DEPARTMENT: Legal	**POLICY DESCRIPTION:** Medicare Bundled Payments
PAGE: 1 of 2	**REPLACES POLICY DATED:** 11/1/16, 9/1/17, 10/1/18
EFFECTIVE DATE: December 1, 2020	**REFERENCE NUMBER:** LL.MBP.001
APPROVED BY: Ethics and Compliance Policy Committee	

SCOPE: This policy applies to all HCA Holdings, Inc. and Affiliated Entities and Facilities (collectively, "Company") participating in a Centers for Medicare and Medicaid Services (CMS) bundled payment program, including but not limited to, the Bundled Payments for Care Improvement (BPCI) model, the Comprehensive Care for Joint Replacement (CJR) model, the Bundled Payments for Care Improvement – Advanced (BPCI-A) model or the Advancing Care Coordination through Episode Payment Models programs. (For reference only, informational overviews of the CMS bundled payment programs in which HCA Healthcare is currently a participant are attached to this policy.)

"Affiliated Entities and Facilities" include any person or entity controlling, controlled by, or under common Control with the Company.

"Control" means the direct or indirect power to govern the management and policies of an entity or facility; or the power or authority through a management agreement or otherwise to approve an entity's or facility's transactions (includes **Controlled**, **Controlling**).

PURPOSE: The purpose of this policy is to set forth the general parameters governing CMS bundled payment programs and provide guidance for participant facilities. Company anticipates that the number of CMS bundled payment programs, both voluntary and mandatory, will continue to grow. Accordingly, and in light of the growing prominence of CMS bundled payment programs, Company seeks to educate participant facilities regarding applicable program requirements and facilitate compliance efforts and administration of such programs.

POLICY: To date, and upon unveiling each CMS bundled payment program, CMS has issued extensive program requirements either through regulations and/or via a contractual agreement with the lead program participant. In addition, and in conjunction with these programs, CMS and the HHS Office of Inspector General (OIG) have jointly issued fraud and abuse waivers to allow sharing of certain savings generated or financial losses suffered with physicians and certain other types of providers ("gainsharing") and/or beneficiary incentive arrangements that may otherwise be barred or limited by existing federal fraud and abuse laws. Additionally, Congress continues to consider the possibility of enacting new exceptions to applicable fraud and abuse laws to allow such arrangements.

Thus, and as a general policy, all Company participants in a CMS bundled payment program must comply with: (1) applicable CMS bundled payment program requirements, as set forth in CMS regulations and/or a CMS contractual agreement (or as otherwise issued by CMS); (2) the requirements set forth in CMS and OIG fraud and abuser waivers, where applicable; and (3) any new exceptions to applicable fraud and abuse laws enacted by Congress pertaining to such arrangements, where applicable, necessary or required.

Given the existence of CMS and OIG fraud and abuse waivers, gainsharing arrangements with physicians that are made pursuant to a CMS bundled payment program, and that are protected by CMS and OIG gainsharing waivers; and Participating Provider Agreements with Post-Acute Care providers pursuant to a Medicare Bundled Payment program, without any exchange of

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compensation, are subject to this and the related Medicare Bundled Payments Policies, LL.MBP.001, *et seq.* and are not within the scope of the General Statement on Agreements with Referral Sources; Approval Process Policy, LL.001, the Professional Services Agreements Policy, LL.002, or other Company legal policies that otherwise would be applicable to or govern such arrangements.

PROCEDURE: With each new CMS bundled payment program in which Affiliated Entities and Facilities participate, Company shall:

1. Inform and educate applicable Company stakeholders regarding CMS bundled payment program requirements
2. To the extent participating Affiliated Entities and Facilities intend to enter into gainsharing arrangements, and such gainsharing arrangements are permitted by the applicable CMS bundled payment program, Company shall:
    a. Require Affiliated Entities and Facilities to obtain approval from the Group President or Group Chief Financial Officer before offering any gainsharing agreements;
    b. Establish template gainsharing arrangements in conjunction with Operations Counsel; and
    c. Establish systems to administer, track, and monitor gainsharing arrangements.
3. Ensure processes are in place to address Affiliated Entities and Facilities' participation in the CMS bundled payment program, including any gainsharing program, if applicable, and including informing, educating and notifying participating patients while continuing to respect patient choice in accordance with Company Policy LL.HH.016.
4. Where appropriate, Company shall develop additional policies to facilitate oversight of, and compliance with, CMS bundled payment programs.

