The Law Offices of Jason M. Healy PLLC

Long-Term Acute Care Hospital Legal Alert

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CMS Innovation Center Unveils Bundled Payments Initiative Providing Shared Savings Opportunities for LTACHs

On August 25, 2011, CMS published a notice in the Federal Register requesting applications from Medicare providers, including long-term acute care hospitals ("LTACHs"), to participate in one or more of the initial four models to test Medicare payment bundling.[1] A nonbinding Letter of Intent is due by *November 4, 2011*, and an Application is due by *March 15, 2012*, for the two models available to LTACHs.[2] Please let us know if you have any questions about this initiative or would like assistance with preparing the submissions.

Officially called the Bundled Payments for Care Improvement Initiative, the Bundled Payments initiative was developed by the Center for Medicare and Medicaid Innovation ("CMMI"), a component of CMS created by Section 3021 of the Affordable Care Act. Please note that this initiative is *not* the National Pilot Program on Payment Bundling required to begin prior to January 1, 2013 under Section 3023 of the Affordable Care Act. Rather, the Bundled Payments initiative is being used by CMMI as an early test of different payment bundling models.

The initiative seeks to make a single bundled payment for all items and services provided during an episode of care, rather than paying each provider separately. CMMI believes that bundled payments could lead to better coordination of care among providers, improving patient experience from hospitalization through recovery. In addition, CMMI hopes that the resulting increase in efficiency could lower the amount Medicare pays across an entire episode of care. For LTACHs, the Bundled Payments initiative provides an opportunity for shared savings if participating providers can reduce costs below a set target.

The two models available to LTACHs and other post-acute providers – models two and three – are retrospective, meaning that LTACHs will receive the traditional payment under the LTACH prospective payment

system ("LTACH-PPS"), which will later be reconciled with aggregate fee-for-service payments to providers who treated the patient's condition during the defined episode of care. If aggregate payments made for included services are *lower* than the negotiated target amount, then the applicant will be paid the difference as a bonus, which may be shared among the participating providers. However, if aggregate payments made for included services are *higher* than the negotiated target amount, then the applicant must repay Medicare the difference. This type of financial risk is heightened by the fact that aggregate payments include payments made to providers who furnished care but are not participating in testing the bundled payment model. Because patient freedom of choice must be preserved, applicants cannot guaranty that the patient will obtain health care services from providers who choose to participate.

Four additional models are forthcoming, with two relating to chronic care and two that will address the same categories as models 2 and 3 but use prospective payment. With prospective payment, CMS will pay a single payment in advance for an episode of care in lieu of traditional fee-for-service payments. Providers may participate in multiple models, and also may enroll in the Bundled Payments initiative even if the provider also wishes to take part in an Accountable Care Organization ("ACO").[3]

Some other features are common to the four models. All of the proposed models run for three years, with a possible two year extension. The programs would start quickly, with Model 1 beginning as early as the first quarter of calendar year 2012 and the others following thereafter. CMS will monitor episodic and post-episodic expenditures against historical figures and include a risk threshold to account for random fluctuations. Also, like the proposed ACO rules, certain statutory waivers will be necessary to allow gainsharing,[4] and providers must meet minimum quality standards. Lastly, CMS will make historical Medicare claims data available to potential applicants for Models 2, 3, and 4 as long as the applicant submits a Research Study Protocol and Data Use Agreement with its Letter of Intent.[5] For Model 1, a Letter of Intent is due by September 22, 2011 and the Application is due by October 22. For the other three models, a Letter of Intent is due by November 4, 2011 and the Application is due by March 15, 2012.[6]

The Two IPPS-Only Models. Models 1 and 4 only cover the inpatient stay, and are only available to hospitals paid under the inpatient prospective payment system ("IPPS"). Model 1 is a retrospective model that provides acute care hospitals with a discounted payment (progressive increasing over three years from 0% to 2%) for all Part A services. Part B services will be paid at the normal physician fee schedule rate. On a case-by-case basis, gainsharing will be available to participating hospitals, with the possibility for owing a liability to Medicare. Model 4 is similar, except that payments are made

prospectively. CMS describes it as an outgrowth of the Acute Care Episode ("ACE") Demonstration.

