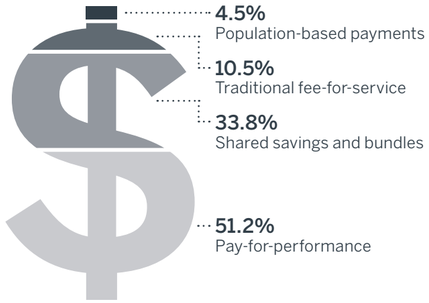
THE FIELD GUIDE TO

Medicare Payment Innovation

CMS has created both voluntary and mandatory payment innovation programs to accelerate providers' transition to value-based payment models. This field guide helps clear up the confusion when it comes to value-based payment by detailing the highest-profile programs as of March 2020 that provider organizations can, or are required to, participate in. It's important to know how these programs disrupt your provider partners' traditional fee-for-service business model to think about how you can be their strategic partner as they move to take on more risk.

ALTERNATIVE PAYMENT PROGRESS

Medicare payments tied to alternative payment models, 2018[1]



1 Medicare fee-for-service beneficiaries only, excludes Medicare Advantage.

PAYMENT PROGRAM KEY

Pay-for-performance
Rewards or penalizes providers for performance against select quality and cost metrics; often focuses on safety, outcomes, and patient satisfaction measures.

Primary care transformation
Provides upfront and performance-based payments to encourage investment and innovation in the delivery of primary care services; motivates development of advanced primary care models.

Bundled payment
Establishes a single price for a comprehensive episode of care, often spanning the care continuum; modifies the incentives of fee-for-service economics.

Total cost of care
Holds providers accountable for the overall quality and total cost of care for patient populations over time; eliminates the volume-based incentives of fee-for-service economics.

Hospital Value-Based Purchasing Program

- Pay-for-performance program creating 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/payback structure
- CMS withholds 2% of all base operating amounts to fund the program; hospitals can receive a bonus or penalty

38% of hospitals received a penalty in FY 2020

Disruption to Fee-for-Service Business Model
Mandatory
STARTED 2013
ENDING Undefined

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 potential)

81% of hospitals received a penalty in FY 2020

Disruption to Fee-for-Service Business Model
Mandatory
STARTED 2013
ENDING Undefined

Hospital-Acquired Condition Reduction Program

- Reimbursement penalty targeting hospitals with comparatively 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 infection (HAI) measures; all measures are weighted equally as of FY 2020
- Imposes 1% reimbursement penalty on worst-performing quartile of hospitals

25% of hospitals mandated to face the penalty

Disruption to Fee-for-Service Business Model
Mandatory
STARTED 2015
ENDING Undefined

Merit-Based Incentive Payment System

- Medicare Physician Fee Schedule methodology that incorporates EHR Incentive Program, Physician Quality Reporting System, and Value-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 model track that offers additional incentives

9% Physician Medicare payment at risk when fully implemented in 2022

Disruption to Fee-for-Service Business Model
Mandatory
STARTED 2019
ENDING Undefined

Comprehensive Primary Care Plus

- Multi-payer program offering two tracks that provide primary care practices with upfront monthly care management payments, performance-based incentives payments, and comprehensive primary care payments
- CMS is partnering in four-year program with primary care practices, commercial payers, and state health insurance plans in 18 regions
- Initiative focuses on improving care management, access and continuity, care planning, patient engagement, and care coordination

2,851 Primary care practices participating in the program

Disruption to Fee-for-Service Business Model
Voluntary
STARTED 2017
ENDING 2021

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 population-based payment and a flat fee for primary care visits, as well as performance-based payment adjustments that can increase payment by up to 50% or decrease it by 10%
- Optional participation and higher payments for practices that serve seriously ill beneficiaries who have experienced fragmented care

125 Minimum number of attributed Medicare beneficiaries per practice location

Disruption to Fee-for-Service Business Model
Voluntary
1ST COHORT 2021–2025
2ND COHORT 2022–2026 current CPC+ practices only

Bundled Payments for Care Improvement Advanced

- CMMI 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

1,500+ Organizations participating in the program in 2020

Disruption to Fee-for-Service Business Model
Voluntary
STARTED 2018
ENDING 2023

Comprehensive Care for Joint Replacement Model

- CMMI bundled payment program with a 3% episode discount for lower extremity joint replacement 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 2018 participation became optional for all providers in 33 markets, and for rural and low-volume providers in the remaining 34 markets

465 Hospitals participate in 67 Metropolitan Statistical Areas

Disruption to Fee-for-Service Business Model
Blended
STARTED 2016
ENDING 2020

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 for reducing total Medicare spending on oncology patients
- 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

$960 Per-beneficiary care management fee for six-month episode of care

Disruption to Fee-for-Service Business Model
Voluntary
STARTED 2016
ENDING 2021

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

517 ACOs participating in the program in 2020

Disruption to Fee-for-Service Business Model
Voluntary
STARTED 2012
ENDING Undefined

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/loss rates between 80% and 100%
- ACOs select one of three different payment models, including All-Inclusive Population-Based Payments, a variant of capitation

41 ACOs participating in the program in 2019

Disruption to Fee-for-Service Business Model
Voluntary
STARTED 2016
ENDING 2020

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 broad range of physician groups, hospitals, and other types of health care organizations such as Medicaid Managed Care Organizations and Medicare-Medicaid Plans
- Includes participation option for organizations serving high-needs populations such as individuals dually eligible for Medicare and Medicaid

3 Types of Direct Contracting Entities

Disruption to Fee-for-Service Business Model
Voluntary
STARTED 2021
ENDING 2025

Source: *2018 APM Measurement Infographic*, Health Care Payment Learning and Action Network.

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