REFERENCES:

1. Applicable BPCI Awardee Agreement(s) and Implementation Protocol(s)
2. CJR Regulations 42 C.F.R 510.1 *et. seq.*
3. OIG and CMS Fraud and Abuse Waivers for BPCI Model 2, which can be accessed at https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Downloads/BPCI-Model-2-Waivers.pdf
4. OIG and CMS Fraud and Abuse Waivers for CJR Model, which can be accessed at https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Downloads/2015-CJR-Model-Waivers.pdf.
5. OIG and CMS Fraud and Abuse Waivers for BPCI-A Model
6. LL.MPB.002, Medicare Bundled Payments: CJR Collaborator Selection Criteria
7. LL.HH.016, Discharge Planning and Referrals of Patients to Post Discharge Providers Policy

INFORMATIONAL OVERVIEW OF BUNDLED PAYMENTS FOR CARE IMPROVEMENT (BPCI) MODEL 2 PAYMENT MODEL

1. Brief Summary

BPCI Model 2 is a voluntary bundled payment program. Persons or entities interested in participating must apply to CMS and receive approval (although note that the application period has since closed). With some exception, the term of the BPCI Model 2 program is three years, with the model set to expire effective September 30, 2018.

2. Key definitions

Awardee: As a general matter, the Awardee is entity that spearheads participation in, and is ultimately responsible for compliance with, the BPCI Model 2 payment model. The Awardee is also financially liable for all amounts potentially due to CMS as a result of such participation.

Episode of Care: Nearly all Medicare Part A and B items and services furnished to a Model 2 Beneficiary during the time period that begins with the Model 2 Beneficiary's admission to an episode initiator and ends on the 30th, 60th, or 90th day after the date of discharge from the initial hospitalization.

Episode Integrated Provider (EIP) or Gainsharer: An Awardee's gainsharing partner. EIPs or Gainsharers include any Medicare provider or supplier that is participating in BPCI Model care redesign efforts and has entered into a written gainsharing agreement.

Incentive payment: A payment made by an Awardee to its EIP or Gainsharers, pursuant to the terms of a "Participant Agreement" (i.e., the written agreement between the parties setting forth the terms of the gainsharing methodology). Incentive Payments may be comprised of only NPRA, ICS, or both.

Internal cost saving (ICS): Measurable, actual, and verifiable cost savings realized by an EIP, resulting from care redesign undertaken by the EIP in connection with providing items and services to Model 2 beneficiaries within specific Episode of Care.

Model 2 Beneficiary: All Medicare fee-for-service (FFS) beneficiaries, with some exception, admitted to an "episode initiator" (generally, the hospital where the Model 2 beneficiary is admitted to receive care) in order to receive treatment for a "clinical episode" (select families of MS-DRGs defining a specific clinical condition).

Reconciliation: The process in which CMS determines whether an Awardee, in the aggregate, generated savings or loss across each Episode of Care within a given BPCI Model 2 performance quarter. To the extent an Awardee realizes savings, CMS will make a "net reconciliation payment amount" (NPRA) to the Awardee.

3. Description

To improve patient outcomes and reduce costs, the BPCI program encourages participant hospitals to engage in care redesign across not only each CJR beneficiary's inpatient hospital stay, but also a 30, 60, or 90 day post-discharge period (i.e., the "Episode of Care"). All Model 2 beneficiaries must be notified of their participation in BPCI Model 2 upon admission. In addition,

and while participant hospitals have flexibility to partner with high quality, efficient post-acute care providers for purposes of implementing care redesign, patient choice, and all laws and requirements related to patient choice, must be abided by and respected.