Model 2 – Hospitalization Through Post-Acute Care. Model 2 seeks to compare a single bundled payment for all physicians' services, inpatient hospital services, readmissions, post-acute care, hospital outpatient services, independent outpatient therapy services, clinical laboratory services, durable medical equipment, and Medicare Part B drugs with the current Part A and Part B expenditures. A beneficiary will be "anchored" to this model by admission to a participating acute care hospital for one of many predetermined clinical conditions.

Under this model, one expenditure target will be established for an entire episode of care within a clinical category, starting with the acute care hospitalization and continuing through a pre-defined post-discharge period. Applicants will propose the specific bounds of an episode of care, the quality measurements to be used, and the target prices. However, during participation in the model, provider(s) will be paid under their respective PPS or physician fee schedule, less a discount proposed by the applicant that is at least 3% (if the participant selects a post-discharge period of between 30 and 89 days) or at least 2% (if the participant selects a longer discharge period). A regular retrospective reconciliation will occur, as described above. To minimize some of the risk, CMS will consider risk adjustment proposals.[7]

There are a number of factors that providers should weigh in considering this model. First, the proposed target price needs to account for a single rate of discount for all Part A and Part B services for the clinical condition, including the base payment for a MS-DRG and outlier payments, but excluding DSH, hospital capital and IME payments. While the discount remains constant, CMS will index it against annual fee-for-service changes. LTACHs will only participate in the episode of care after an inpatient stay in completed at a short-term care hospital. This may make it more difficult for an LTACH to manage the episode of care and overall costs.

Model 3 – Post-Acute Care Only. Model 3 is similar to Model 2 except that the short-term acute care hospitalization is excluded from the episode of care. The beneficiary is "anchored" to this model by the initiation of post-acute care at a participating LTACH, inpatient rehabilitation facility ("IRF"), skilled nursing facility ("SNF"), or home health agency ("HHA") within 30 days of discharge from a short-term care hospital. The episode of care being tested will cover a period of at least 30 days post-discharge from the short-term care hospital. Like Model 2, payments will be made under the appropriate fee-for-service payment system, to be reconciled regularly against the target prices at a later date. Applicants are to propose a percentage discount from the

LTACH-PPS or relevant payment system for initial payments under this model; however, a minimum discount is not required. In most other respects, Model 3 is the same as Model 2. Since the episode of care will generally begin (and may end) with the patient's stay in the LTACH, this model could provide LTACHs a better chance of managing overall costs.

Selecting a Model. Both Model 2 and Model 3 present opportunities for LTACHs to obtain shared savings from Medicare for patient conditions they currently treat if they can successfully coordinate care with other acute and post-acute providers to meet payment targets without sacrificing quality of care. As with most of the new CMS payment models being tested, there is financial risk involved for participants. Of the two models available to LTACHs, Model 2 should present less of a risk because the LTACH stay may comprise most or all of the episode of care being tested.

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1. Bundled Payments for Care Improvement Initiative: Request for Applications, 76 Fed. Reg. 53,137-38 (Aug. 25, 2011).
2. Bundled Payments for Care Improvement Initiative - Request for Application (RFA), available at: http://www.innovations.cms.gov/documents/payment-care/Request_for_Applications.pdf.
3. The CMMI provided a caveat in its Frequently Asked Questions, noting that "each application will be reviewed in light of the programs the applicant is participating in and the applicant's individual circumstances. [ ] CMS reserves the right to potentially subject these entities to additional requirements, modify program parameters, or ultimately exclude participation in multiple programs, based on a number of factors, **including the capacity to avoid counting savings twice in interacting programs** and to conduct a valid evaluation of the proposed interactions. Available at: http://www.innovations.cms.gov/documents/payment-care/Bundled%20Payment%20CMS%20Technical%20FAQ%20FINAL%208_25.pdf.
4. See RFA at 24-25. Normally, financial arrangements known as "gainsharing," where hospitals pay physicians to reduce or limit care to Medicare and Medicaid patients, are prohibited by the federal anti-kickback statute and subject to civil money penalties. However, CMS will permit certain gainsharing arrangements here if they satisfy requirements discussed in the RFA to ensure that care is not inappropriately reduced, quality of care does not suffer, utilization or referral patterns are not inappropriately changed, and there are safeguards against fraud, waste, and abuse.
5. The data are intended to allow applicants to define the episode of care and discount proposals based on the historical experience of providers in that geographic area. All required forms are linked at the CMMI's Bundled Payments initiative website, http://www.innovations.cms.gov/areas-of-focus/patient-care-models/Bundled-Payments-%20Care-Improvement-Application.html.
6. See n.5 for forms.
7. See RFA at 14.

