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HEALTH CARE

November 2011 Vol. 7 healthcare@joneswalker.com

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CMS ANNOUNCES TERMS OF BUNDLED PAYMENTS FOR CARE IMPROVEMENT INITIATIVE

On August 23, 2011, the U.S. Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS) announced a new initiative designed to encourage physicians, hospitals and other healthcare providers to work together to better coordinate the provision of care to patients both when they are in the hospital and after they are discharged. To that end, CMS issued a request for applications to participate in its Bundled Payments for Care Improvement Initiative (the Initiative).[1] The Initiative was designed to, "test alternative models for payment to incentivize care redesign; engage and protect beneficiaries; and learn and diffuse best practices, in order to inform potential changes to the Medicare fee-for-service (FFS) program."[2] Through the Initiative, CMS seeks to improve patient care, "through payment innovation that fosters improved coordination and quality through a patient-centered approach."[3] Under the current FFS system, CMS noted that separate FFS payment to numerous providers for a single episode of care may result in the fragmentation of care and the duplication of services, without providing incentives for providers to invest in quality improvement and coordination activities. The Initiative's bundled payments are expected to improve quality of care and lower costs by, among other things, reducing the unnecessary duplication of services and aligning providers' incentives to deliver healthcare services more efficiently.

The Initiative's Request for Applications (RFA) sets forth four broad approaches to bundled payments. A bundled payment refers in this context, to a single, negotiated episode payment of a predetermined amount for all services (physician, hospital and other provider services) furnished during an episode of care. Providers have the flexibility to select conditions to bundle, to develop the healthcare delivery structure, and to determine how payments will be allocated among participating providers. All models require providers to include a discount on Medicare FFS expenditures. Three of the models (Models 1, 2, & 3) involve a retrospective bundled payment arrangement where CMS and the providers would set a target payment amount for a defined episode of care. Specifically, providers would propose a target price, which would be determined by applying a discount to the total costs for a similar episode of care based on historical data

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[1] Bundled Payments for Care Improvement Initiative: Request for Application, 76 Fed. Reg. 53137 (Aug. 25, 2011)

[2] Bundled Payments for Care Improvement Initiative, Request for Application at 2, *available at* http://www.innovations.cms.gov/areas-of-focus/patient-care-models/bundled-payments-for-care-improvement.html.

[3] *Id.*

that has been trended over time and that includes a risk threshold. Providers would be paid under the FFS system but at a negotiated discount. At the end of the episode, total payments would be compared to the target price and participating providers may be able to share in any savings. Under the fourth model (Model 4), CMS would make a single, prospectively determined bundled payment to the hospital that would encompass all services furnished by the hospital, physicians, and other practitioners during an inpatient stay. The hospital would pay the physicians and other practitioners out of the bundled payment.

Retrospective Payment Models

Model 1:

Under Model 1, an episode of care is defined as the inpatient stay in a general acute care hospital. The episode of care will include all Part A services provided to eligible beneficiaries (*i.e.*, all patients who have both Medicare Part A and Part B and for whom FFS is the primary payer), regardless of the MS-DRG. In other words, all eligible beneficiaries who are treated in the participating hospital must be included in the payment model. The Model 1 episode of care also includes hospital diagnostic testing and related therapeutic services furnished by the hospital or an entity wholly owned or wholly operated by the hospital in the three days prior to an eligible beneficiary's admission.

Under Model 1, hospitals must offer a discount to Medicare from the usual Part A hospital inpatient payments. Hospitals must propose the discounted rate, but the amount of the discount is subject to a minimum set rate which will increase over the course of the three-year period. The minimum discount for the first six months is 0 percent, and then increases to 0.5 percent for the second six months, 1 percent in the second year, and 2 percent in the third year.