BPCI Model 2 participating hospitals continue to be paid in the normal, FFS course throughout the term of the BPCI Model 2 program. That said, their financial performance is retrospectively assessed by CMS on a quarterly basis. It is this CMS retrospective assessment that determines whether a participant hospital realizes savings from CMS, thus receiving positive NPRA, or experiences losses, thereby owing CMS negative NPRA. EIPs may also achieve their own internal cost savings (ICS) in caring for Model 2 beneficiaries, e.g., by standardizing certain orthopaedic supplies and equipment.

Savings realized by an Awardee – be it NPRA and/or ICS – may be gainshared, subject to CMS limitations, with EIPs and/or Gainsharers. To participate, all EIPs and Gainsharers must enter into a gainsharing arrangement with the Awardee (either directly or indirectly) and agree to meet all terms and requirements of the BPCI Model 2 program.

Of note, participation in the BPCI Model 2 program is subject to strict CMS oversight. All gainsharing partners must first be approved by CMS. In addition, an Awardee's plans with respect to both its care redesign and its gainsharing methodology must be submitted to CMS for approval.

Questions regarding the BPCI Model 2 program should be directed to the President, Post-Acute Services or the AVP, Bundled Payments Innovation.

Additional information concerning the CJR program is available here: https://innovation.cms.gov/initiatives/BPCI-Model-2/index.html.

INFORMATIONAL OVERVIEW OF COMPREHENSIVE CARE FOR JOINT REPLACEMENT (CJR) PAYMENT MODEL

1. Brief Summary

CJR is a mandatory bundled payment program for all hospitals located in select metropolitan statistical areas. CJR, while modeled in large part off of the Bundled Payments for Care Improvement (BPCI) Model 2 program, is focused exclusively on certain Medicare fee-for-service (FFS) beneficiaries receiving lower extremity joint replacement (LEJR) procedures. The CJR program started April 1, 2016, and will run for five performance years.

2. Key definitions

CJR beneficiary: All Medicare fee-for-service (FFS) beneficiaries, with some exception, admitted to a CJR participant hospital for a lower extremity joint replacement (LEJR) procedure that is paid under the IPPS MS–DRG 469, 470, 521 or 522.

CJR episode: Nearly all Medicare Part A and B items and services furnished to a CJR beneficiary during the time period that begins with the CJR beneficiary's admission to a participant hospital and ends on the 90th day after the date of discharge from the initial hospitalization.

CJR collaborator: A participant hospital's gainsharing partner. CJR collaborators are limited to certain types of providers and suppliers, but include physician and physician practice groups. CJR collaborators must participate in care redesign and enter into a gainsharing agreement with the participant hospital.

Gainsharing payment: A payment made by a participant hospital to a CJR collaborator, under the terms of a sharing arrangement (i.e., the written agreement between the parties setting forth the terms of the gainsharing methodology). Gainsharing payments may be comprised of only reconciliation payments, ICS, or both.

Internal cost saving (ICS): Measurable, actual, and verifiable cost savings realized by a participant hospital, resulting from care redesign undertaken by the participant hospital in connection with providing items and services to CJR beneficiaries within specific CJR episodes of care.

Reconciliation: The process in which CMS determines whether a participant hospital, in the aggregate, generated savings or loss across each CJR episode within a given CJR performance year. To the extent a participant hospital realizes savings, CMS will make a "reconciliation payment" or "net reconciliation payment amount" (NPRA) to the participant hospital.

Participant hospital: An IPPS hospital located in one of the geographic areas selected for participation in the CJR model

3. Description

To improve patient outcomes and reduce costs, the CJR program encourages participant hospitals to engage in care redesign across not only each CJR beneficiary's inpatient hospital stay, but also a 90-day post-discharge period (i.e., the "CJR episode"). All CJR beneficiaries must be notified of their participation in the CJR model upon admission. In addition, and while participant hospitals have flexibility to partner with high quality, efficient post-acute care providers for purposes of implementing care redesign, patient choice, and all laws and requirements related to patient choice, must be abided by and respected.

