

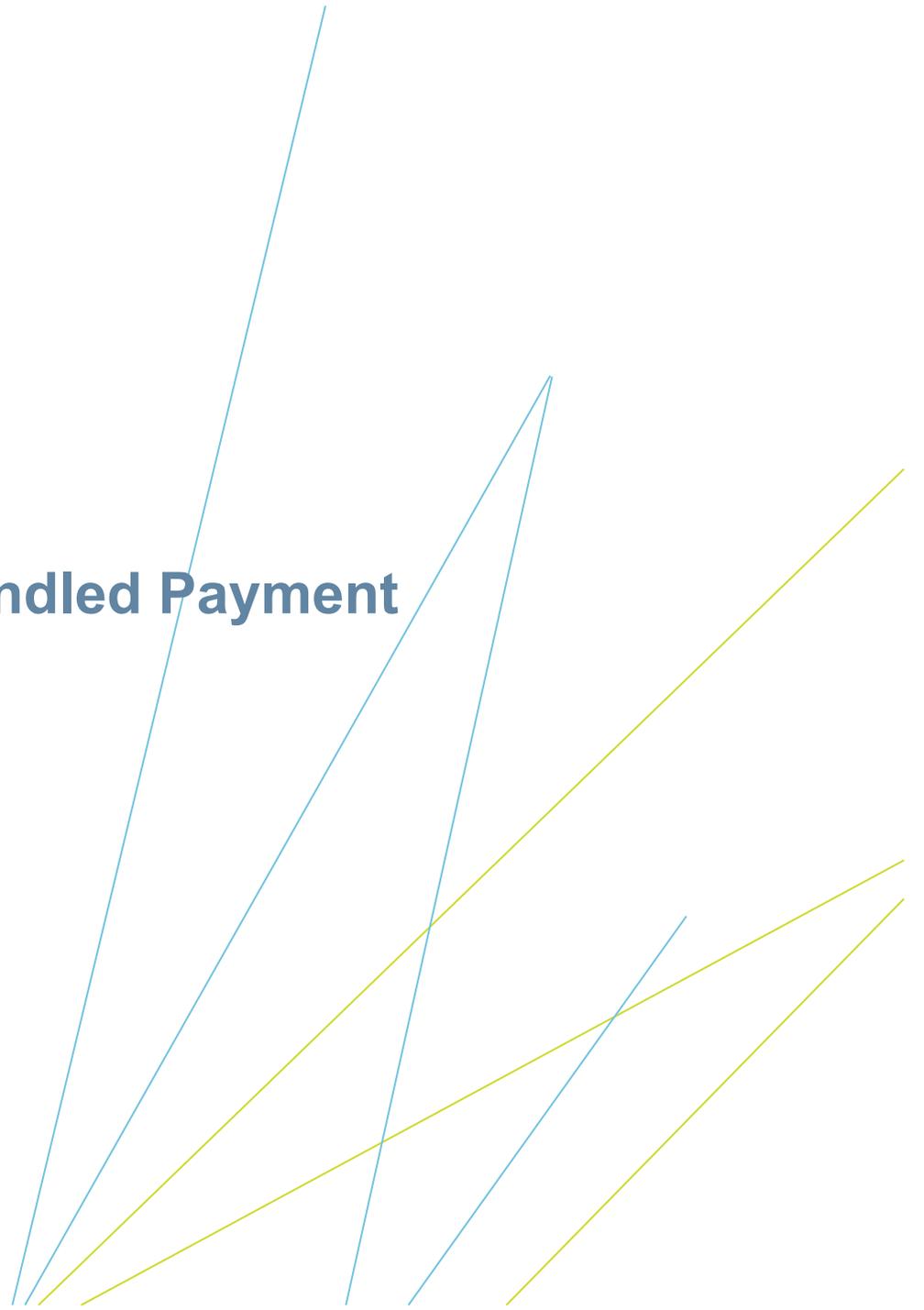


**American Medical Rehabilitation
Providers Association**
7th Annual AMRPA Educational Conference

Changing IRFs: How to Succeed Under Bundled Payment

October 5, 2009

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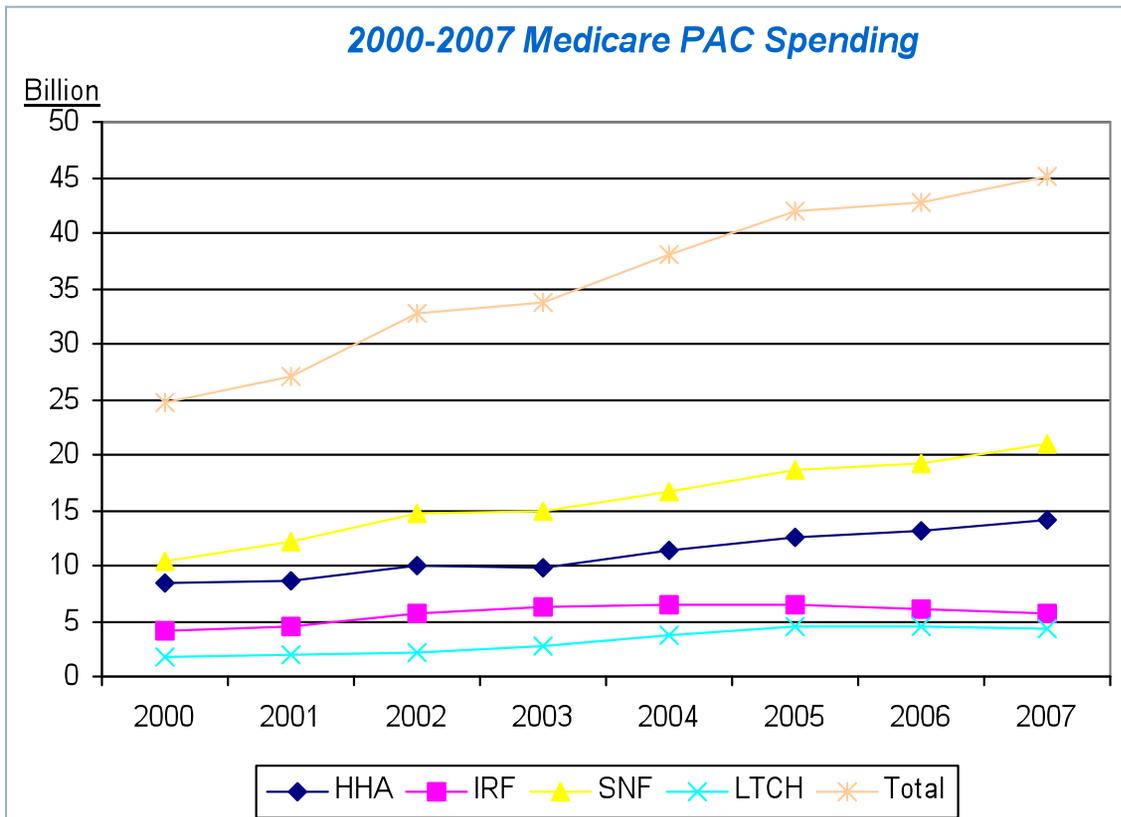


Agenda

- Provide brief overview of CMS post-acute assessment
- Review current health reform proposals relative to IRFs
- Discuss strategic implications
- Present IRF provider options
- Discussion

IRF and Post-Acute Continuum Poised For Change

- Undoubtedly, payment reform is one of the biggest issues on the table for healthcare providers
- CMS had been looking at the post-acute continuum closely for several years, with an eye towards reducing costs, even prior to the current debate



