



To Bundle or Not to Bundle: Lawmakers Explore the Question

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The current fervor to overhaul the nation's health care system has some legislators discussing how to change the way post-acute care providers, including long-term acute care hospitals (LTACHs), home health agencies, skilled nursing facilities (SNFs), and inpatient rehabilitation facilities (IRFs), are reimbursed for treating Medicare beneficiaries. One potential solution proposed by President Obama, the Congressional Budget Office, the Senate Finance Committee, and certain congressional leaders is to bundle payments for acute and post-acute care services provided within the first 30 days after a Medicare beneficiary is discharged from an acute care hospital (ACH).



The post-acute care bundled payment model generally involves the elimination of separate payments for acute care hospital services and post-acute care services for a patient in a single episode of care. The separate payments to the ACH and post-acute care provider(s) are combined into a single “bundled” payment for the entire episode of care. Post-acute care bundled payment models typically include requirements for ACHs to manage and assume risk for post-acute care services and payment disincentives designed to eliminate unnecessary readmissions to ACHs¹ (usually within a period of 30 days).

One of the greatest criticisms of the current system of separate payments for acute care and post-acute care services is that there is a lack of coordination of care between acute care and post-acute care settings. This lack of coordination creates “silos” resulting in increased costs, lower quality of care, and poor outcomes.² Payment bundling is intended to reduce duplicate payments for overlapping services and improve coordination of care across the continuum.

I. Legislators Poised to Overhaul Medicare Payments to Post-Acute Care Providers

The post-acute care bundled payment model, which has been proposed and rejected many times since being introduced in the 1980s, was resurrected in December 2008 when the U.S. Congressional Budget Office (CBO) released a report to the House and Senate Committees on the budget providing an expansive list of options for reducing federal health care spending.³ The CBO's report proposed bundling acute care and post-acute care services into one payment as a way to “reduce federal outlays by an estimated \$0.7 billion over the 2010-2014 period, and by almost \$19 billion over the 2010-2019 period.”⁴ Under the CBO proposal, ACHs would receive a bundled payment to cover both acute care and post-acute care services. ACHs would be responsible for determining how much post-acute care a patient needs and for selecting the post-acute care setting capable of providing the best patient outcomes in the most cost-effective manner. ACHs

1 The need to reduce re-admission rates is demonstrated by a recent article published in the *New England Journal of Medicine*. The authors analyzed Medicare claims using Medicare claims information from October 2003 through December 2004, and found that of 11,855,702 patients, 19.6% of patients were rehospitalized within 30 days, and that 34.0% were rehospitalized within 90 days. The estimated cost of unplanned hospital re-admissions in 2004 accounted for \$17.4 billion of the \$102.6 billion total hospital payments made by Medicare during that year. See Stephen F. Jencks, M.D., M.P.H., Mark V. Williams, M.D., and Eric A. Coleman, M.D., M.P.H., *Rehospitalizations among Patients in the Medicare Fee-for-Service Program*, 360 *NEW ENG. J. MED.* 1418 (Apr. 2, 2009).

2 See Medicare Payment Advisory Commission, *Testimony Before the Committee on Ways and Means, U.S. House of Representatives: Reforming the Health Care Delivery System, Statement of Glenn M. Hackbarth, J.D.*, at 15 (Apr. 1, 2009).

3 The Congress of the United States, Congressional Budget Office, *Budget Options: Volume 1: Health Care*, at <http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf> (Dec. 2008).

4 *Id.* at 62.

would be expected to provide post-acute care services on their own behalf or to enter into contracts, partnerships, collaborations, or other arrangements with post-acute care providers for this purpose.

President Obama's 2010 proposed federal budget lends further support to the CBO's post-acute care bundling proposal by suggesting that adopting a bundled payment model that incorporates a "combination of incentives and penalties" should decrease ACH re-admission rates for preventable re-admissions and result in significant Medicare cost savings.⁵



These recent proposals are consistent with the view of the Medicare Payment Advisory Commission (MedPAC). MedPAC has testified before Congress on multiple occasions recommending a reduction in payments to hospitals with relatively high readmission rates for select conditions, and making a single payment to acute care hospitals (a bundled payment) intended to cover the costs of providing the full range of care needed over the hospitalization episode, including the period 30 days after discharge.⁶ Under this payment scheme, ACHs would be expected to choose new partners or collaborate with existing ones to improve their collective performance.