Under Model 1, claims for acute inpatient hospital stays will continue to be processed under existing Inpatient Prospective Payment System (IPPS) payment rules. The IPPS payments will be reduced by the agreed-upon discount as claims are paid. Physicians will be paid separately for their services under the Medicare Physician Fee Schedule. CMS will monitor the care provided during the episode of care, as well as during the 30-day post hospital discharge period, to sure that aggregate Medicare Part A and Part B spending does not increase as a result of participation in the Initiative. The monitoring will also include measuring expenditures for beneficiaries at non-participating providers. The expenditures during monitored periods will then be compared to a historical baseline payment that has been trended over time and that includes a risk threshold. If the comparison shows that the aggregate Medicare Part A and Part B expenditures for the monitored periods exceed the risk threshold, the hospital must pay Medicare the excess amount. Any internal cost savings achieved by the hospital may, under certain circumstances, be shared with participating providers, physicians, and practitioners. Model 1 arrangements are also subject to certain parameters to ensure that the arrangements promote improved quality and involve significant provider participation, beneficiary protection, and program quality assurance initiatives.

Model 2:

Model 2 extends the episode of care beyond the acute care inpatient hospitalization to include the post-acute care following, and associated with, the acute care episode. Retrospectively adjusted payments will be made for hospital, physician, and post-acute provider services during the episode of care. CMS and the applicant will agree upon the MS-DRGs that will be included in an episode of care and then all beneficiaries admitted to the participating acute care hospital for those MS-DRGs will be included in the Model. Episodes of care under Model 2 will begin with the inpatient hospital admission and will continue through a minimum of 30 days following discharge from the hospital. The episode will include all hospital diagnostic testing and all related therapeutic services furnished in the three days prior to a covered hospital admission by entities wholly owned or wholly operated by the admitting hospital, Part A and Part B services that are furnished during the acute hospital inpatient stay, and Part A and Part B services furnished during a set post-discharge period that are related to the inpatient acute hospital admission. All Part A services for related readmissions, as well as all related Part B services furnished during the post-discharge period, including during related and unrelated readmissions, must be included in the episode. Applicants for Model 2 would propose further definitions of the episode of care, including the length of the episode (discussed in more detail below), identified beneficiaries (identified through MS-DRGs), excluded unrelated Part A services, such as certain unrelated readmissions, and excluded unrelated Part B services.

Model 2 provides two options for defining an episode of care, depending on the length of the episode of care. Under the first option, the episode of care would extend 30 to 89 days following the hospital discharge. Under the second option, the episode of care would extend 90 days or longer following the hospital discharge. Physician and post-acute services furnished during the episode must be included in the episode under either option. Applicants under the first option must offer a minimum 3 percent discount off all included MS-DRGs and other Part A and Part B services within the episode of care. Applicants for the second option must offer a minimum 2 percent discount off all included MS-DRGs and other Part A and Part B services within the episode of care. Applicants will be expected to propose a target price for the episode that includes a single rate of discount on the expected Medicare payments for all included Part A and Part B services.

Under Model 2, claims are paid under the relevant IPPS, Physician Fee Schedule, and post-acute payment system rules and then retrospectively reconciled against the target price. CMS will conduct regular retrospective reconciliations against the target price. If the aggregate FFS payments for included services exceed the target price, the payment must be made to Medicare. This excess amount would include any care furnished by providers who are not participating in Model 2. If the aggregate FFS payments are less than the target price, CMS will pay the difference, which may be shared among the participants, subject to certain requirements. Provider participation in the sharing element of the payment model must be voluntary. Additionally, CMS will monitor the care provided during a 30-day post episode period to sure that aggregate Medicare Part A and Part B spending does not increase as a result of participation in the Initiative. The monitoring will also include measuring expenditures for beneficiaries at non-participating providers. The expenditures during monitored periods will then be compared to a historical baseline payment that has been trended over time and that includes a risk threshold. If the comparison shows that the aggregate Medicare Part A and Part B expenditures for the monitored periods exceed the risk threshold, the awardee must pay Medicare the excess amount.