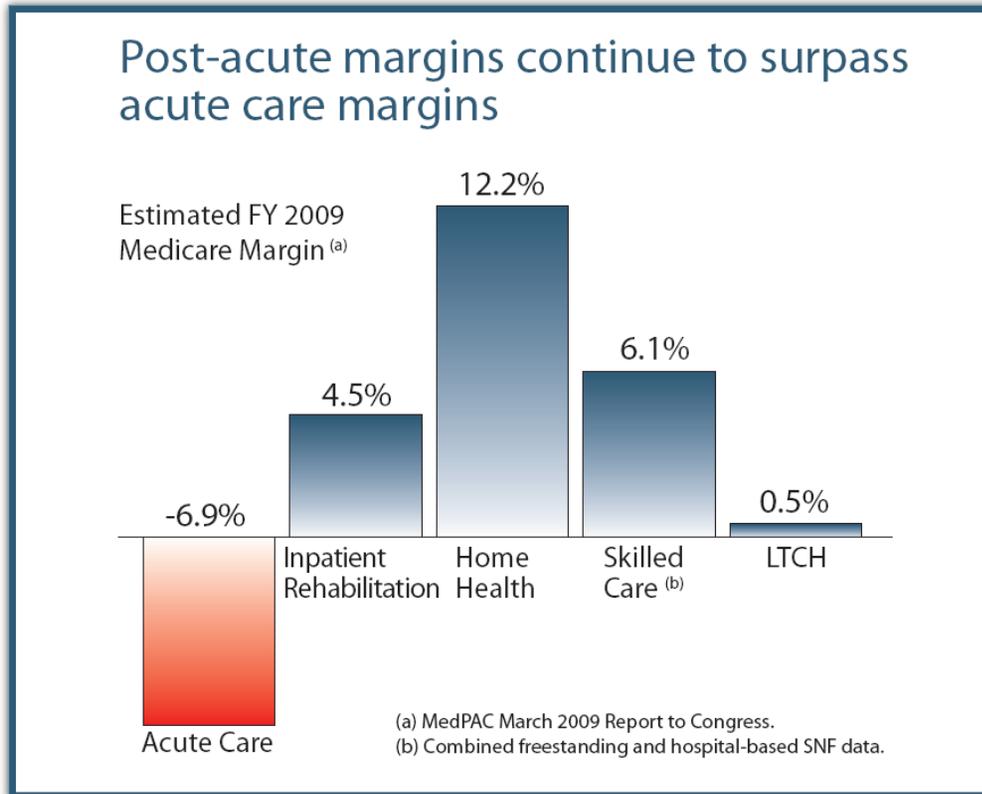
- From 2000 to 2007, CMS spending for PAC increased an average of 9 percent per year
- Over the same time period, spending for acute care increased just 3.9 percent per year
- The CMS PAC expenses have increased from 12 percent of all fee-for-service spending in 2000 to 15 percent in 2007

Source: (a) MedPAC, Healthcare and Spending and the Medicare Program, June 2007.