The post-acute care bundling model received an additional boost when the Senate Finance Committee released its first of three health reform option papers on April 29, 2009 exploring proposals for reducing costs and improving quality and efficiency of care.⁷ The policies contained in the option paper mirror and expand upon bundling concepts proposed by MedPAC, the CBO, and President Obama. These policies include:

Reducing Preventable Hospital Re-admissions

The option paper contains a proposal for reducing preventable hospital re-admissions and establishing payment incentives intended to improve patient care by encouraging greater care coordination among ACHs and post-acute care providers. CMS would begin calculating national and hospital-specific re-admission rate data for hospitals in fiscal year (FY) 2010, to determine the eight conditions with the highest volume and rates of re-admission.⁸

CMS would then provide re-admission rate information to hospitals in FY 2011, and inform them of their re-admission rates in relation to a national re-admissions benchmark for each of the selected conditions. The re-admissions benchmark would include all re-admissions that are the result of complications or related conditions, but would exclude re-admissions that are not potentially preventable (e.g., planned re-admissions or re-admissions related to cancer care, burn care, trauma care, and scheduled surgeries).

5 Office of Management and Budget, *A New Era of Responsibility: Renewing America's Promise*, 29, at http://www.whitehouse.gov/omb/assets/fy2010_new_era/A_New_Era_of_Responsibility2.pdf (Feb. 26, 2009).

6 See Medicare Payment Advisory Commission, *Report to the Congress: Reforming the Health Care Delivery System*, Statement of Mark E. Miller, Ph.D., at 13 (Sept. 16, 2008); see also Medicare Payment Advisory Commission, *Testimony Before the Committee on Ways and Means, U.S. House of Representatives: Reforming the Health Care Delivery System*, Statement of Glenn M. Hackbarth, J.D., at 15 (Apr. 1, 2009).

7 United States Senate Finance Committee, *Description of Policy Options: Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs*, at 13-16 <http://finance.senate.gov/sitepages/leg/LEG%202009/042809%20Health%20Care%20Description%20of%20Policy%20Option.pdf> (Apr. 29, 2009).

8 *Id.* at 14.

In FY 2013, hospitals with re-admission rates above the 75th percentile for selected conditions would be subject to a payment withhold based on the prior year's performance that would be equal to 20% of the MS-DRG payment amount. The re-admissions policy would not apply to conditions included in the bundled payment discussed below, and would expire once the bundled payment policy is fully implemented.

Implementing a Post-Acute Care Payment Bundle



Beginning in FY 2015, post-acute care provider services occurring or initiated within 30 days of discharge from an ACH would be paid through a bundled payment. Under this policy, post-acute bundled payments would be made for LTACH, home health, SNF, and IRF services. ACHs or other eligible entities would receive a bundled payment for each patient, regardless of whether the patient receives post-acute care services. No additional payments would be made to the hospital or organizing provider for re-admissions during this timeframe, and Medicare would no longer make separate payments to post-acute care providers for care initiated within 30 days post-discharge.⁹

The bundled payment proposal would be implemented in three phases. Phase one would be implemented in FY 2015, and would apply to admissions for conditions that account for the top 20% of post-acute spending. Phase two would be implemented in FY 2017, and would apply to admissions for conditions that would account for the next 30% of post-acute care spending. Starting in FY 2019, the final phase of bundling would be implemented, and would include all other conditions and MS-DRGs that account for the remaining 50% of post-acute care spending.¹⁰

CMS would be permitted to waive laws to implement these policies and develop patient protection rules to ensure that patients receive appropriate post-acute care, and that access to care is maintained.¹¹ This summary review of one proposal for a post-acute care bundled payment model is helpful in identifying some of the possible strengths and weaknesses of such an approach, and raises a number of questions for ACHs and post-acute care providers.

II. Virtues & Vices of Post-Acute Payment Bundling

Bundling advocates believe that the model offers providers incentives to reduce costs of services, decrease preventable re-admissions, and increase the efficiency with which they provide medical care.¹² Advocates also contend that bundling would eliminate the need for a variety of regulations regarding payment for coverage of services furnished under the current non-bundled system.¹³ For example, with respect to SNFs, compliance with and administration of the qualifying three-day hospitalization and 30-day transfer rule implemented under 42 U.S.C. § 1395x(i) would become obsolete.

⁹ *Id.* at 15.

¹⁰ *Id.* at 15.

¹¹ *Id.*

¹² See generally *supra* note 7.

