HEALTH REFORM: CMS Innovation Center Announces Four Models in Bundled Payments for Care Improvement Initiative

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On August 23, 2011, the Centers for Medicare & Medicaid Services ("CMS") Innovation Center announced a new initiative to encourage health care providers to better coordinate patient care.[1] The Bundled Payments for Care Improvement Initiative ("Bundled Payments Initiative") seeks to align the financial incentives among hospitals, physicians, and non-physician practitioners through the use of a single negotiated payment for all services provided during an episode of care. The use of a bundled payment is expected to encourage hospitals, doctors, and other specialists to coordinate in treating a patient's specific condition during a single hospital stay and recovery.

This is one of several new initiatives from the CMS Innovation Center intended to change the existing Medicare payment structure from one that pays for the quantity of care to one that pays for the quality of care. Participation in the Bundled Payments Initiative may serve as a first step for forming partnerships to improve care coordination and encourage participants to move into initiatives aimed at improving population health.

The Bundled Payments Initiative is separate from the Medicare National Pilot Program on Payment Bundling, established under Section 3023 of the Patient Protection and Affordable Care Act.[2] The Section 3023 pilot is a five-year program that must be established by January 1, 2013. While the statute outlines certain parameters for the Section 3023 pilot around the establishment of "episodes of care" based on medical conditions chosen by the Secretary of Health and Human Services and a specified time period for inclusion in the bundle, in the Bundled Payments Initiative, the CMS Innovation Center has allowed for more flexibility for providers to determine how their payment bundles and episodes of care will be structured.

The Bundled Payments Initiative is focused on an episode-based payment for acute care and/or associated post-acute care. Under this initiative, CMS will link payments for multiple services a patient receives during an episode of care. Participating organizations will propose a target price for an episode of care, which will be set by applying a discount to the total costs for a similar episode of care as determined from historical Medicare claims data.

The Bundled Payments Initiative includes four broadly defined models of care. Three of the models involve a retrospective bundled payment arrangement while the fourth

model involves a prospective bundled payment arrangement. In the retrospective payment arrangements, the participating organization will be paid for the services provided under the traditional fee-for-service system, but at a negotiated discount. At the conclusion of a patient's episode of care, the total payments will be compared with the target price. If total payments are below the targeted price, the participating organization may share the savings with participating providers. However, if total payments exceed the discounted price, the participating organization will be required to remit the difference to CMS. In the prospective payment arrangement, the participating organization will be paid a single prospective bundled payment for the episode of care.

Within each broadly defined model of care, participating organizations have great flexibility in determining which conditions and services are bundled and how payments will be allocated among participating providers. In addition, participating organizations may suggest and develop their own health care delivery structures for each condition.

Overview of the Four Models

	Model 1	Model 2	Model 3	Model 4
"Episode of Care"	All hospital services provided to a Medicare patient during an acute inpatient hospital stay	Services provided during a patient's inpatient hospital stay and services provided after discharge (either 30 or 90 days)	Services provided after discharge from an acute inpatient hospital stay (at least 30 days)	All services furnished during an inpatient hospital stay
Method of Payment	Retrospective bundled payment	Retrospective bundled payment	Retrospective bundled payment	Prospective bundled payment
Diagnosis-Related Groups ("DRGs") Included in the Episode of Care	All DRGs may be included, but participants can choose to focus on certain conditions	Organizations must indicate which DRGs will be included in the episode of care; the bundle may include inpatient hospital and physician services, related post-acute	Organizations must indicate which DRGs will be included in the episode of care; the bundle may include post-acute care provider services, related readmissions, and other	Organizations must indicate which DRGs will be included in the episode of care; the bundle may include inpatient hospital and physician services and

		provider care services, related readmissions, and other Medicare-covered services[3]	Medicare-covered services	related readmissions
Expected Discount to Medicare	Minimum discount of 0 percent in the first six months, 0.5 percent in months seven through 12, 1 percent in the second year, and 2 percent in the third year	Minimum discount of 3 percent for episodes that include a post-discharge period of 30 to 89 days and a minimum discount of 2 percent for 90-day or longer episodes	CMS has not indicated an expected discount for services	Minimum discount of 3 percent; a larger discount may apply for DRGs included in the ACE Demonstration
Participating Providers	Physician group practices, acute care hospitals paid under the IPPS, health systems, physician-hospital organizations, and conveners of participating health care providers[4]	Physician group practices, acute care hospitals paid under the IPPS, health systems, physician-hospital organizations, post-acute providers, and 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 agencies, physician-hospital organizations, and conveners of participating health care providers	Physician group practices, acute care hospitals paid under the IPPS, health systems, physician-hospital organizations, and conveners of participating health care providers

Application Process and Deadlines

Participation in the initiative will be awarded through a competitive bidding process. In order to be considered for the initiative, organizations must submit an initial non-binding letter of intent to CMS. Those organizations that submit an application without first submitting a letter of intent will not be considered. Letter of intent forms and applications for all of the models are available on the CMS Innovation Center website at http://innovations.cms.gov/areas-of-focus/patient-care-models/Bundled-Payments-%20Care-Improvement-Application.html.