In Addition to Rapid Payment Increases, Post-acute Margins Also High

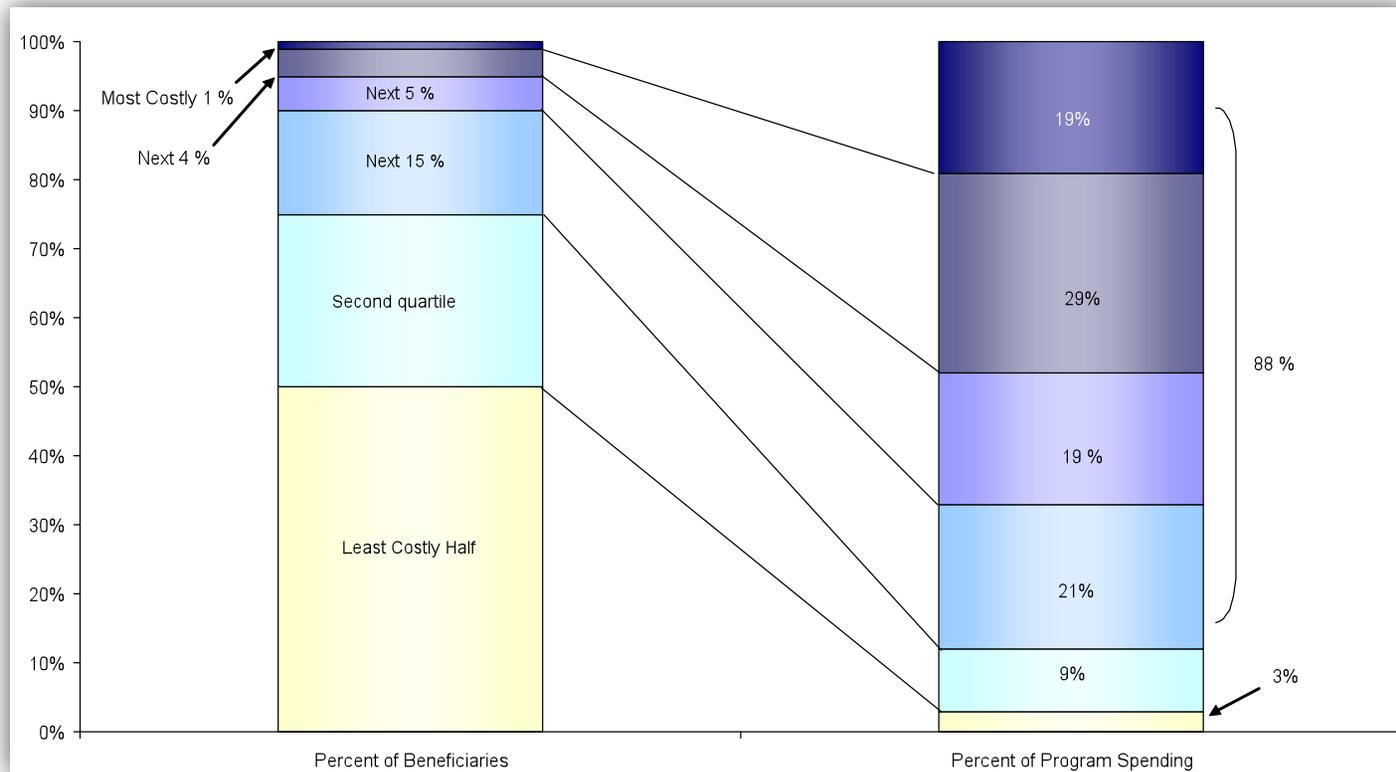
- In recent years, IRF and other post-acute levels of care have consistently outperformed acute care from a financial perspective



IRF not as high as other PAC providers, but was 8.4% prior year, and still perceived to be high by CMS

Healthcare Reform – Where Would You Focus?

Medicare (FFS) Spending Highly Concentrated on Small Population, 2002 (a)



- 40 percent of all Medicare acute care discharges access some level of PAC.
- IRFs are a smaller piece of this dynamic, but a major focus for change will be those populations that require multiple services over a long period of time.

Source: (a) MedPAC, Healthcare and Spending and the Medicare Program, June 2007.



Even Prior To Current Effort for Major Reform, Multiple CMS Efforts to Control Spending for Most “At-Risk” Beneficiaries

- Multiple CMS demonstration projects designed to evaluate more efficient and cost-effective means to manage most “at risk” and costliest patients, including PAC

Demonstration Project	Goal
<i>Post-acute Care Payment Reform</i> (2007 – 2011)	Examine differences in cost and outcomes of similar patients using different PAC settings – patient centered care
<i>Medical Home Management</i> (2008 – 2012)	Provide MD and technology services in the home to “high-need populations” – family centered care
<i>Chronic Care</i> (2004 – 2010)	Decrease Medicare expenditures through disease management – payment given to care management companies; providers still FFS
<i>High-Cost Beneficiaries</i> (2005 – 2009)	Decrease Medicare expenditures through disease management – dollars given to care management companies; providers still FFS
<i>Other – Senior Risk, OP Chronic Care</i> (2007 – 2010)	Provide comprehensive approach to disease prevention and risk reduction