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Model 3:

An episode of care under Model 3 will involve the post-acute care following an acute inpatient hospital stay, but the initial inpatient hospital stay will *not* be included in the episode. Thus, the episode of care will begin at the initiation of post-acute care services at a skilled nursing facility, inpatient rehabilitation facility, long-term care hospital or home health agency that occurs within 30 days of a beneficiary's discharge from the acute care hospital for an agreed-up MS-DRG. The episode will continue for a minimum of 30 days following the initiation of the episode, but the applicant may choose a longer period of time. The episode will include all Part A and Part B services furnished during the episode, including those furnished during related readmissions. This includes all Part A services for related readmissions, as well as all related Part B services furnished during the episode period, including during both related and unrelated readmissions. Model 3 will apply to all beneficiaries who initiate post-acute care services with a participating provider within 30 days of an inpatient admission for MS-DRGs that have been agreed upon by CMS and the applicant. Applicants would define the episode of care, including the length of the episode, identified beneficiaries (using MS-DRGs), excluded unrelated Part A services such as certain readmissions, and excluded unrelated Part B services.

The target price for the episode of care under Model 3 must include a single rate of discount applied to the expected Medicare Part A and Part B payments for all services included in the episode. Accordingly, applicants are advised to factor expected readmissions, as well as expected outlier payments, into their financial models when proposing the target price. CMS has not yet set a minimum discount rate for Model 3.

Under Model 3, claims for all services will continue to be processed under the relevant physician, post-acute provider, and other provider and supplier payment systems and rules. These claims will be regularly retrospectively reconciled against the target price. If the aggregate FFS payments are less than the target price, the difference will be paid to the awardee and may be shared among the participants, subject to certain requirements. If the aggregate FFS payments exceed the target price, Medicare must be repaid. Additionally, CMS will monitor the care provided during a 30-day post episode period to be sure that aggregate Medicare Part A and Part B spending does not increase as a result of participation in the Initiative. The monitoring will also include measuring expenditures for beneficiaries at non-participating providers. The expenditures during monitored periods will then be compared to a historical baseline payment that has been trended over time and that includes a risk threshold. If the comparison shows that the aggregate Medicare Part A and Part B expenditures for the monitored periods exceed the risk threshold, the awardee must pay Medicare the excess amount.

Prospective Payment Model

Model 4:

Model 4 builds on CMS' ongoing ACE Demonstration expanding to additional geographic areas and clinical conditions (although Model 4 does not include sharing costs with patients as in the ACE Demonstration). The model will provide a single prospectively-administered bundled payment for Part A hospital services and Part B professional services provided during an acute inpatient hospital admission for certain agreed-upon MS-DRGs through discharge. This will include Part A hospital services and Part B professional services for diagnostic and therapeutic services furnished in the three days prior to admission by the hospital or entities wholly owned or wholly operated by the hospital. Additionally, episodes of

care under Model 4 will include Part A hospital services during related readmissions and Part B professional services during related or unrelated readmissions.

Model 4 will apply to all beneficiaries eligible for the episode that are admitted for an agreed-upon MS-DRG at a participating acute care hospital. All physicians and other practitioners who provide care to identified beneficiaries during an episode of care will also be subject to the payment provisions of Model 4. Payments to all physicians and other practitioners who provide care to included beneficiaries will be made through a single bundled payment. Given this, applicants will be expected to provide evidence of active participation by physicians in the Initiative.

CMS and the applicant will agree upon the MS-DRGs, the price for the bundle of services, and the amount of the discount in advance. Applicants must propose a target price for the episode of care that includes a single discount rate of at least 3 percent off the expected Medicare Part A and Part B payments for all hospital facility and professional services furnished during the hospitalization and related readmissions for all beneficiaries with the agreed-upon MS-DRGs. (If the MS-DRG in one that is included in the ACE Demonstration, CMS expects a discount greater than 3 percent.) CMS will make one discounted prospectively-determined payment to the hospital for each episode of care and the hospital will distribute the fee among other providers as appropriate. Physicians would be paid by the hospital for their professional services, which would be the same rate as the FFS payment that would otherwise apply, or could be at another rate agreed to between the providers and physicians, as proposed by the applicant.

If any Part B claims for services furnished during the episode, or other Part A and/or Part B claims for included services (such as for a related readmission), are submitted and paid separately by Medicare, the awardee must repay Medicare for those Medicare expenditures. Additionally, if Medicare Part A and Part B expenditures for identified beneficiaries during a post-episode monitoring period of 30 days post-hospital discharge exceed trended historical aggregate Part A and Part B payment beyond a risk threshold, the awardee must repay Medicare the excess amount. In addition to the bundled payment amount that participating providers will receive from Medicare, beneficiaries will pay a fixed Part B copayment in lieu of standard Part B coinsurance.

