Proposed Quality Changes

- In the proposed 2022 MPFS rule, CMS proposes further changes to APP policies including:
  - Delaying the requirement to move to eCQM reporting for ACOs
  - Freezing the MSSP quality performance standard threshold for one additional year
  - Providing incentives to ACOs who elect to report eCQMs earlier than required
  - Soliciting comments on a number of additional policy issues related to quality
- **NAACOS and ACO advocacy was critical in obtaining these policy changes, thank you to our members for your participation in our grassroots advocacy on this issue!**

Proposed Quality Changes

Proposed Quality Reporting Options		
2021	Report via Web Interface	Report via APP eCQMs/MIPS CQMs
2022	Report via Web Interface	Report via APP eCQMs/MIPS CQMs If electing to report eCQM/MIPS CQMs, ACOs only need to meet or exceed the performance standard for at least one of the measures. This is a lower standard than WI reporting and is designed to act as an incentive for ACOs to elect to report the eCQMs/MIPS CQMs
2023	Report via WI + one APP eCQM/MIPS CQM	Report via APP eCQMs/MIPS CQMs If electing to report eCQM/MIPS CQMs, ACOs only need to meet or exceed the performance standard for at least one of the measures. This is a lower standard than WI reporting and is designed to act as an incentive for ACOs to elect to report the eCQMs/MIPS CQMs
2024	All ACOs must report the APP eCQMs/MIPS CQMs. The quality performance standard also rises in 2024, as proposed, to the 40th percentile of all MIPS quality performance category scores	

Note: If an ACO elects to report eCQMs/MIPS CQMs, data completeness and case minimum requirements must be met

Comments

- NAACOS comments in response to the MPFS rule urged the following, among other points:
  1. Work with ACOs and EHR vendors to find solutions to data aggregation problems, and until these solutions are widely available, eCQMs should not be mandated for ACOs. CMS should continue to offer the Web Interface reporting option for ACOs until standard data fields exist across EHRs and true interoperability is achieved
  2. Abandon the strategy of aligning ACO quality with MIPS
  3. Revise the new MSSP quality performance standard. It is inappropriate to compare ACO quality performance to MIPS quality performance category scores
  4. Remove the all-payor requirement for ACOs reporting eCQMs and instead require reporting on a sample of ACO assigned patients meeting the denominator criteria
  5. Identify ways to evaluate quality within APMs in a more strategic manner

eCQM/MIPS CQMs

- Key differences in reporting APP eCQMs/MIPS CQMs to note:
  - All payor requirement – ACOs will be evaluated on all patients meeting the measure criteria, regardless of whether that patient is an ACO assigned patient or even a Medicare patient. This expands the denominator size drastically and is a big departure in the way ACOs have previously been evaluated on quality.
  - **NAACOS comments**: NAACOS opposes the all payor requirement. It is not appropriate to hold ACOs accountable when ACOs may not even have access to such patient data, this also removes the ability to evaluate ACO quality vs FFS quality

  - Sampling approach removed- Web Interface used a sample of ACO assigned patients (248) to evaluate quality and compared quality scores to other Web Interface reporters, most of which were ACOs. Moving to eCQM/MIPS CQMs will increase the number of patients ACOs are evaluated on dramatically (could be thousands of patients)
  - **NAACOS comments:** CMS should instead use a sampling approach, focused on assigned ACO patients meeting the measure criteria

eCQM/MIPS CQMs

- Key differences in reporting APP eCQMs/MIPS CQMs to note:
  - Performance standard- the APP will compare ACOs' final quality score to all MIPS quality performance category scores to determine whether an ACO has met/exceeded the 30th or 40th percentile performance standard threshold. This is comparing apples to oranges and looking at CMS estimates, will cause many more ACOs to be ineligible to share in savings. Those meeting or exceeding the performance threshold will earn the maximum shared savings rate, but those who do not meet the standard will be ineligible for shared savings
  - **NAACOS comments:** Revise the new MSSP quality performance standard. It is inappropriate to compare ACO quality performance to MIPS quality performance category scores. NAACOS urges CMS to revert to previous methods for evaluating the quality performance standard

