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Client Alert

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CMS Announces Bundled Payments for Care Improvement initiative in Effort to Save Money and Improve Care

On August 23, 2011, the Center for Medicare & Medicaid Services (CMS) announced its new Bundled Payments for Care Improvement Initiative as a means by which providers may apply to enroll in and help test four different models of bundling payments for acute care services. The Initiative was created by the Affordable Care Act and is intended to better align incentives among hospitals, physicians and other providers for an entire episode of care. An objective of such bundled payment programs is to reward the simultaneous delivery of high quality and low cost care.

The application and design process is significant, but the three-year program may be particularly attractive to providers who have prior experience and success with physician alignments and prior experience with and the ability to bear financial risk. Participation in the Initiative may be a valuable step for providers who are interested in developing greater care integration among providers and providing accelerated competitive delivery services, but who are not currently interested in other possible options, such as employment or development of an accountable care organization.

Specific Models—Varying Payment Systems

The Initiative applies to four specific models of bundling payments—all of which are designed to address particular participant-defined episodes of care. Providers may propose to participate in more than one model. The broad components of the model follow and all include some aspect of risk sharing by way of repayment obligations by the participating providers:

1. **Model 1: Only the acute care hospital stay (retrospective payment).** Under this model, the payment to the hospital will reflect an agreed upon discount for Part A hospital inpatient services. Participating parties will be required to report, and CMS will monitor a defined set of quality metrics. Medicare Part A and Part B payment performance will be monitored by CMS, both during and after the defined episode. To the extent that payments (both during the episode and after the episode) exceed historical payments above an established risk threshold, the difference must be repaid by the participating party. Eligible participating parties include physician group practices, acute care hospitals, health systems, physician hospital organizations and conveners of participating healthcare providers.

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2. **Model 2: The acute care hospital stay plus associated post-acute care (retrospective payment).**
This model includes both hospital acute care services and post-acute care associated with the particular episode. This model may be applied to specific episodes defined under two scenarios: a) the end of the episode is measured as a minimum of 30 days post-hospital discharge and a maximum of 89 days post-hospital discharge; or b) a minimum of 90 days post-hospital discharge. Scenarios under the first option must provide a minimum 3 percent discount against all included MS-DRGs and other Part A and Part B services within the episode. Scenarios under the second option must provide a minimum 2 percent discount (the lower discount corresponds to the longer risk period under the second scenario). If the fee for service payments during the episode are less than the agreed upon target price, Medicare will pay the difference to the participant. If the payments exceed the agreed upon target price, then the participant must pay Medicare. In addition, Medicare Part A and Part B payments will be monitored for the agreed upon period following the episode. If the payments exceed an agreed upon risk threshold, the participant will be required to pay the difference to Medicare. Eligible participating parties include acute care hospitals, health systems, post-acute providers, physician hospital organizations, physician group practices and conveners of participating healthcare providers.

3. **Model 3: Only the post-acute care services (retrospective payment).**
This model includes only post-acute care provided following an acute care hospital stay. Though definition of the episode is up to the participant, the "anchor" of the episode will be the initiation of post-acute care services at a skilled nursing facility, inpatient rehabilitation facility, long term care hospital or a home health agency, within 30 days of the discharge from an acute care hospital. The length of the episode will be defined by the participant, but must be at least 30 days. As with model 2, if the fee for service payments during the episode are less than the agreed upon target price, Medicare will pay the difference to the participant. If the payments exceed the agreed upon target price, then the participant must pay Medicare. In addition, Medicare Part A and Part B payments will be monitored for the agreed upon period following the episode. If the payments exceed an agreed upon risk threshold, the participant will be required to pay the difference to Medicare. Eligible participating parties include acute care hospitals, health systems, post-acute providers, physician hospital organizations, physician group practices, conveners of participating healthcare providers, long-term care hospitals, inpatient rehabilitation facilities, skilled nursing facilities and home health agencies.

4. **Model 4: A single prospective payment that encompasses all services delivered during an inpatient stay (prospective payment).**
This model is an expansion of the existing ACE Demonstration. The episode will begin upon the admission of a patient for a defined episode and continue through discharge, and will include related readmissions. The episode will include Part A and Part B services. Under model 4, payment for the services will be made prospectively, and will include costs for any readmissions. Following the episode, costs incurred by Medicare above an agreed upon risk threshold will be paid by the participant. Eligible participating parties include acute care hospitals, health systems, post-acute providers, physician hospital organizations, physician group practices and conveners of participating healthcare providers.

The design specifics (e.g., discounts, quality metrics and episodic definitions) of each applicant's model proposal(s) are largely left to each individual applicant; however, the expected discount to be provided to Medicare as a result of an applicant's model is between 0 percent and 3 percent over the three-year period of the Initiative.

The Bundled Payments Initiative is Open to Gainsharing

Under all of the four models, the participants may elect to include a gainsharing component as a means of sharing payments based upon improvements in efficiency and quality. The Initiative specifically identifies several design, quality and payment methodology requirements—largely focused on ensuring that the quality of care is improved or remains consistent and to protect against inappropriate changes in referral or utilization patterns, and general fraud and abuse.

Applicable Deadlines

Providers who wish to participate in model 1 must submit a letter of intent to CMS no later than September 22, 2011, and a completed application no later than October 21, 2011. The letter of intent is non-binding.

Providers who wish to participate in models 2–4 must submit a letter of intent to CMS no later than November 4, 2011, and a completed application no later than March 15, 2012. As with model 1, the letter of intent is non-binding.

For more information, please see the information page provided by CMS Center for Innovation by clicking here.[1]

1 http://www.innovations.cms.gov/areas-of-focus/patient-care-models/bundled-payments-for-care-improvement.html#