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IMPLEMENTING HEALTH AND INSURANCE REFORM:
Opportunities & Challenges for Your Organization

HEALTH CARE & LIFE SCIENCES

Thought Leaders in Health Law®

November 3, 2011

Health Care Innovation in the Medicare Program: Value-Based Initiatives Beyond Accountable Care Organizations

IMPORTANT DATES

Important Dates for Bundled Payments for Care Improvement Program

Deadline for Submitting Nonbinding Letters of Intent:
Model 1—October 6, 2011
Models 2, 3, and 4—November 4, 2011

Deadline for Submitting Research Request Packets and Data Use Agreements:
Models 2, 3, and 4—November 4, 2011

Deadline for Submitting Applications:
Model 1—November 18, 2011
Models 2, 3, and 4—March 15, 2012

Important Dates for Innovation Advisors Program

Deadline for Submitting Applications:
November 15, 2011

Important Dates for Comprehensive Primary Care Initiative

Deadline for Submitting Nonbinding Letters of Intent:
November 15, 2011

Deadline for Submitting Completed Geographic Service Area Worksheets:
November 15, 2011

Deadline for Submitting Applications:
January 17, 2012

As the health care industry analyzes the recently released final rule and related guidance regarding the Medicare Shared Savings Program ("MSSP") for accountable care organizations ("ACOs") (see Epstein Becker Green's *Implementing Health and Insurance Reform* alert of October 27, 2011, here), it is important for the industry to also pay attention to key deadlines related to initiatives being implemented by the Center for Medicare and Medicare Innovation ("CMMI" or "Innovation Center") within the Centers for Medicare & Medicaid Services ("CMS").

By way of background, the MSSP is being implemented under the Center for Medicare within CMS. The Innovation Center is a new center organized under CMS, and has a different mission, organizational structure, and leadership than the Center for Medicare. The Innovation Center was created under the 2010 Patient Protection and Affordable Care Act ("ACA") to test innovative payment and service delivery models to reduce program costs, while also preserving the quality of care for Medicare, Medicaid, and CHIP beneficiaries. Funding in the amount of $10 billion already was provided to the Innovation Center through fiscal year 2019.

While the MSSP ACO initiative is a permanent Medicare program, CMMI is developing and promoting other initiatives—some related to the MSSP, others not—which should be part of any provider's considerations related to the "Medicare Menu" of options now available to customize an entity's Medicare payment methodologies. This alert will address a number of key Medicare initiatives currently under way at the Innovation Center and another to be implemented by the Center for Medicare within CMS. Please pay attention to the highlighted deadlines, especially those

occurring in November 2011. A table has been included at the end of the alert to provide a snapshot of some of the programs and initiatives that have been launched in the past year.

Bundled Payments for Care Improvement

In late August 2011, CMS announced an initiative to help improve care for patients while they are in the hospital and after discharge. The Bundled Payments for Care Improvement initiative is being launched by CMMI. Physicians, hospitals, and other health care providers can now apply to participate in this initiative pursuant to the ACA. Bundled payments will give doctors and hospitals new incentives to coordinate care, improve the quality of care, and save money for Medicare.

The Bundled Payments for Care Improvement initiative is seeking applications for four defined models of care. The first three models are retrospective bundled payment arrangements with a target payment amount for a defined episode of care. The fourth involves prospective payment in which CMS would make a single predetermined bundled payment to a hospital for all care. Providers will have the flexibility to determine which episodes of care and which services will be bundled together.

Model 1

The "episode of care" would be defined as the inpatient stay in a general acute care hospital. Medicare will pay the hospital a discounted amount based on the payment rates established under the Medicare Inpatient Prospective Payment System. Medicare will pay physicians separately for their services under the Medicare Physician Fee Schedule. Hospitals and physicians will be permitted to share gains that arise from better coordination of care.

Model 2

The episode of care would include the inpatient stay and post-acute care. The bundle would include physicians' services, related readmissions, and post-acute care provider (such as skilled nursing, home health, etc.) and other services (such as clinical laboratory services, durable medical equipment, etc.).

Model 3

The episode of care would include physician, post-acute provider, and other Medicare-covered services beginning with the initiation of post-acute care services after discharge from an acute inpatient hospital stay. The bundle would include physicians' services, related readmissions, and post-acute care provider and other services (such as clinical laboratory services, durable medical equipment, etc.).