Performance Standard

- CMS provides prior year performance data in this rule as an example of what the quality performance standard could look like:
  - For PY 2018 the MIPS Quality performance category score at the 30th percentile was equivalent to 83.9 and the MIPS Quality performance category score at the 40th percentile was equivalent to 93.3. For PY 2019 the MIPS Quality performance category score at 30th percentile was equivalent to 87.9 and the MIPS Quality performance category score at the 40th percentile was equivalent to 95.7
  - **Roughly 1-in-5 ACOs, or approximately 20 percent of ACOs, could fall below the 40th percentile MIPS Quality performance category score by performance year 2023, and would not be eligible to share in savings or would owe maximum shared losses, if applicable**
- **NAACOS comments:** Provide greater transparency around this calculation. NAACOS opposes an evaluation approach that would penalize approximately 20% of ACOs with quality scores in the 90's.

Proposed Quality Changes

- Other key points:
  - If an ACO decides to report both the ten CMS Web Interface measures and the three eCQM/MIPS CQM measures, it will receive the higher of the two quality scores
  - CMS clarifies that ACOs must de-duplicate patient data when submitting aggregate QRDA III files
  - CMS left many APP implementation questions unanswered – we will continue to seek greater detail to support ACOs working on transitioning to eCQM reporting
  - New approach also will suppress measures that have BM issues or undergo significant changes mid-year; given the dramatic decrease in total measures this could place all scoring emphasis on less than 3 measures
- CMS APP Resources:
  - CMS APP resources
  - CMS APP toolkit

Beneficiary Notification

- CMS is maintaining the beneficiary notification requirement but proposed a modification for ACOs using prospective assignment
  - Specifically, ACOs using selected prospective assignment must provide standardized written notice to each prospectively assigned beneficiary prior to or at the first primary care visit of the performance year but would not have to provide the notice to beneficiaries not prospectively assigned
- **NAACOS comments:**
  - We support this proposal as it reduces administrative burden
  - However, we urge CMS to take a step further by removing the beneficiary notification requirement altogether
    - At a minimum, it's more appropriate for CMS to send these notifications

Benchmarking

- CMS sought feedback on the regional adjustment of MSSP benchmarks
  - Specifically, how to account for the removal of ACO-assigned beneficiaries from the regional reference population
  - This benchmarking flaw is often referred to as the “rural glitch”
- CMS sought comment on what would constitute a heavy market penetration and how to strike a balance between helping ACOs with high market share without harming ACOs with relatively low market share
- **NAACOS comments:**
  - Fix the rural glitch by removing ACO-assigned beneficiaries from the regional reference population, which should be implemented as soon as possible
  - Use a regional-only trend, which is a better reflection of a local market than a national trend or a blended national-regional trend

Risk Adjustment

- CMS sought feedback on the MSSP risk adjustment methodology
  - Specifically, how to improve risk adjustment for ACOs with medically complex, high-cost beneficiaries
  - Want to balance the need for accurate and complete coding while protecting against incentivizing ACO coding intensity practices
  - CMS discussed alternative approaches to their current methodology such as increasing the cap on an ACO's risk score growth in relation to the risk score growth in the ACO's region
- **NAACOS comments:**
  - Apply a risk adjustment cap of no less than 5% and a downward cap no greater than -5%
  - Align the use of a risk adjustment cap for the ACO and its region, applying a consistent capping policy to both

Assignment

- CMS proposed to amend the list of primary care services it uses to assign beneficiaries to ACOs by adding seven codes starting in PY 2022. The additional proposed codes include:
  - 99X21 (chronic care management)*, 99X22, 99X23, 99X24, and 99X25 (principal care management)*, G2212 (prolonged office or other outpatient evaluation and management [E/M] service)*, G2252 (communication technology-based service)

  **not yet finalized*
- CMS also proposed to keep using 99441, 99442, and 99443 in MSSP assignment until they are no longer payable under Medicare FFS policies
- Finally, CMS proposed to use CPT codes that are directly replaced by another code in the fee schedule for purposes of MSSP assignment
- **NAACOS comments:** We support the proposed assignment changes

