A comprehensive overview of Medicare payment programs is provided, including key features, start and end dates, and participant details for various programs.

**Hospital Value-Based Purchasing Program**
- Pay for every performance program created differential hospital inpatient payment rates based on success against patient safety, outcomes, patient satisfaction, and spending efficiency measures.
- Holds providers accountable for either absolute success or improvement against established performance measures via withhold/offset payment structure.
- CMS withheld 2% of all base operating amounts to fund the program, hospitals can receive a bonus or penalty.

**Hospital Readmissions Reduction Program**
- Reimbursement penalty targeting hospitals with excessive 30-day readmission rates for select clinical conditions.
- Penalty based on 30-day risk-standardized unplanned readmissions for acute myocardial infarction, chronic obstructive pulmonary disease, heart failure, pneumonia, coronary artery bypass graft surgery, and total hip/knee arthroplasty.
- Can result in up to a 3% reduction in reimbursement; hospitals can only be penalized (no bonus penalty).

**Hospital-Acquired Condition Reduction Program**
- Reimbursement penalty targeting hospitals with more frequent health care–associated infections and select patient safety events.
- Penalty based on PSI-90 performance and Standardized Infection Ratios (SIRs) for 5 CDC NHSN health-care associated infections (HAI) measures; all measures are weighted equally as of FY 2020.
- Imposes 1% reimbursement penalty on worst performing quartile of hospitals.

**Bundled Payments for Care Improvement Advanced**
- CMS program offering providers a bundled payment for treating Medicare fee-for-service beneficiaries.
- Uses a retrospective bundled payment with a 90 day clinical episode timeframe; bundle includes all related Part A and Part B services.
- Includes 31 inpatient clinical episodes and 4 outpatient clinical episodes.

**Comprehensive Care for Joint Replacement Model**
- CMMI bundled payment program with a 3% episode discount for lower extremity joint replacement payment for procedures in 67 select markets.
- Retrospective bundled payment model holds hospitals accountable for episodes of care extending 90 days post-discharge; bundle includes all related Part A and Part B services.
- Initially created as mandatory program; in 2023 participation became optional for all providers in 33 markets, and for rural and low-volume providers in the remaining 34 markets.

**Direct Contracting**
- CMMI program that includes two alternative payment models offering either capitated or partially capitated population-based payments with 50% or 100% shared savings and losses.
- Aims to engage a broader range of physician groups, hospitals, and other types of health-care organizations such as Medicare Managed Care Organizations and Medicare Care Plans.
- Includes participation option for organizations serving high-need populations such as individuals dually eligible for Medicare and Medicaid.

**Merit-Based Incentive Payment System**
- Medicare Physician Fee Schedule methodology that incorporates EHR Incentive Program, Physician Quality Reporting System, and Merit-Based Payment Modifier.
- Performance measures evaluate providers in four categories: quality, cost, promoting interoperability (electronic health record use), and improvement activities.
- Providers may opt out by participating in alternative payment models that offer additional incentives.

**The Field Guide to Medicare Payment Innovation**

- CMS is deploying an array of voluntary and mandatory payment innovation programs to accelerate the transition to accountable payment models. This field guide details the 12 highest profile programs as of March 2020. Learn how these programs disrupt the traditional fee-for-service business model.

**The Field Guide to Payment Transformation**
- See our latest on payment transformation: advisory.com/hcab/paytransformation

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**ALTERNATIVE PAYMENT PROGRESS**

<table>
<thead>
<tr>
<th>Medicare Payments Tied to Alternative Payment Models, 2018</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Population-based payments</td>
<td>4.5%</td>
</tr>
<tr>
<td>Traditional fee-for-service</td>
<td>10.5%</td>
</tr>
<tr>
<td>Shared savings and bundles</td>
<td>33.8%</td>
</tr>
<tr>
<td>Pay for performance</td>
<td>51.2%</td>
</tr>
</tbody>
</table>

**PAYMENT PROGRAM KEY**

- **Primary Care First**
  - Center for Medicare and Medicaid Innovation (CMMI) program for advanced primary care practices in 26 regions that are ready to take on financial risk.
  - Practices receive a prospective payment based on the population they serve.
  - Minimum number of attributed Medicare beneficiaries per practice location.

- **Oncology Care Model**
  - CMMI program seeking to inflect quality and costs for patients receiving chemotherapy across six-month episodes of care.
  - Physician practices receive fee-for-service payments, monthly per-beneficiary care management fees, and shared savings payments.
  - Participants that had not earned at least one performance-based payment in the first four performance periods were forced to drop out or take on two-sided risk starting January 1, 2020.

- **Medicare Shared Savings Program**
  - Program enabling providers to form accountable care organizations (ACOs) that serve Medicare fee-for-service beneficiaries.
  - Establishes financial accountability for the quality and total cost of care for an attributed population of at least 5,000 Medicare beneficiaries.
  - Offers two tracks—BASIC and ENHANCED—that feature varying levels of financial risk, bonus opportunity, and flexibility in program design.

- **Next Generation ACO Model**
  - CMMI program offering advanced population health managers higher levels of risk and reward than the Medicare Shared Savings Program.
  - Participants must choose between two risk arrangements—shared risk or full risk—that feature shared savings/losses rates between 80% and 100%.
  - ACOs select one of three different payment models, including All Inclusive Population-Based Payments, a variant of capitation.

- **Direct Contracting**
  - CMMI program that includes two alternative payment models offering either capitated or partially capitated population-based payments with 50% or 100% shared savings and losses.
  - Aims to engage a broader range of physician groups, hospitals, and other types of health-care organizations such as Medicare Managed Care Organizations and Medicare Care Plans.
  - Includes participation option for organizations serving high-need populations such as individuals dually eligible for Medicare and Medicaid.

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**THE FIELD GUIDE TO**

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