Biggest potential IRF impact

Chronic Care initiatives may be component of health reform

Two Biggest IRF Concerns From Current Reform Efforts

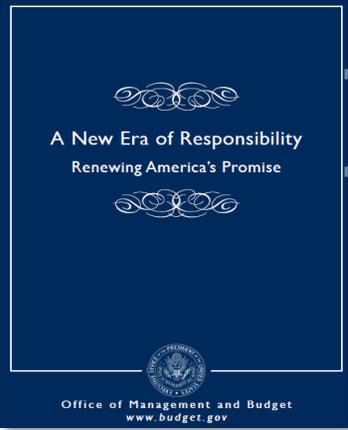
- Readmission Reduction Efforts
 - 18 percent of Medicare discharges from acute care result in readmissions within 30 days of discharge; approximately same number of PAC admissions are readmitted
 - ◆ *10 percent for IRFs, but increasing for many providers*
 - MedPAC estimates that readmissions cost CMS \$15 billion in 2005 - *and that \$12 billion was potentially preventable*
- Bundled Payment - *a single Medicare payment for acute care, post-acute care, and/or physician*
 - Although all PAC programs have transitioned to PPS, CMS and MedPAC have concerns that separate payments to providers across an episode of care do not create financial incentives to coordinate care
 - Also believes there is lack of accountability of providers for all care during the episode



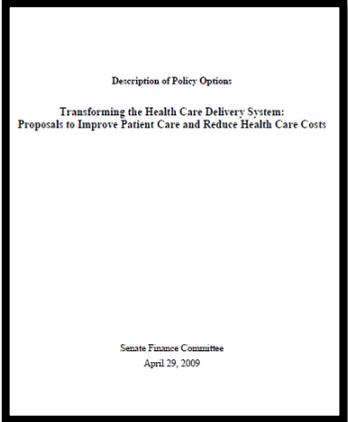
- *90+ percent of all IRF patients referred from acute care*
- *+/- 65 percent of all IRF patients Medicare beneficiaries*

Surprising Agreement On Key Post-acute Issues

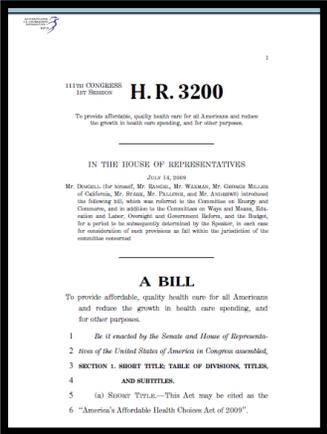
White House Proposal 2/26/09



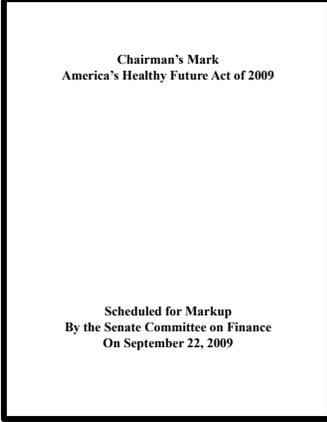
\$8.4B savings in reduced acute care readmissions
 \$17.8B savings through bundled Medicare payments for acute & post-acute



- Reduced acute payment for acute care readmissions
- Acute & post-acute bundled payment starting FY 2015



- Acute "penalty" for readmission beginning FY 2012
- Pilot project for bundled payments to be initiated by 1/1/11



- Voluntary bundled payment pilot project started in FY 2013
- Acute care readmission penalty to begin FY 2013

While there is major disagreement over a public insurance option, universal coverage, and adding employer funding, there is surprising overlap with regard to post-acute care.

