DEPARTMENT: Legal	**POLICY DESCRIPTION:** Medicare Bundled Payments
PAGE: 1 of 2	**REPLACES POLICY DATED:** 11/1/16, 9/1/17, 10/1/18, 12/1/20
EFFECTIVE DATE: February 26, 2024	**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 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

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 Participation 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 CJR Model, which can be accessed at https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Downloads/2015-CJR-Model-Waivers.pdf.
4. OIG and CMS Fraud and Abuse Waivers for BPCI-A Model
5. LL.MPB.002, Medicare Bundled Payments: CJR Collaborator Selection Criteria
6. LL. 016, Discharge Planning and Referrals of Patients to Post Discharge Providers Policy

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

1. Brief Summary

CJR is a mandatory bundled payment program for all urban hospitals located in select metropolitan statistical areas. CJR 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 is scheduled to end on December 31, 2024.

2. Key definitions

Anchor Procedure: means a hospital outpatient LEJR procedure performed in a hospital outpatient department of an Acute Care Hospital (ACH) identified by HCPCS code 27130 or 27447 for which a CJR participant 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 MS-DRG 469, 470, 521 or 522 for which a CJR participant submits a claim to Medicare FFS. The first day of the Anchor Stay initiates a Clinical Episode.

CJR beneficiary: All Medicare fee-for-service (FFS) beneficiaries, with some exception, receiving a lower extremity joint replacement (LEJR) procedure at a CJR participant hospital.

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 LEJR procedure at a participant hospital and ends on the 90th day after the date of inpatient discharge or completion of the outpatient procedure.

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 urban (non-rural status) acute care 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 LEJR procedure, 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 prior to discharge from the anchor hospitalization or prior to discharge from the anchor procedure. 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 CJR program.

While 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 the AVP of Bundled Payments.

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 application period has since closed). In general, the term of the BPCI Advanced program is seven years, with the model set to expire effective December 31, 2025.

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. Starting January 2024, a

Convener Participant must be a Medicare-enrolled provider (prior to 2024, a convener participant was permitted to be a supplier or an entity that was 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, 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.

NPRA earned by the participating Episode Initiator, 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 AVP of Bundled Payments.

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