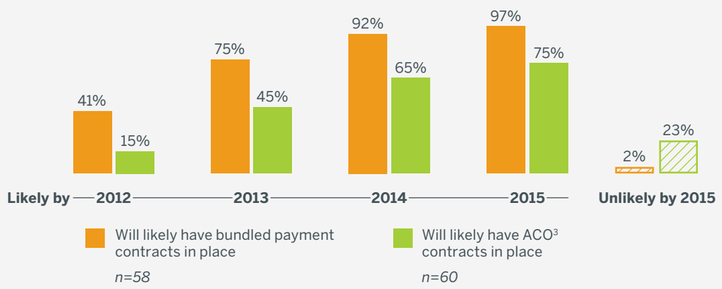
The Field Guide to Medicare Payment Innovation

Change accelerator	Provides funding and peer networking to support local delivery system innovation; ultimately seeks to identify and disseminate best practices
Performance risk model	Holds providers accountable for cost and quality within individual episodes of care; retains the growth incentives of fee-for-service economics
Utilization risk model	Holds providers accountable for overall quality and total cost of care for patients over time; breaks the volume-based incentives of fee-for-service economics

Momentum Building Toward Payment Transformation

Anticipating Rapid Adoption of New Incentive Models

Advisory Board Survey of Health Care Leaders [1,2]



PARTNERSHIP FOR PATIENTS

- CMMI[4] grant program composed of two initiatives seeking to improve patient safety in hospitals and during transitions to other care sites
- Supports organizations working to advance goals of reducing hospital-acquired conditions by 40% and readmissions by 20% by the end of 2013

6,500
CURRENT PARTNERS, INCLUDING PROVIDERS, EMPLOYERS, UNIONS, AND CONSUMER GROUPS

HEALTH CARE ADVISORY BOARD ASSESSMENT

The program's initiatives, the Hospital Engagement Networks and the Community-Based Care Transitions Program, each provide up to $500 million in total grant funding to providers. For organizations actively working to reduce hospital-acquired conditions and readmissions, the program's funding may provide the financial support necessary to accelerate quality improvement efforts.

DISRUPTION TO FEE-FOR-SERVICE BUSINESS MODEL

START DATE: CY2011 | PARTICIPATION: V Voluntary

HEALTH CARE INNOVATION CHALLENGE

- CMMI grant program offering financial support to organizations with innovative proposals for advancing CMS's[5] triple aim for Medicare, Medicaid, and CHIP[6] beneficiaries
- Seeks to test new care delivery models for targeted populations, identify new models of workforce development, and support innovators who can rapidly deploy new care models

$1 Billion
TOTAL GRANT FUNDING AVAILABLE THROUGH THE INNOVATION CHALLENGE

HEALTH CARE ADVISORY BOARD ASSESSMENT

Applicants selected for support will receive substantial grant funding—generally between $1 million and $30 million. For organizations preparing for accountable payment models, this funding may accelerate the care model redesign and workforce deployment strategies needed to ultimately improve quality and reduce costs for high-risk patient populations.

DISRUPTION TO FEE-FOR-SERVICE BUSINESS MODEL

START DATE: CY2012 | PARTICIPATION: V Voluntary

The New Normal for Fee-for-Service

HOSPITAL VALUE-BASED PURCHASING PROGRAM

- Pay-for-performance program creating differential hospital inpatient payment rates based on success against process, outcomes, and patient satisfaction measures
- Holds providers accountable for either absolute success or improvement against established performance measures via withhold/payback structure

1%–2%
TOTAL HOSPITAL INPATIENT MEDICARE PAYMENT AT RISK

HEALTH CARE ADVISORY BOARD ASSESSMENT

Through the program's budget-neutral payment structure, hospitals with superior performance may earn more than their initially withheld reimbursement, profiting from exceptional quality. Given the mandatory nature of the program and significant payment at risk, no hospital can afford to ignore the program's performance standards.

DISRUPTION TO FEE-FOR-SERVICE BUSINESS MODEL

START DATE: FY2013 | PARTICIPATION: M Mandatory

HOSPITAL READMISSIONS REDUCTION PROGRAM

- Reimbursement penalty targeting hospitals with excessive 30-day readmission rates for select clinical conditions
- Initially focuses on heart failure, myocardial infarction, and pneumonia readmissions
- May expand to include additional conditions beginning in FY2015

1%–3%
TOTAL HOSPITAL INPATIENT MEDICARE PAYMENT AT RISK

HEALTH CARE ADVISORY BOARD ASSESSMENT

The program's downside-only design precludes hospitals from earning bonuses for high performance; at best, hospitals can avoid the penalty. Although hospitals successfully reducing readmissions may forgo revenue from prevented admissions, the program's close alignment with other payment reforms amplifies the financial and strategic value of readmission reduction.