Model 1 – Organizations interested in participating in Model 1 must submit, by email, a non-binding letter of intent to CMS no later than October 6, 2011, at 5:00 p.m. EDT. Applications for Model 1 must be received by CMS no later than 5:00 p.m. EDT on November 18, 2011.

Models 2, 3, and 4 – Organizations interested in participating in Models 2 through 4 must submit, by email, a non-binding letter of intent to CMS no later than November 4, 2011, at 5:00 p.m. EDT. Applications for Models 2 through 4 must be received by CMS no later than 5:00 p.m. EDT on March 15, 2012.

To assist organizations interested in Models 2, 3, and 4, CMS will provide historical de-identified Medicare claims data for use in determining episode of care definitions to organizations that complete a research request packet and data use agreement.[5] The completed research request packet and data use agreement must be submitted by email with the organization's letter of intent and are due by 5:00 p.m. EDT on November 4, 2011. The historical data will be provided for approved requests before the application is due.

Organizations interested in participating in more than one of Models 2, 3, and 4 should only submit one letter of intent and one research request packet and data use agreement. A data use agreement signature addendum is only needed if all of the proposed data users cannot fit on the main data use agreement form.[6]

Overlap with Medicare Shared Savings Program and Other Initiatives

At this time, CMS encourages providers participating in the Medicare Shared Savings Program, the Pioneer ACO Model, medical home initiatives, and other shared savings initiatives to apply for and participate in the Bundled Payments Initiative. CMS has indicated that it will review each application in light of all initiatives an applicant is participating in.[7] Additionally, CMS may require organizations that participate in more than one initiative to fulfill additional requirements or modify program parameters. Finally, CMS has reserved the right to ultimately eliminate participation in multiple programs.

Conclusion

The Bundled Payments Initiative appears to provide more flexibility and choices for organizations interested in exploring shared savings than earlier proposals, including the Shared Savings Program and the Pioneer ACO Model. The initiative allows applicants to design their own programs to meet local needs rather than establishing a single, nationwide model. Each organization may determine the conditions, length of an episode of care, target price, discount provided, and other components that will best suit the organization's needs. In addition, the Bundled Payments Initiative may cover multiple providers in multiple care delivery settings. For interested organizations, this may be a good opportunity to look at redesigning care delivery and forming partnerships with other providers in order to share in savings achieved from these care coordination efforts.

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For more information about this issue of IMPLEMENTING HEALTH AND INSURANCE REFORM, please contact one of the authors below or the member of the firm who normally handles your legal matters.

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ENDNOTES:

[1] Two days after announcing the pilot program, CMS published a notice announcing a request for applications for organizations to participate in the initiative. CMS Bundled Payments for Care Improvement Initiative: Request for Applications, 76 Fed. Reg. 53,137 (Aug. 25, 2011).

[2] Pub. L. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152).

[3] Examples of "other Medicare-covered services" include clinical laboratory services; durable medical equipment, prosthetics, orthotics, and supplies; and Part B drugs.

Centers for Medicare & Medicaid Services, Bundled Payments for Care Improvement Initiative Fact Sheet (Aug. 23, 2011), *available at* http://innovations.cms.gov/documents/pdf/Fact-Sheet-Bundled-Payment-FINAL82311.pdf.

[4] A convener is defined as "an entity that can bring together multiple participating health care providers, such as a state hospital association or a collaborative of providers." Center for Medicare & Medicaid Innovation, Bundled Payments for Care Improvement Initiative Request for Application 39 (Aug. 22, 2011), *available at* http://innovations.cms.gov/documents/payment-care/Request_for_Applications.pdf.

[5] The Research Request Packet and Data Use Agreement are available on the CMS Innovation Center website at http://innovations.cms.gov/areas-of-focus/patient-care-models/Bundled-Payments-%20Care-Improvement-Application.html.

[6] The Addendum is also available on the CMS Innovation Center website at http://innovations.cms.gov/areas-of-focus/patient-care-models/Bundled-Payments-%20Care-Improvement-Application.html.

[7] Center for Medicare & Medicaid Innovation, Bundled Payments for Care Improvement Initiative Frequently Asked Questions (Aug. 23, 2011), *available at* http://www.innovations.cms.gov/documents/payment-care/Bundled%20Payment%20CMS%20Technical%20FAQ%20FINAL%208_25.pdf.