¹³ See RehabCare Group Inc., Position Paper on Post-Acute Care Bundling, at http://www.rehabcare.com/documents/PositionPaperonPAC04-15-09Final_001.pdf (last visited May 31, 2009).

However, opponents of bundling argue that it is inherently difficult to craft a bundled payment system in which ACHs would be responsible for compensating post-acute care providers because:

- A patient's post-acute care needs may be different from the reason for an ACH admission.
- Providing a fixed payment to ACHs creates an inherent financial incentive for such facilities to underserve the most severely impaired patients.¹⁴
- Post-acute care providers, especially smaller freestanding providers, may not have the organizational muscle to negotiate favorable reimbursement contracts with ACHs controlling the flow of post-acute care services.¹⁵
- Relying on ACHs as the focal point for post-acute care runs contrary to the trend toward community and home-based care, which often reduces both patient length of stay and cost.¹⁶
- Bundling may propel acquisitions of post-acute facilities by ACHs as they attempt to better manage their spending throughout the post-acute care spectrum—thereby creating a “supermarket” approach to health care.



Some organizations have already begun planning for the bundling trend either by creating integrated post-acute care and senior living campuses with a full array of long-term care services, or by developing post-acute care facilities capable of catering to more acutely ill patients in more cost-effective settings. For example, Tom Clarke, president and CEO of Kissito Post-Acute, a national provider of post-acute care services, recently noted that Kissito's SNF facilities provide ventilator weaning programs, which are commonly found in LTACHs, while achieving comparable clinical outcomes and Medicare cost savings.¹⁷

III. Bundling Proposals Raise Questions

Industry leaders have raised a number of questions about these bundling proposals, some of which were voiced by National Association of Long Term Hospital (NALTH) members and conference attendees during the organization's 2009 annual meeting in Washington, D.C., including, among others:

- What laws (e.g., Stark and Federal Antikickback laws, Federal Conditions of Participation, patient privacy laws, LTACH and IRF-specific payment policies such as the 5% Rule, 25% Rule, 60% Rule, etc...) would CMS waive to implement the bundled payment policy?¹⁸

14 Brain Injury Association of America, Response to Delivery System Recommendations, at http://www.biausa.org/elements/policy/2009/biaa_finance_committee_response.pdf (May 15, 2009).

15 A study completed in 1998 found that financial risk to ACHs would not increase under post-acute care bundled payments. See W. Pete Welch, Bundled Medicare Payment for Acute and Postacute Care, *Health Affairs* 69 (Dec. 1998).

16 American Association of Homes and Services for the Aging, Response to Senate Finance Committee Delivery System Recommendations, at http://www.aahsa.org/uploadedFiles/Providers/Advocacy/Policy_Statements/Baucus_Delivery_Options_AAHSAs.pdf (May 15, 2009).

17 Interview with Tom Clarke, president and CEO, Kissito Post-Acute (May 29, 2009).

18 See generally supra note 14.

- How would legislation ensure that post-acute care providers are not penalized for patient non-compliance that could be mischaracterized as a preventable re-admission?¹⁹
- How would Medicare reimburse post-acute care providers for care initiated 31 or more days post-discharge?

According to Neleen Eisinger, one of Senator Max Baucus' congressional staffers, who addressed NALTH conference attendees, these are issues that the Senate Finance Committee hopes the post-acute care industry will raise and to which the industry should propose solutions.²⁰ Post-acute care providers and their trade organizations are closely monitoring the status of these proposals, which may appear in some form in a bill to overhaul the nation's health care delivery system likely to be introduced this month.²¹



In a year in which the Obama administration and legislators appear to have the political appetite to enact substantial health care reform, proposals for bundled payment models deserve the full attention of post-acute care providers. Carefully crafted legislation that takes into consideration the reimbursement needs of post-acute care providers could produce a new and tenable model. It will be important, however, for all stakeholders to be represented at the negotiation table since the potential pitfalls associated with post-acute care payment bundling may have unintended, adverse financial consequences for some providers.

¹⁹ Interview with Bob Desotelle, president and CEO of Asheville Specialty Hospital, in Washington, D.C. (Apr. 30, 2009).

²⁰ Neleen Eisinger, Address at the NALTH annual conference (May 1, 2009).

²¹ The Hill (May 22, Young) reported that Senate Finance Committee Chairman Max Baucus, speaking to reporters on May 21, 2009 predicted "a 75% to 80% chance that his panel will advance a bipartisan bill" to overhaul the nation's health care delivery system in June 2009.