

# Latest Accountable Care Act Initiative: Bundled Payments for Care Improvement

**September 19, 2011**

*Don't miss the first deadline of September 22, 2011 to apply for one of the four voluntary Bundled Payment Programs.*

In another attempt to encourage the health care industry to try methods of payment that are patient-centric and provide incentives for efficient care, the U.S. Department of Health & Human Services' Centers for Medicare & Medicaid Services (CMS) is seeking applications from providers to participate in one or more models of bundling Medicare payments through the Bundled Payments for Care Improvement Initiative. Bundled payment, or episode-based payment, reimburses multiple providers (hospitals, physicians, and post-acute care) in a single, comprehensive payment that covers all of the services involved in the patient's care. An "episode" can take many forms, from a single rate for all services relating to a particular procedure, combining hospital care and post-acute care, to all treatment associated with a chronic condition for a defined period of time.

The new bundled payment program is established under the Center for Medicare and Medicaid Innovation's (CMMI) authority under the 2010 Affordable Care Act (ACA).<sup>[1]</sup> Unlike the Accountable Care Organization (ACO) program, the bundled payment program is not specifically provided for in the ACA. Instead, the ACA created CMMI with broad authority to establish different payment programs. CMMI is encouraging providers to be creative in determining which episodes of care and which services should be bundled together to achieve the goal of reducing Medicare program expenditures while maintaining or improving care for beneficiaries. The first three bundled payment models are retrospective payments arrangements. CMS and providers would agree to a target payment amount which would be set by applying a discount to the total costs for a similar episode of care as determined from historical data. According to an FAQ released by CMS on August 23, 2011, CMS's methodology for trending target prices will be determined after the applications are received and applicants should use data from calendar year 2009 as a guide. Bundled Payment Initiatives participants are paid for their services under the traditional fee-for-service (FFS) system. After the conclusion of the episode, the total payments are compared with the target payment amount and if there are savings, the applicant receives a share of the savings.

The fourth model is prospective. CMS makes a single bundled payment to the hospital for all services furnished during the inpatient stay by the hospital physicians and other practitioners.

Below is a summary of the four models:

- **Model 1:** The episode of care is defined as the inpatient stay in the general acute care hospital. Medicare pays the hospital a discounted amount based on the established Inpatient Prospective Payment System. The discount rate imposed by the program starts at 0% in the first six months and then rises to a minimum of 2% in the third year. Physicians are paid separately for services under the Medicare Physician Fee Schedule. The hospital and physicians are able to share in any savings achieved.
- **Model 2:** The episode of care includes the inpatient stay and post-acute care for at least 30 or 90 days after discharge. The applicant selects the length of time after discharge. The bundle payment includes physicians' services, care by a post-acute provider, related readmissions, and other services proposed in the episode definition such as clinical laboratory services; durable medical equipment, prosthetics, orthotics and supplies; and Part B drugs. The minimum discount to CMS

is 3% for the 30- to 89-day period after discharge and 2% for 90 days and beyond. If the total payments are less than the target price which was set by the applicant, then the applicant shares in the savings. However, if total payments exceed the target price, the provider will be responsible for paying the overage to CMS.

- **Model 3:** The episode of care begins at discharge from the inpatient stay and ends no sooner than 30 days after discharge. The bundle payment is the same as Model 2 with the exception of the discount rate. The applicant is required to set the discount rate instead of CMS.
- **Model 4:** Under the final model, CMS makes a single, prospectively determined bundled payment to the hospital that would encompass all services furnished by the hospital, physicians and other practitioners. "No pay" claims are submitted by the physicians and practitioners during the inpatient stay to Medicare for record-keeping purposes. The minimum discount to CMS would be 3% of the projected total costs for the episode of care.

CMS's Bundled Payment Initiative anticipates applicants to have experience with cross-provider care improvement efforts and either have already begun to redesign care or are prepared to redesign care and enter into payment arrangements that include financial and performance accountability for episodes of care. For all models, CMS will give preference to applicants who are meaningful users of health information technology or who have a minimum of 50% of their providers meeting the standards for meaningful use, and will attempt to achieve geographic diversity. There is no limit on the number of applicants who can be approved.

Participants in the Bundled Payment Initiative must include a strict quality monitoring program that includes quality measures, internal monitoring, and quality improvement protocols. CMS will monitor all participating providers to ensure that the quality of care is at least the same as, if not better than, it was prior to the Initiative. CMS may terminate provider participation in the initiative if the quality of care decreases or there are other significant beneficiary concerns.

CMS is allowing for considerable flexibility for applicants to achieve the goals of the Bundled Payments Initiatives. In response to questions by interested applicants, CMS updated the FAQ on September 9, 2011 to include a discussion on gainsharing. The Secretary of Health and Human Services will consider exercising its waiver authority with respect to the fraud and abuse laws as may be necessary to develop and implement the Bundled Payment Initiative.

Applicants interested in participating in the Bundled Payments Initiative must submit a non-binding letter of intent no later than September 22, 2011 for Model 1, and November 4, 2011 for Models 2 - 4. CMMI's Web site provides a form for the Model 1 letter of intent and applications for all four models.

### **Past ACO Models and Initiatives**

CMS first encouraged health care providers to create and join ACOs in CMS's proposed rule to implement the Medicare Shared Savings Program. In March 2011, HHS, along with the Federal Trade Commission, the Department of Justice and the Internal Revenue Service released guidance describing how an ACO can qualify, and how the agencies will approach the legal issues within their respective jurisdictions raised by ACOs. CMS's Medicare Shared Savings Program and agency guidance are more fully discussed in Proskauer's *prior* client alert dated April 5, 2011: [Long Awaited Guidance on Accountable Care Organizations Issued](#).

After facing significant criticism about the initial ACO regulations, CMS announced three new ACO initiatives on May 17, 2011: (1) a new "Pioneer Accountable Care Organization" Program; (2) an Advance Payment Initiative to pre-pay a portion of future ACO savings; and (3) a set of ACO Accelerated Development Learning Sessions. Each of these initiatives are more fully described in Proskauer's *prior client* alert dated May 20, 2011: [Renewed Federal Effort to Promote Accountable Care Organizations](#). By way of summary, the Pioneer Model is designed for health care organizations and providers that are "mature" and have already begun coordinating care for patients. The Pioneer Model is complementary to, but separate from, the Medicare Shared Savings Program. It provides more flexibility for the program beneficiaries to align prospectively rather than retrospectively. The Advance Payment Initiative was in response to concerns by health care organizations and providers that lack capital to invest in the required infrastructure for coordinating care. The Advance Payment Initiative was an attempt by CMS to see whether they should provide certain ACOs participating in the Medicare Shared Savings Program up-front access to their potential shared savings. Finally, the ACO Accelerated Development Learning Sessions was an attempt by CMS to educate, guide and encourage leaders of health care delivery organizations interested in forming an ACO.

The Bundled Payments for Care Improvement Initiative provides great flexibility for providers to design and propose programs for Medicare patients. For example, unlike the ACO program, no separate legal entity is required. A wide array of providers – including long-term care providers and home health agencies – may be interested in exploring this program.

*If you have any questions about the Bundled Payment Initiative, CMS's other initiatives or ACOs, please contact Ryan P. Blaney, or a member of Proskauer's Health Care Group.*

[\[1\]](#) The "Affordable Care Act" means The Patient Protection and Affordable Care Act ("PPACA") and the Health Care and Education Reconciliation Act of 2010 ("HCERA").