

Payment Bundle Initiatives Proposed by Senate & CMS

Several proposals have been recently advanced by legislators to reduce Medicare costs by various methods of bundling payments to hospitals and physicians for services provided over the course of a patient's treatment plan. On April 29, 2009 as part of their "Proposals to Improve Patient Care and Reduce Health Care Costs," the Senate Finance Committee released a plan to use the bundling of payments for inpatient and post-discharge care that the administration plans to use to provide for 16 billion dollars of Medicare spending reductions.¹ Further, the Centers for Medicare and Medicaid Services (CMS) has also created a pilot program to examine the benefits of bundling Part A and Part B Medicare payments.²

This Senate Finance Committee's proposal would bundle payments for acute inpatient care and post-acute care occurring or initiating up to 30 days following a patient's discharge, including home health, skilled nursing, rehabilitation, and long-term hospital services. This payment bundling would occur in three stages, the first starting in 2014 (FY 2015) and would include only those conditions accounting for the top 20% of post-acute spending.³ In 2016 (FY 2017) phase two would begin including the next 30% of conditions that require post-acute spending and in 2018 (FY 2019), the third and final phase would be implemented to include all remaining conditions. This bundled payment would include the inpatient MS-DRG amount plus post-acute care costs for the treatment of patients in that MS-DRG, including any expected or planned readmissions within the 30-day window. Although the hospital would receive the bundled payment even if no post-discharge care was given, the bundled amount will have already been adjusted to "capture savings from the expected efficiencies gained from improving patient care and provider coordination within the bundled payment system."⁴

In addition to the Senate Finance Committee's proposals, the Acute Care Episode Demonstration (ACE) project, expected to launch later in 2009, is a pilot program developed by CMS to provide for greater efficiencies and continuity of care amongst Part A and Part B providers. The three-year program effectively eliminates the Medicare Physician Fee Schedule and provides one, global payment under the Inpatient Prospective Payment System (IPPS). The new, bundled payment will cover both hospital and physician fees for

one "episode of care" for cardiovascular and/or orthopedic procedures. Participating sites (referred to as "Value Based Centers") have met certain volume thresholds; have quality care initiatives in place; and, have competitively bid for their bundled DRG payment. The program also provides for gainsharing arrangements with physicians who meet or exceed quality standards.⁵ Further, patients who, "based on quality and cost, choose to receive care from participating demonstration providers," are eligible to receive up to fifty percent [50%] of the savings to Medicare, as long as such payments do not exceed the patient's Part B premium of \$1,157 per year.⁶

Proponents of bundled payments assert that the move towards bundled payments provides a higher coordination and more efficient level of care. However, critics articulate concern as to the level of savings and patient care improvement that a blanket bundling of payments will actually generate. For example, the American Medical Association (AMA) expressed concern that such bundling proposals could result in the withholding or limiting of appropriate post-discharge or inpatient services. The AMA also called for the appropriate distribution of the payments to individual providers, risk-adjustment for patients whose care exceeds the amount accounted for in the bundled payment, and safeguards to ensure that patient care decisions remain in the hands of the individual providers.⁷ In a letter to the Senate Finance Committee, the American Hospital Association (AHA) stated that the Administration's approach to bundling payments was "problematic" and would require a "paradigm shift in health service delivery" resulting in the revision or withdrawal of numerous regulations promulgated to manage the current health care delivery and payment system.⁸ Finally, the American Association of Medical Colleges (AAMC), which supports the concept of care coordination provided through bundling, criticized Medicare's ACE program for not ensuring that payments are made directly to all parties (i.e., physicians) who provide the services.⁹

While no actual bundling policy has been implemented, recent actions by both the US Senate and CMS have demonstrated that such initiatives on the healthcare horizon and may soon become a part of the healthcare reimbursement environment.

¹ "Administration News – President Obama's Budget Request

(Continued from previous page)

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- 2 “Acute Care Episode Demonstration,” Centers for Medicare and Medicaid Services, March 20, 2009,
<http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/ACEFactSheet.pdf>(Accessed 6/1/09)
- 3 “Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs” By the Senate Finance Committee. April 29, 2009. p. 14.
- 4 “Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs” By the Senate Finance Committee. April 29, 2009. p. 15.
- 5 “Acute Care Episode Demonstration: Fact Sheet,” Centers for Medicare and Medicaid Services, p. 1-2,
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- 6 “Medicare Acute Care Episode Demonstration for Orthopedic and Cardiovascular Surgery,” Centers for Medicare and Medicaid Services, p. 1,
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- 7 “Statement of the American Medical Association to the Committee on Ways and Means Subcommittee on Health, U. S. House of Representatives.” p. 6. Sept. 11, 2008.
- 8 “Statement of the American Hospital Association to the Senate Finance Committee” p. 7. April 21, 2009.
- 9 “Comments of the American Association of Medical Colleges to the Senate Finance Committee,” May 16, 2009, p. 5,
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Robert James Cimasi, MHA ASA, CBA, AVA, CM&AA, President. Mr. Cimasi is a nationally recognized healthcare industry expert, with over 25 years experience in serving clients, in over 49 states, with a professional focus on the financial and economic aspects of healthcare industry including: valuation consulting; litigation support & expert testimony; business intermediary and capital formation services; certificate-of-need and other regulatory and policy planning; and, healthcare industry transactions, joint ventures, mergers and divestitures.