CJR participating hospitals continue to be paid in the normal, FFS course throughout the term of the CJR program. That said, their performance – both financially and with respect to certain quality metrics – is retrospectively assessed by CMS each performance year. It is this CMS retrospective assessment that determines whether a participant hospital realizes savings from CMS, thus receiving a "reconciliation payment," or experiences losses, thereby owing CMS a "repayment amount." Participant hospitals may also achieve their own internal cost savings (ICS) in caring for CJR beneficiaries (e.g., by standardizing certain orthopaedic supplies and equipment).

Savings realized by a participant hospital – be it NPRA and/or ICS – may be gainshared subject to CMS limitations, with CJR collaborators. To participate, a CJR collaborator must enter into a gainsharing arrangement with the participant hospital and agree to meet all terms and requirements of the BPCI Model 2 program.

While, and in contrast to the BPCI Model 2 program, direct CMS oversight of a participant hospital's care redesign and gainsharing arrangements is limited, upon entering into a gainsharing arrangement, CMS imposes numerous compliance requirements on both the participant hospital and its CJR collaborators. For example, both participant hospitals and their CJR collaborators must update their compliance plans, in addition to closely tracking all gainsharing payments. Participant hospitals must also post to their website a list of all current and historical CJR collaborators.

Questions regarding the CJR program should be directed to President, Post-Acute Services or the AVP, Bundled Payments Innovation.

Additional information concerning the CJR program is available here: https://innovation.cms.gov/initiatives/cjr. The CJR program regulations are set forth at 42 CFR Part 510, *et seq.*

INFORMATIONAL OVERVIEW OF BUNDLED PAYMENTS FOR CARE IMPROVEMENT ADVANCED (BPCI ADVANCED) PAYMENT MODEL

1. Brief Summary

BPCI Advanced is a voluntary bundled payment program. Persons or entities interested in participating must apply to CMS and receive approval (although note that the first application period has since closed). In general, the term of the BPCI Advanced program is five years, with the model set to expire effective December 31, 2023. However, entities will be given an opportunity to stop or reduce their participation at a set time in 2019 and apply to participate during a second application period.

2. Key definitions

Anchor Procedure: means a hospital outpatient procedure performed in a hospital outpatient department of an Acute Care Hospital (ACH) identified by a HCPCS code specified on the Clinical Episode List for which an Episode Initiator submits a claim to Medicare FFS. The first day of an Anchor Procedure initiates a Clinical Episode.

Anchor Stay: means an inpatient stay at an ACH assigned to an MS-DRG specified on the Clinical Episode List for which an Episode Initiator submits a claim to Medicare FFS. The first day of the Anchor Stay initiates a Clinical Episode.

Benchmark Price: means a metric used by CMS, together with the CMS Discount, to calculate an Episode Initiator-specific Target Price for each Clinical Episode.

BPCI Advanced Beneficiary: means a Medicare beneficiary entitled to benefits under Part A and enrolled under Part B on whose behalf an Episode Initiator submits a claim to Medicare FFS for an Anchor Stay or Anchor Procedure. The term BPCI Advanced Beneficiary specifically excludes: (1) Medicare beneficiaries covered under United Mine Workers or managed care plans (e.g., Medicare Advantage, Health Care Prepayment Plans, or cost-based health maintenance organizations); (2) beneficiaries eligible for Medicare on the basis of an end-stage renal disease (ESRD) diagnosis; (3) Medicare beneficiaries for whom Medicare is not the primary payer; and (4) Medicare beneficiaries who die during the Anchor Stay or Anchor Procedure. A BPCI Advanced Beneficiary must meet this definition for the full duration of the Clinical Episode.

Clinical Episode: means the period of time initiated on the first day of an Anchor Stay or an Anchor Procedure, during which all Medicare FFS expenditures for all non-excluded items and services furnished to a BPCI Advanced Beneficiary are bundled together as a unit for purposes of calculating the Target Price and for purposes of Reconciliation. Clinical Episodes may be initiated only during the Agreement Performance Period.

CMS Discount: means a set percentage by which CMS reduces the Benchmark Price in order to calculate the Target Price.

Convener Participant: means an entity that enters into a BPCI Advanced Participation Agreement with CMS to participate in the BPCI Advanced initiative and that brings together at

least one Downstream Episode Initiator to participate in BPCI Advanced, facilitates coordination among them, and bears full financial risk to CMS under the Model. A Convener Participant may be an entity that is either a Medicare-enrolled provider or supplier or an entity that is not enrolled in Medicare.