DISRUPTION TO FEE-FOR-SERVICE BUSINESS MODEL

START DATE: FY2013 | PARTICIPATION: M Mandatory

HOSPITAL-ACQUIRED CONDITION PENALTY

- Reimbursement penalty targeting hospitals with comparatively more frequent hospital-acquired conditions and infections
- Imposes 1% reimbursement penalty on hospitals in the top quartile of patients with hospital-acquired conditions

25%
SHARE OF HOSPITALS MANDATED TO FACE PENALTY

HEALTH CARE ADVISORY BOARD ASSESSMENT

The relative nature of the penalty poses a major threat to hospitals; regardless of absolute performance, a subset of facilities will always fall in the top quartile of hospital-acquired infections. Forthcoming program rules and regulations will need to clarify critical program details, such as the specific conditions in question, method of comparison, and precise payment structure.

DISRUPTION TO FEE-FOR-SERVICE BUSINESS MODEL

START DATE: FY2015 | PARTICIPATION: M Mandatory

Opportunities to Evolve Beyond Fee-for-Service

BUNDLED PAYMENTS FOR CARE IMPROVEMENT INITIATIVE

- CMMI program offering providers four bundled payment models for treating Medicare fee-for-service beneficiaries
- Models vary by scope of service included, duration, minimum discount required, and use of either prospective or retrospective bundling methodology
- All four models enable hospitals to gainshare with physicians

2%–3%
TYPICAL MINIMUM DISCOUNT RATE REQUIRED BY CMMI

HEALTH CARE ADVISORY BOARD ASSESSMENT

The high degree of program flexibility and newfound legal ability to gainshare with independent physicians make this initiative an attractive option for many organizations. Bundling represents a less dramatic departure from the current hospital business model than utilization risk models and can deliver tangible near-term benefits for participating providers.

DISRUPTION TO FEE-FOR-SERVICE BUSINESS MODEL

START DATE: CY2012 | PARTICIPATION: V Voluntary

MEDICARE SHARED SAVINGS PROGRAM

- Program enabling providers to form ACOs serving Medicare fee-for-service beneficiaries
- Establishes financial accountability for quality and total cost of care for attributed population of beneficiaries
- Offers two tracks: 1) No downside risk but lower bonus potential, and 2) Downside risk but higher bonus opportunity

5,000
MINIMUM NUMBER OF ATTRIBUTED MEDICARE BENEFICIARIES REQUIRED

HEALTH CARE ADVISORY BOARD ASSESSMENT

Revisions in the final rule—especially the improved financial model, simplified quality requirements, and reduced barriers to entry—make this program worthy of reconsideration. Despite updates in the final rule, there is no change in how providers succeed under shared savings; ACOs must manage utilization risk, ensure exceptional quality, and operate under heightened transparency.

DISRUPTION TO FEE-FOR-SERVICE BUSINESS MODEL

START DATE: CY2012 | PARTICIPATION: V Voluntary

PIONEER ACO MODEL

- CMMI program offering an advanced path for providers to form ACOs serving Medicare fee-for-service beneficiaries
- Offers higher financial reward and more flexibility in program design than the Medicare Shared Savings Program
- Intended for organizations with experience managing risk-based payments

50%+
REQUIRED PROPORTION OF REVENUE GENERATED THROUGH OUTCOMES-BASED CONTRACTS BY 2014

HEALTH CARE ADVISORY BOARD ASSESSMENT

Pioneer offers an accelerated track for organizations already functioning as ACOs. Pioneer ACOs will enjoy generous bonus opportunities, but they must eventually migrate to population-based payments for Medicare beneficiaries and generate a majority of their total revenue through outcomes-based contracts. The application process is complete, resulting in 32 Pioneer ACOs.

DISRUPTION TO FEE-FOR-SERVICE BUSINESS MODEL

START DATE: CY2012 | PARTICIPATION: V Voluntary

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1 Sum of 2015 participation decisions does not total 100% due to rounding and adoption in 2011.
2 Results from November 2011 Financial Leadership Council Accountable Care Survey. Respondents likely reflect a disproportionately progressive subset of health systems.
3 Accountable Care Organization.
4 Center for Medicare and Medicaid Innovation.
5 Centers for Medicare and Medicaid Services.
6 Children's Health Insurance Program.

Sources: Center for Medicare and Medicaid Innovation; Centers for Medicare and Medicaid Services; Health Care Advisory Board analysis.

LEARN MORE AT:
advisory.com/HCAB/PaymentPoster