Model 4

Medicare would make a single prospective bundled payment to the hospital to cover all services furnished (by the hospital, physicians, and other practitioners) during the inpatient stay. Physicians and other practitioners would be required to submit "no-pay" claims to Medicare and would be paid by the hospital out of the bundled payment.

Put another way, applicants for these models would decide whether to define the episode of care as the acute care hospital stay only (Model 1); the acute care hospital stay plus post-acute care associated with the stay (Model 2); or just post-acute care beginning with the initiation of post-acute care services after discharge from an acute inpatient stay (Model 3). Applicants could also decide to avail themselves of a prospective bundled payment to cover all inpatient services (Model 4).

Nonbinding letters of intent for organizations interested in **Model 1** were due on October 6, 2011. ***Nonbinding letters of intent for Models 2-4 are due by November 4, 2011***. For applicants who want to receive historical Medicare claims data in preparation for **Models 2-4**, a separate research request packet and data use agreement must be filed in conjunction with the letter of intent. ***Final applications for Model 1 must be received on or before November 18, 2011. Final applications for Models 2-4 must be received on or before March 15, 2012.*** You can find more information here.

Innovation Advisors Program

On October 17, 2011, CMS announced that it was accepting applications for the new Innovation Advisors Program—an initiative to help individuals refine the managerial and technical skills necessary to test new models of care and payment. The Innovation Center is creating a national network of experts to test and refine new care delivery models.

The Innovation Advisors Program will select approximately 200 individuals in the first year. The first group of "Innovation Advisors" will begin their six-month intensive orientation and applied research period in December 2011. Among other things, these experts will:

- Support the Innovation Center in testing new models of care delivery;
- Utilize their knowledge and skills in their home organization or area in pursuit of the three-part aim of improving health, improving care, and lowering costs through continuous improvement;
- Work with other local organizations or groups in driving delivery system reform;
- Develop new ideas or innovations for possible testing of diffusion by the Innovation Center; and
- Build durable skill in system improvement throughout their area or region.

Individuals can be any professional employed by a public health or health care facility, institution, or department. Candidates may be, among other things, physicians, nurses, allied health professionals, instructors, executives, or practice managers. Advisors ***will not*** be CMS employees. ***The deadline to submit applications is November 15, 2011.*** Innovation Advisors will be notified of their selection by mid-December 2011.

The Innovation Advisors Program may be an opportunity for clients to place key individuals in what could be an influential network of health care thinkers with access to the CMS and Innovation Center hierarchy. You can access the application here and find out more about the program here.

Comprehensive Primary Care Initiative

The Comprehensive Primary Care ("CPC") initiative being developed under the auspices of the Innovation Center is a new multi-payer initiative bringing together public and private health care payers. The CPC initiative will test two models: (i) a service delivery model, and (ii) a payment model. The payment model includes a monthly care management fee paid to the selected primary care practices on behalf of their fee-for-service Medicare beneficiaries.

For the first two years of the initiative, the per-beneficiary, per-month ("PBPM") amount will average out to $20. For years 3 and 4, the PBPM will be reduced to an average of $15.

In the second, third, and fourth years of the initiative, the primary care practices are eligible to potentially share in any Medicare savings. Practices will also receive compensation from other payers participating in the initiative (*i.e.*, including private insurance, Medicare Advantage Plan), which will allow them to integrate multi-payer funding streams to strengthen their capacity to implement practice-wide quality improvement.

This initiative will also provide practices serving Medicaid patients with support to enable those practices to participate in the initiative. State Medicaid programs are invited to apply to participate in the multi-payer approach.

Payers (public and private payers, including states) must indicate their interest to CMS by submitting a nonbinding letter of intent and a completed Geographic Service Area Worksheet by November 15, 2011. Final applications must be received on or before January 17, 2012. CMS will evaluate the proposals and select the markets, after which a second solicitation will be issued for primary care practices in those markets. You can find more information about the CPC initiative here.

Advance Payment ACO Model

In conjunction with the October 2011 release of the MSSP final rule, CMS also announced the Advance Payment ACO Model — an Innovation Center initiative by which selected participants in the MSSP will receive advance payments that will be recouped from the shared savings they subsequently earn. Under the Advance Payment ACO Model, ACOs otherwise participating in the MSSP will receive three types of payments:

- An upfront, fixed payment;
- An upfront, variable payment (each ACO will receive a payment based on the number of its historically assigned beneficiaries); or
- A monthly payment of varying amount depending on the size of the ACO.

