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Health Care
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August 26, 2011

CMS Bundled Payment Initiative Represents Opportunity to Participate in New Models of Care

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The Centers for Medicare & Medicaid Services (CMS) announced on August 23 a new Bundled Payment Initiative designed to help improve care for patients during their hospital stays and after they have been discharged and reduce Medicare expenditures. The Initiative is another attempt by Medicare to incentivize providers by giving them an opportunity to have some "skin in the game." Authorized by the Patient Protection and Affordable Care Act, the Initiative provides for four broadly defined models of care in which providers or conveners of providers work together by linking payments for multiple services that patients receive during an episode of care. The Initiative is intended to provide hospitals, physicians and health care organizations with new incentives to coordinate care, improve quality of care, deliver services more efficiently and generate savings under the Medicare program.

Eligible Applicants

The Initiative may be of interest to many health care providers who participate in Medicare and wish to partner across specialties and settings to improve the patient experience of care during a hospital stay. Depending upon which of the four models of payment the applicant chooses, physician group practices, acute care hospitals, health systems, long term care hospitals, inpatient rehabilitation facilities, skilled nursing facilities, home health agencies, physician hospital organizations, and conveners of participating health care providers are eligible to apply.

Description of Models

Three of the models involve retrospective bundled payment arrangements with a target price for a defined episode of care. Model 1 defines the episode of care as the inpatient stay in an acute care hospital. Model

2 addresses an inpatient stay and post-acute care ending either a minimum of 30 days or 90 days after discharge (at the applicant's option). Model 3 defines the episode of care as beginning at discharge and ending no sooner than 30 days after discharge.

Model 4 involves a single prospective payment to encompass all services furnished during an inpatient stay by a hospital, physicians and other health care practitioners. Applicants may also include gainsharing arrangements in the proposals. Attached is an appendix from the CMS Fact Sheet comparing the key features of the models.

Timelines

For Model 1, a nonbinding Letter of Intent (LOI) is due on September 22, 2011 and the Application is due on October 21, 2011. For Models 2-4, the nonbinding LOI is due on November 4, 2011 and the Application is due on March 15, 2012. CMS is making historical Medicare claims data available to applicants for Models 2-4. Applicants that wish to receive such claims data must complete a Research Request Packet by November 4, 2011. Applicants for Models 2-4 also must execute a Data Use Agreement limiting the applicants' use of CMS provided data. That Agreement is also due November 4, 2011.

Organizational Issues

Each of the Models contemplates the creation of legally binding arrangements among the participating providers. In the agreements, providers must agree to participate in the model contemplated. Participating providers will have to commit to participation for a specified period of time and agree to engage in developing evidenced-based tools and methods for patient involvement in their care, coordination of care and care transitions. An organization that is awarded a contract is obligated to coordinate any distribution of gains among participating organizations resulting from care improvement under the Initiative. Participating providers must also commit to repay to Medicare the amount by which aggregate Medicare Part A and Part B expenditures for included beneficiaries during the episode and post-episode monitoring period exceed trended baseline historical payments.

Applicants must provide detailed descriptions of cost-saving, quality improvement, quality assurance and patient protections built into their programs. Applicants must also provide detailed descriptions of gainsharing arrangements associated with the program, including gainsharing pay for performance experience of all participants, how best practices and norms will play a part in gainsharing payments, how gainsharing will support care improvement, what safeguards will be in place to ensure medically necessary care is not reduced to achieve savings and the metrics to be utilized for quality, patient safety, patient experience and efficiency improvements. Applicants will be required to disclose the proportion of gains that would be shared and how and when that sharing would take place and also demonstrate the gainsharing payments will not be excessive.

In Model 1, for example, Applicants must offer an escalating discount to the Medicare program of at least 2% for year three of the program. In Model 2, discounts can be either 2% or 3%, depending on options the applicant elects. Model 3 does not set a minimum discount and Model 4 specifies a 3% minimum discount. To back up the obligation to repay excess amounts to Medicare, applicants that are conveners of providers are required to post a letter of credit for CMS's benefit to secure the conveners' obligation to pay.

For more information, please contact a member of Pillsbury's health care group, the Pillsbury attorney with whom you usually work, or the authors below:

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Appendix

Bundled Payments for Care Improvement Initiative
Key Features of Bundled Payment Models Compared*

Feature / Model	Model 1 – Inpatient Stay Only	Model 2 – Inpatient Stay Plus Post-Discharge Services	Model 3 – Post-discharge Services Only	Model 4 – Inpatient
Eligible Awardees	▪ Physician group practices ▪ Acute care hospitals paid under the IPPS ▪ Health systems ▪ Physician-hospital organizations ▪ Conveners of participating health care providers	▪ Physician group practices ▪ Acute care hospitals paid under the IPPS ▪ Health systems ▪ Physician-hospital organizations ▪ Post-acute providers ▪ Conveners of participating health care providers	▪ Physician group practices ▪ Acute care hospitals paid under the IPPS ▪ Health systems ▪ Long-term care hospitals ▪ Inpatient rehabilitation facilities ▪ Skilled nursing facilities ▪ Home health agency ▪ Physician-hospital organizations ▪ Conveners of participating health care providers	▪ Physician group practices ▪ Acute care hospitals paid under the IPPS ▪ Health systems ▪ Physician-hospital organizations ▪ Conveners of participating health care providers
Payment of Bundle and Target Price	Discounted IPPS payment; no separate target price	Retrospective comparison of target price and actual FFS payments	Retrospective comparison of target price and actual FFS payments	Prospectively set payment
Clinical Conditions Targeted	All MS-DRGs	Applicants to propose based on MS-DRG for inpatient hospital stay	Applicants to propose based on MS-DRG for inpatient hospital stay	Applicants to propose based on MS-DRG for inpatient hospital stay
Types of Services Included in Bundle	Inpatient hospital services	▪ Inpatient hospital and physician services ▪ Related post-acute care services ▪ Related readmissions ▪ Other services defined in the bundle	▪ Post-acute care services ▪ Related readmissions ▪ Other services defined in the bundle	▪ Inpatient hospital and physician services ▪ Related readmissions

Feature / Model	Model 1 – Inpatient Stay Only	Model 2 – Inpatient Stay Plus Post-Discharge Services	Model 3 – Post-discharge Services Only	Model 4 – Inpatient
Expected Discount Provided to Medicare	To be proposed by applicant; CMS requires minimum discounts increasing from 0% in first 6 mos. to 2% in Year 3	To be proposed by applicant; CMS requires minimum discount of 3% for 30-89 days post-discharge episode; 2% for 90 days or longer episode	To be proposed by applicant	To be proposed by applicant; subject to minimum discount of 3%; larger discount for MS-DRGs in ACE Demonstration
Payment from CMS to Providers	▪ Acute care hospital: IPPS payment less pre-determined discount ▪ Physician: Traditional fee schedule payment (not included in episode or subject to discount)	Traditional fee-for-service payment to all providers and suppliers, subject to reconciliation with predetermined target price	Traditional fee-for-service payment to all providers and suppliers, subject to reconciliation with predetermined target price	Prospectively established bundled payment to admitting hospital; hospitals distribute payments from bundled payment
Quality Measures	All Hospital IQR measures and additional measures to be proposed by applicants	To be proposed by applicants, but CMS will ultimately establish a standardized set of measures that will be aligned to the greatest extent possible with measures in other CMS programs		

*Source: CMS Fact Sheet, Bundled Payments for Care Improvement Initiative, Appendix (August 23, 2011)