Application Process

- To alleviate burden, CMS proposed several changes to the application process, including:
  - Remove requirements that ACOs tell CMS about past participation
    - Would only be required if CMS requests it
  - Remove requirements that ACOs submit sample participant agreements during the application process
    - Would only be required if CMS requests it
  - Remove the requirement that ACOs submit executed participant agreements for returning participant during the renewal process
    - Instead, ACOs would only be required to submit agreements during initial application and when requesting additions to their ACO participant list
- **NAACOS comments:** We support these proposals

Repayment Mechanisms

- CMS requires repayment mechanisms (letter of credit, surety bond, funds in escrow) for ACOs in risk-based MSSP tracks
- CMS proposed to cut in half the percentages required for ACO repayment mechanisms:
    1) 0.5% of total per capita Medicare Parts A and B FFS expenditures for the ACO's assigned population
    2) 1.0% of the total Medicare Parts A and B revenue of ACO's participants
- ACOs' would pay the lesser of either amount
- If finalized, CMS would allow certain ACOs that already have established repayment mechanisms an option to decrease those to reflect the rule changes
- CMS also proposed to only require an ACO to increase its repayment mechanism if the required amount were to increase by at least $1 million
- **NAACOS comments:** We support these proposals

Telehealth

- CMS proposed to keep all of the services temporarily added to the list of those eligible to be delivered via telehealth on the list through the end of 2023, regardless of when the PHE ends
  - This move, if finalized, will allow CMS more time to collect additional information regarding utilization of these services
- CMS proposed to permanently cover G2252 (a “virtual check-in” between 11 and 20 minutes) beyond the PHE
  - Virtual check-ins are audio-only, patient-initiated communications with a practitioner
  - G2252 was temporarily added last year but CMS is moving to make it permanent in 2022 given concerns about avoiding unnecessary in-person visits
  - Payment would be cross-walked with 99442
- **NAACOS comments:** We support these proposals. All ACOs should be given the freedom to use telehealth in broader circumstances.

Telehealth

- CMS proposed to make a patient's home a permissible originating site for the diagnosis, evaluation, or treatment of mental health disorders via telehealth
  - If finalized, audio-only tele-mental health services delivered at patients' homes would be allowed
  - However, CMS proposed that beneficiaries must have an in-person visit within six months before the date of their at-home tele-mental health service
  - This in-person requirement wouldn't apply to telehealth services for treatment of a diagnosed substance use disorder with a co-occurring mental health disorder
  - If finalized, these changes would also apply to FQHCs and RHCs
- CMS continued to seek feedback on flexibility around allowing direct supervision and immediate availability requirements to be provided via telehealth
- **NAACOS comments:** Audio-only visits should not be reimbursed at the same level as video-based telehealth

Remote Monitoring

- CMS proposed to add five new “remote therapeutic monitoring” (RTM) codes (989X1, 989X2, 989X3, 989X4, and 989X5) in 2022
- In contrast to the remote physiological monitoring (RPM) codes, RTM could be used to cover “non-physiologic” patient data such, as pain and medication adherence
- Expected to be primarily billed by nurses and physical therapists, although conducted “incident to” physician supervision
- RTM would include self-reported data - a departure from RPM requirements that require data be automatically transmitted by a connected device
  - Would require the use of a medical device approved by the FDA
- **NAACOS comments:** Generally support the proposals, but making remote monitoring too easy to bill might make it susceptible to fraud and overuse

Innovation Center Updates

Innovation Center Models

- Since taking over the Innovation Center, Liz Fowler has said value-based care is at a “crossroads” and new CMS leadership must evaluate where we are and where we’re going
- Has taken action on existing models, not yet rolling out new ones
- NAACOS continues to build a strong relationship with her