The Advance Payment ACO Model is only open to two types of organizations otherwise participating in the MSSP:

- ACOs that do not include any inpatient facilities ***AND*** have less than $50 million in total annual revenue; and

- ACOs in which the only inpatient facilities are critical access hospitals and/or Medicare low-volume rural hospitals ***AND*** have less than $80 million in total annual revenue.

Only those ACOs that enter the MSSP in April or July 2012 will be eligible for advance payments at this time. The model is designed to determine whether providing advance payments will increase participation in the MSSP, and whether these payments will allow ACOs to generate Medicare savings more quickly. You can find more detailed information on this initiative by clicking on this link.

Hospital Value-Based Purchasing Program

In addition to the Innovation Center initiatives discussed above, another significant value-based initiative will launch next year under the direction of the Center for Medicare within CMS. Effective October 2012, Medicare will reward hospitals that provide high quality care through the Hospital Value-Based Purchasing Program, which will pay hospitals for providing inpatient acute care services based on the quality of care—not just the quantity of the services provided. CMS believes that the program will distribute an estimated $850 million to hospitals based on their overall performance on a set of quality measures linked to improved clinical care. You can learn more here.

MEDICARE MENU

VOLUNTARY OPTIONS

Center for Medicare		Center for Medicare & Medicaid Innovation	
Program	Date*	Program	Date*
Medicare Shared Savings Program Encourages the formation of accountable care organizations that coordinate care across the care continuum and share in Medicare savings	January 2012	**Hospital Engagement Contractors (Partnership for Patients)** Provides funding for contractors to design programs, conduct training, and provide technical assistance to support hospitals in making care safer and to reduce hospital-acquired conditions	October 2011
Community-Based Care Transitions Program (Partnership for Patients) Provides funding to test models for improving care transitions from the inpatient hospital setting to other care settings	Second Quarter 2011	**Innovation Advisors Program** Selects individuals in the health care system (clinicians, health care executives, etc.) to test and refine new models of payment and care delivery focusing on healthcare finance, population health, systems analysis, and operations research	December 2011
Hospital Value-Based Purchasing Program (Partnership for Patients) Rewards hospitals for overall performance based on a set of quality measures that have been shown to improve clinical care	October 2012	**Pioneer ACO Model** Tests alternative payment models that include escalating levels of financial accountability and sharing in Medicare savings — Organizations participating in the Pioneer ACO Model will not be eligible to participate in the Medicare Shared Savings Program	Fourth Quarter 2011
		Advance Payment ACO Model Provides opportunities to participants in the Medicare Shared Savings Program to receive advanced payments to be recouped from shared savings earned	January 2012
		Bundled Payments for Care Improvement Tests models that combine payment for physician, hospital, and other provider services of a predetermined amount during an episode of care	First & Second Quarters 2012 (depending on model)
*Dates represent when the programs will be implemented (following letters of intent, applications, etc.)		**Comprehensive Primary Care Initiative** Pays primary care providers for improved and comprehensive care management, and provides them with an opportunity to share in savings generated — Multi-payer initiative — Markets participating in a Multi-Payer Advanced Primary Care Practice demonstration are not eligible	Second Quarter 2012

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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Join Epstein Becker Green, KPMG, and JHD Group on Nov. 9 for a Joint Webinar:

Healthcare Transformation Accelerates: What Could the MSSP and Other Value-Based Purchasing Initiatives Mean for Your Organization?

Epstein Becker Green, KPMG Healthcare, and the JHD Group invite you to join the fourth webcast in a series that will explore the new regulations and the broader implications of moving toward payment systems that reward enhancements to quality, cost, and access.

The 120-minute session, which will dedicate 30 minutes to Q&A, will focus on how organizations can begin to connect the dots from the final MSSP rule to accountable care organizations, the increasing movement across the industry to new quality and cost-based payment models, and the regulations' strategic and operational implications for care delivery systems.

Wednesday, November 9, 2011

1:00 pm - 3:00 pm EDT

*For those interested, please click **here** to register.*

If you would like to be added to our mailing list, please click here, complete the form below, or contact:

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