Senate Finance Committee Mark-Up - Sept. 22, 2009

Recommendation	Time Frame
Bundled Payment Pilot Project	<ul style="list-style-type: none"> ➤ Bundled payment defined as the period beginning 3 days prior to hospitalization and continuing thru 30 days following hospital discharge ➤ Voluntary pilot project started in FY 2013 for 8 specific conditions ➤ Payment made to hospital, physician group, post-acute provider, or other entity comprised of multiple providers ➤ Provider receives bundled payment for all patients regardless of use of post-acute care ➤ Quality measures established for participants ➤ If results positive, CMS to provide implementation plan to Congress by FY 2016, with implementation by FY 2018
Reducing Avoidable Hospital Readmissions	<ul style="list-style-type: none"> ➤ Beginning FY 2012, national and hospital-specific readmission rates published ➤ Beginning FY 2013, hospitals with excessive readmissions in any of 8 specific conditions will have reimbursement for original admission reduced by up to 20 percent ➤ Potential to expand to additional conditions after 3 years ➤ Implementation not intended to be budget neutral!

Still a moving target, however, so stay tuned!
Time frames and logistics could loosen or tighten...

IRF Strategic Planning – Readmission Penalties

IRF Success Criteria

1. Minimal returns to acute care
2. Measurable outcomes that meet/exceed industry standards required.

Referral sources may look for alternative placement options if these criteria are not met.

FY 2010 IRF Check List

- Perform internal evaluation
 - ✓ What kind of patients are we admitting?
 - ✓ What kind of a job are we doing?
 - ✓ Are we doing as well as the industry, or more importantly, our competitors?
 - ✓ Can we do better?

Two Potential Areas For Review for Readmissions



How well do you manage current referrals?

- ◆ What is your current rate for returns to acute care?
- ◆ What is your current case mix index?
- ◆ What is your current rate for returns to acute care, particularly for those patients with CMI of 1.2 or higher?
- ◆ What is the reason for bounce-backs?

Reality Check-

If you score well, be sure to look at other side of the equation.

- ◆ Are your days on-set prior to IRF admission higher than industry?
- ◆ Are discharges to community significantly higher than norm?
- ◆ Are discharges back to acute significantly lower than norm?

Do You Have Balanced Score Card?

- Could be helpful in ongoing program assessment

	Target	Actual			
		Oct	Nov	Dec	Total
Admissions	75	80	70	70	73.3
ALOS	15.5	14	14.5	15	15
Days Onset	4.5	4.5	4	5.5	6
Return Acute	12.0%	10.0%	10.0%	15.0%	15.0%
CMI	1.05	1.05	1.04	1.07	1.1
Admit FIM	55	50	50	52	51
Discharge FIM	75	70	74	75	73
FIM Change	20	20	24	23	22
FIM Efficiency	1.3	1.4	1.7	1.5	1.5
Net Rev/Pt Day	\$1,200	\$1,200	\$1,100	\$1,100	\$1,400
Expense/Pt Day	\$1,000	\$1,100	\$1,000	\$1,100	\$1,200
Nurse HPPD	6.5	6.0	7.5	7.0	70.0
Other					

Frequently, if Problems Exist, It May Suggest Need to Assess Clinical Staff Competencies

- Could find greater skills are required to either reduce returns to acute or increase patient acuity
- Program might require infusing of new staff or more robust medical/surgical skills for nursing staff
- Sicker patients are not necessarily the “fun” patients for therapy staff – these patients are more of a challenge
- Will require added education and justification as to “why this patient was ever admitted”