With respect to all models, pursuant to section 3021 of the Patient Protection and Affordable Care Act, the Secretary may consider waivers of certain program requirements, including fraud and abuse laws, as may be necessary to develop and implement the Initiative.

Providers may apply to participate in the Initiative by submitting a letter of intent followed by an application. Applicants must submit detailed information regarding how they would implement the various requirements of the Initiative. For example, applicants must include information such as a description of how the proposal will protect beneficiaries, how it will ensure beneficiaries have complete freedom of choice, the rationale for excluded services, identification of participating providers, letters of agreement from participating providers, descriptions of the terms of any gainsharing arrangements, descriptions of actions that will result in increased efficiency and reduced spending, and evidence of success and readiness to proceed with the Initiative.

Providers who wish to participate in Models 2, 3, or 4 may request historical data from CMS that will assist with preparing proposals, including developing robust episode definitions and discounts. Providers desiring this data must

submit a research request packet that provides specific information about the study design, including how the provider plans to use the data to construct an episode definition and develop care episode redesign protocols. Additionally, applicants requesting data must submit a Data Use Agreement, which should be based on a template provided by CMS.

CMS expects applicants for all models to include care redesign and enhancements such as reengineered care pathways using evidence-based medicine, standardized care using checklists, and care coordination. Applications must identify a single entity, such as a hospital, health system, or physician hospital organization, which will accept financial responsibility to Medicare, demonstrate the necessary partnerships between the awardee and its participating providers, and demonstrate the awardee's ability to bear the financial risk to be undertaken.

Approved participants will be required to provide various data to CMS and its contractors to allow for monitoring and evaluation of the program, including data related to cost savings, incentive payments, clinical quality, patient experience of care, and readmission rates.

As part of its announcement, CMS stated that it is looking for providers who, "are committed to using bundled payments as a tool towards redesigning care to achieve three-part aim outcomes." CMS will consider a wide range of criteria in order to determine which proposals to accept for participation in the Initiative, including the number of conditions covered by a proposal, the number of beneficiaries covered by a proposal, the amount of savings offered to Medicare, proposed participation by other payors, and the applicant's ability to implement the Initiative on an aggressive timeline. CMS states it will give preference to providers who meet certain other standards, such as providers who are "meaningful users" of health information technology, providers who propose episodes of care of longer than 30 days for Models 2 and 3, and providers with high rates of physician participation in the Physician Quality Reporting System.

Letters of intent for participation under Model 1 must have been submitted by October 6, 2011, with the completed application due by November 18, 2011. Letters of intent and requests for historical data for Models 2, 3, or 4 must be submitted by November 4, 2011, with completed applications due by March 15, 2012.

Agreements with approved participants will have a performance period of three years, with the possibility of a two-year extension.

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JONES WALKER PRESENTS FLORIDA HEALTH CARE SEMINAR

Join us on November 17 in Hollywood, Florida, as we present "***Recent Health Care Trends from a Legal and Compliance Perspective***," another popular Jones Walker Health Care Seminar targeted to health care organizations and their key personnel, such as executives, counsel, compliance officers, and auditors. This seminar will comprise six sessions of topics, including legal issues with physician arrangements and other referral sources; readmissions, quality reporting, and payment models; and enforcement trends. We are pleased to announce that due to newly released federal guidance, we are offering a new session on "***Accountable Care Organizations—Key Legal and Operational Issues Under New Federal Guidance***."

Jones Walker attorneys **Lynn M. Barrett**, **David G. Radlauer**, and **Myla R. Reizen** will be presenting. Additional speakers include **Mark Lavine,** Assistant U.S. Attorney for the Southern District of Florida, **Kathy Reep** of the Florida Hospital Association, **Tim Renjilian** of FTI Consulting, and **Elizabeth White** of Shands HealthCare.

For more information or to register for this seminar, please click here to view the seminar brochure.

Space is limited, so please e-mail Nicole Csintyan or call 504.582.8456 for more information or to register for this program today.

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