Episode Initiator: means any ACH or a Physician Group Practice (PGP) that participates in BPCI Advanced as either: (1) the Participant; or (2) a Downstream Episode Initiator. Any Episode Initiator identified on the Participant Profile can trigger Clinical Episodes under BPCI Advanced.

Net Payment Reconciliation Amount (NPRA): means the amount paid to the Participant by CMS if the sum of all Adjusted Negative Total Reconciliation Amounts and all Adjusted Positive Total Reconciliation Amounts for the Participant (if the Participant is an Episode Initiator) and/or for all of the Participant's Downstream Episode Initiators (if the Participant is a Convener Participant) is positive.

NPRA Sharing Partner: means a Participating Practitioner, a PGP, an ACH, an ACO, or a PAC Provider that is: (1) participating in BPCI Advanced Activities; (2) identified as an NPRA Sharing Partner on the Financial Arrangements List; and (3) has entered into a written NPRA Sharing Arrangement.

Participating Practitioner: means a Medicare-enrolled physician or non-physician practitioner who: (1) is identified by an individual NPI; (2) is participating in BPCI Advanced Activities; (3) has a written agreement with the Participant that requires the Participating Practitioner to comply with all applicable terms and conditions of this Agreement; and (4) is identified on [a designated] List.

Reconciliation: means the semi-annual process of comparing the aggregate Medicare FFS expenditures for all items and services included in a Clinical Episode attributed to the Participant against the final Target Price for that Clinical Episode to determine whether the Participant is eligible to receive an NPRA payment from CMS, or is required to pay a Repayment Amount to CMS.

3. Description

To improve patient outcomes and reduce costs, the BPCI Advanced program encourages participant hospitals to engage in care redesign across not only each Medicare beneficiary's inpatient hospital stay, but also a 90-day post-discharge period (i.e., the "Clinical Episode"). All beneficiaries must be notified of their participation in the BPCI Advanced prior to discharge from the Anchor Stay, or prior to completion of the Anchor Procedure, as applicable. In addition, and while Episode Initiator hospitals have flexibility to partner with high quality, efficient post-acute care providers for purposes of implementing care redesign, patient choice, and all laws and requirements related to patient choice, must be abided by and respected.

BPCI Advanced is a two-sided risk model. In the Convener Participant model (HCA Healthcare's model), a Convener Participant, (Advanced Bundle Convener, LLC) enters into a BPCI Advanced Participation Agreement with CMS bringing together downstream Episode Initiators (ACHs and PGPs) to participate in BPCI Advanced, facilitate coordination among them, and bear full financial risk to CMS. Episode Initiator hospitals and PGPs continue to be paid in the normal, FFS course throughout the term of the program. Their financial performance

is retrospectively assessed by CMS through a semi-annual reconciliation process. It is this CMS reconciliation that determines whether, in the aggregate, the downstream Episode Initiators realize savings from CMS, thus resulting in positive NPRA subject to a quality adjustment being paid to the Convener Participant, or experiences losses, thereby resulting in the Convener Participant owing CMS a “Repayment Amount”. Episode Initiators may also achieve their own internal cost savings in caring for beneficiaries.

NPRA earned by the Convener Participant, and Internal Cost Savings contributed by Episode Initiators, may be gainshared, subject to CMS limitations, with NPRA Sharing Partners. To participate, NPRA Sharing Partners must enter into a written NPRA Sharing Arrangement with the Participant and agree to meet all terms and requirements of the program.

Of note, participation in the BPCI Advanced program is subject to strict CMS oversight. All NPRA Sharing Partners must first be approved by CMS. In addition, plans for care redesign must be submitted to CMS for approval. Other ongoing reporting requirements must also be met.

Questions regarding the BPCI Advanced program should be directed to the President, Post-Acute Services or the AVP, Bundled Payments Innovation.

Additional information concerning the BPCI Advanced program is available here: https://innovation.cms.gov/initiatives/bpci-advanced/