Innovation Center Models

- CMS leaders laid out their vision for CMMI in an Aug. 12 Health Affairs blog
- **What we've learned through CMMI:**
  - Make equity a centerpiece of every model
  - Offering too many models is overly complex, particularly when models overlap
  - Re-evaluate how financial incentives to ensure meaningful provider participation
  - Providers find it challenging to accept downside risk if they do not have the right tools
  - Challenges in setting financial benchmarks have undermined our models' effectiveness
  - Other ways to define success other than each individual model's cost and quality improvements
- **What to expect next:**
  - Drive Accountable Care
    - Increase the number of people in relationships with care providers, including ACOs, that are accountable for their patients' costs
  - Advance Health Equity
  - Support Innovation
  - Address Affordability
  - Partner To Achieve System Transformation

Innovation Center Models

Global and Professional Direct Contracting (GPDC)

- The first performance year of the GPDC Model began on April 1
- There are 53 Direct Contracting Entities in model
  - 39 Global DCEs and 14 Professional DCEs
  - 31 Standard DCEs, 16 New Entrant DCEs, and 6 High Needs DCEs
- More DCEs will be added starting next year, including Next Gen ACOs
- Additional model changes expected in 2023; CMMI thinking about those
- Status of the “Geo” Model and Medicaid-MCO option are TBD

Innovation Center Models

Global and Professional Direct Contracting (GPDC) – NAACOS Resources

- Stand-alone webpage with CMS and NAACOS resources
- Overview of financial updates and PY2 Participation Agreement
- Key Takeaways from the PY1 Participation Agreement
- In-depth analysis of Direct Contracting
- Chart comparing Direct Contracting to other high-risk ACOs
- Chart on the overlap of CMMI models and ACOs
- Summary of Direct Contracting Financial Specifications
- Overview of Direct Contracting Quality Measurement Methodology
- Hosted several webinars, town halls and learning discussions
- We encourage use of our Direct Contracting Listserv. You must sign up first and can do so here.
- NAACOS staff is also available at DirectContracting@naacos.com

Innovation Center Models

Global and Professional Direct Contracting (GPDC) – NAACOS Advocacy

- NAACOS continues to meet with CMMI on shaping Direct Contracting
- Specific Direct Contracting recommendations:
  - Improve program transparency
  - Allow greater flexibility in participation selections (DCE type and capitation option)
  - Reduce the mandatory discount
  - Release further details on quality benchmarks and Continuous Improvement bonus
  - Improve data sharing
  - Make use of fraud and abuse waivers
- Benchmark and risk adjustment changes:
  - In setting benchmarks, CMS should give greater weight to the least recent year
  - CMS should add shared savings earned by a DCE back in the PY benchmark
  - CMS should give more weight to the regional rates for all DCEs
  - End risk adjustment policy for voluntarily aligned beneficiaries that incentivizes gaming
  - Use a regional retrospective trend adjustment

Innovation Center Models

Next Generation ACO Model

- Due to formally sunset at the end of the year
- An extension was a top policy priority for NAACOS

CHART Model

- The ACO track of the rural-focused CHART Model still expected to accept applications next spring

Primary Care First

- 827 practices and 14 payers participating in Cohort 1
- Cohort 2 will start in January
- The Seriously Ill Population component still under review

Vermont All-Payer ACO Model

- Received a positive first formal evaluation

Most Favored Nation Model

- Formally delayed through rulemaking published in early August

Innovation Center Models

ESRD Treatment Choices (ETC) Model

- CMS proposed for 2022:
  - Stratifying benchmarks into two groups based on proportion of dual eligible/low-income benes
  - Creating a Health Equity Incentive bonus for score improvement

Comprehensive Care for Joint Replacement (CJR) Model

- Extended for three additional years through 2024

Home Health Value-Based Purchasing (HHVBP) Model

- Formally proposed for nationwide expansion starting in 2022

Innovation Center Models

Kidney Care Choices Model

- Delayed to start in 2022
- No word on another application cycle

Emergency Triage, Treat, and Transport (ET3) Model

- Started on Jan 1, 2021
- 184 ambulance providers participating

Radiation Oncology Model

- Delayed to start January 2022
- 30 percent of all eligible Medicare FFS radiotherapy episodes nationally

Oncology Care Model

- Anticipated to end on June 30, 2022
- Additional details on Oncology Care First haven't been released

Comprehensive ESRD Care Model (CEC)

- Ended in March

Questions