About Us

The Law Offices of Jason M. Healy PLLC is a health care law firm that focuses exclusively on legal issues affecting health care providers. We help health care providers and their trade associations understand Medicare and Medicaid laws and regulations. We also represent health care providers in reimbursement audits, appeals, and litigation. Located in Washington, DC, we are well positioned to provide legal support for advocacy efforts. Our principal, Jason M. Healy, is a health care lawyer with over 14 years of experience with the array of legal issues facing health care providers.

Key Features of Bundled Payments Initiative Models Compared

Adapted from Appendix to CMS Fact Sheet dated August 23, 2011

MODEL → FEATURE ↓	MODEL 1 – Inpatient Stay Only	MODEL 2 – Inpatient Stay Plus Post-Discharge Services	MODEL 3 – Post-Discharge Services Only	MODEL 4 – Inpatient Stay Only
Eligible Awardees	• Physician group practices • Acute care hospitals paid under the IPPS • Health systems • Physician-hospital organizations • Conveners of participating health care providers	• Physician group practices • Acute care hospitals paid under the IPPS • Health systems • Physician-hospital organizations • Post-acute providers • Conveners of participating health care providers	• Physician group practices • Acute care hospitals paid under the IPPS • Health systems • LTACHs, IRFs, SNFs and HHAs • Physician-hospital organizations • Conveners of participating health care providers	• Physician group practices • Acute care hospitals paid under the IPPS • Health systems • Physician-hospital organizations • Conveners of participating health care providers
Payment of Bundle and Target Price	Discounted IPPS payment; no separate target price	Retrospective comparison of target price and actual FFS payments	Retrospective comparison of target price and actual FFS payments	Prospectively set payment
Clinical Conditions Targeted	All MS-DRGs	Applicants to propose based on MS-DRG for inpatient hospital stay	Applicants to propose based on MS-DRG for inpatient hospital stay	Applicants to propose based on MS-DRG for inpatient hospital stay
Types of Services Included in Bundle	Inpatient hospital services	• Inpatient hospital and physician services • Related post-acute care services • Related readmissions • Other services defined in the bundle	• Post-acute care services • Related readmissions • Other services defined in the bundle	• Inpatient hospital and physician services • Related readmissions
Expected Discount Provided to Medicare	To be proposed by applicant; CMS requires minimum discounts increasing from 0% in first 6 mos. to 2% in Year 3	To be proposed by applicant; CMS requires minimum discount of 3% for 30-89 days post-discharge episode; 2% for 90 days or longer episode	To be proposed by applicant	To be proposed by applicant; subject to minimum discount of 3%; larger discount for MS-DRGs in ACE Demonstration
Payment from CMS to Providers	• Acute care hospital: IPPS payment less pre-determined discount • Physician: Traditional fee schedule payment (not included in episode or subject to discount).	Traditional fee-for-service payment to all providers and suppliers, subject to reconciliation with predetermined target price	Traditional fee-for-service payment to all providers and suppliers, subject to reconciliation with predetermined target price	Prospectively established bundled payment to admitting hospital; hospitals distribute payments from bundled payment
Quality Measures	All Hospital IQR measures and additional measures to be proposed by applicants.	To be proposed by applicants, but CMS will ultimately establish a standardized set of measures that will be aligned to the greatest extent possible with measures in other CMS programs		