Mr. Cimasi holds a Masters in Health Administration from the University of Maryland, and several professional certifications. He has been certified and has served as an expert witness on cases in numerous states, and has provided testimony before federal and state legislative committees.

Mr. Cimasi is a nationally known speaker on healthcare industry topics, is the author of several nationally published books, chapters, published articles, research papers and case studies, and is often quoted by healthcare industry press. Mr. Cimasi's latest book, "*The U.S. Healthcare Certificate of Need Sourcebook*", was published in 2005 by Beard Books. In 2006, Mr. Cimasi was honored with the prestigious "*Shannon Pratt Award in Business Valuation*" conferred by the Institute of Business Appraisers and was elevated to the Institute's College of Fellows in 2007.



Todd A. Zigrang, MHA, MBA, CHE, Senior Vice-President. Mr. Zigrang has over twelve years experience in providing valuation, financial analysis, and provider integration services to HCC's clients nationwide. He has developed and implemented hospital and physician driven MSOs and networks involving a wide range of specialties; developed a physician-owned ambulatory surgery center; participated in the evaluation and negotiation of managed care contracts, performed valuations of a wide array of healthcare entities; participated in numerous litigation support engagements; created pro-forma financials; written business plans and feasibility analyses; conducted comprehensive industry research; completed due diligence analysis; overseen the selection process for vendors, contractors, and architects; and, developed project financing.

Mr. Zigrang holds a Masters in Business Administration and a Master of Science in Health Administration from the University of Missouri at Columbia. He holds the Certified Healthcare Executive (CHE) designation from, and is a Diplomat of, the American College of Healthcare Executives and a member of the Healthcare Financial Management Association.



Lance A. Haynes, MSF, Vice President. Mr. Haynes focuses on the area of financial and economic analysis and consulting. His main responsibilities are comprised of business, tangible asset and intangible asset valuations, as well as financial analysis and forecasting for healthcare services related enterprises. Mr. Haynes has performed valuations for many types of ancillary services providers including Surgical/Specialty Hospitals and Ambulatory Surgery Centers, Cardiac Catheterization Labs, Diagnostic Imaging Centers and Kidney Dialysis Centers, and has also performed valuations and financial analyses for Home Healthcare

Providers, Long-term Care Facilities and Physician Medical Practices across various specialties. In addition, Mr. Haynes has performed joint venture service line and lease arrangement valuations for hospitals and physician groups, and has assisted with numerous litigation support engagements. Prior to joining HCC, Mr. Haynes was a Research Associate with Flagstone Securities, a specialty investment bank, located in St. Louis, Missouri, where his main responsibilities included the development and maintenance of company earnings models and proprietary stock indices for publicly traded companies.

Mr. Haynes received his Bachelor of Arts in Finance from the University of Northern Iowa and his Master of Science in Finance from St. Louis University. Mr. Haynes is a Level III candidate in the Chartered Financial Analyst (CFA) Program, and is a member of both the CFA Institute and CFA Society of St. Louis.



Anne P. Sharamitaro, Esq., Vice President. Ms. Sharamitaro focuses on the areas of Certificate of Need (CON); regulatory compliance, managed care, and antitrust consulting. Ms. Sharamitaro was admitted to the Missouri Bar in 2005 after graduating with J.D. and Health Law Certificate from St. Louis University School of Law. At St. Louis University, served as an editor and staff member of the Journal of Health Law, published by the American Health Lawyers Association. She has presented healthcare industry related research papers before Physician Hospitals of America (f/k/a American Surgical Hospital Association) and the National Association of Certified Valuation Analysts.



Kelly Gordon is a Research Associate at Health Capital Consultants (HCC). Ms. Gordon is in her second year of the Master of Health Administration program at Saint Louis University and will graduate in May 2009. Ms. Gordon also has a Master of Social Work from Washington University in Saint Louis. At HCC, Ms. Gordon provides research support in the areas of medical specialty trends related to a wide and diverse array of healthcare industry enterprises.