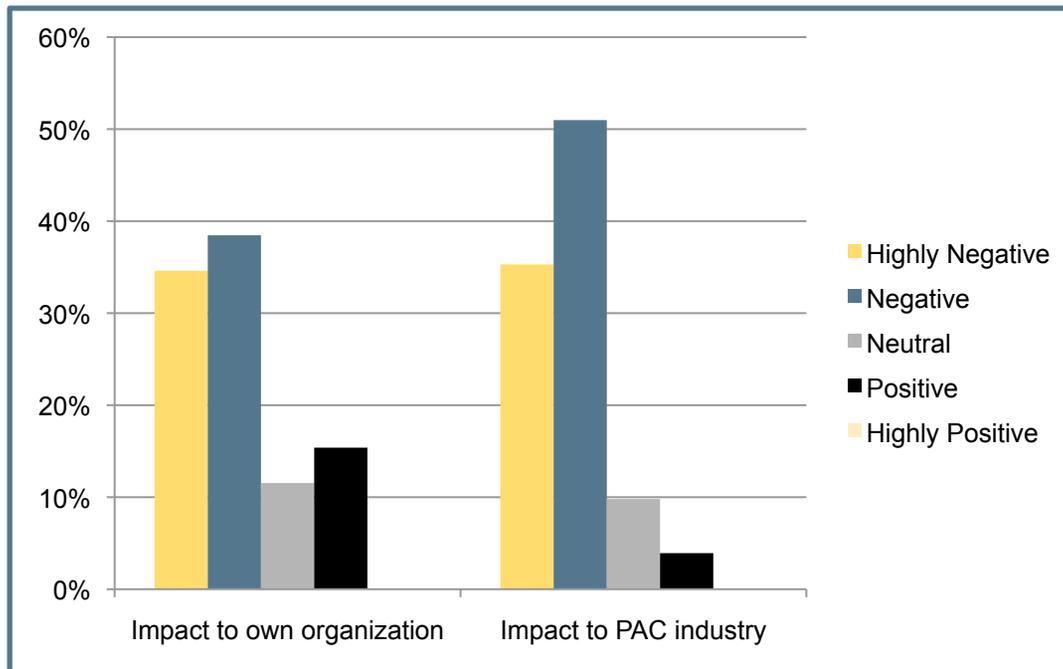
Bottom Line on Readmissions: *Delivering on Your Promise!*

- Take sicker patients only when you know you can manage them
- Sicker patients mean that your programs lives up to being a “hospital” level of care
- Bounce-backs for less than emergent conditions lose credibility for the program and result in fewer referrals
- Accept patients at least as acute as your competitors and achieve outcomes at least as good as these providers
- When problems occur (and they will), marketing oriented “damage control” is a must



Bundled Payments

- While CMS and Congress might like the idea, the IRF industry has other thoughts!



Would a bundled payment be good for:

- Your organization?
- The PAC Industry?

Source: Noblis/AMPRA Post-acute Insights Panel, Sept. 2009

Survey Findings: Will Bundled Payment Be Good For You?

Depends on your current situation...

Yes	No	Maybe
<ul style="list-style-type: none"> ➤Part of health system ➤Most of referrals come from health system ➤Low cost provider ➤Positive outcomes 	<ul style="list-style-type: none"> ➤Freestanding, unaffiliated ➤Competitive market, referrals come from many sources ➤No CON/barrier to entry ➤High cost ➤Average outcomes 	<ul style="list-style-type: none"> ➤Freestanding, unaffiliated ➤Dominant market position ➤Low cost ➤Positive outcomes ➤Strong relationships/ partnerships with major referral sources

Different strategy for each provider type.

IRF Strategies to Succeed Under Bundled Payment

- As with most other key issues, success in a post-bundled payment world will boil down to three easy objectives:
 1. Cost
 2. Quality
 3. Relationships/Partnerships

IRF Strategies to Succeed Under Bundled Payment

- IRFs (and all other PAC providers) are best served by **“swimming upstream”** and becoming part of the culture of referral sources
 - If not part of a large health system, develop “strategic partnerships” with key referral sources, not just a referral relationship
 - Providing therapy services is a great start
 - Medical staff, clinical staff, program protocols, patient care should also become integrated
 - ◆ Develop a pilot project in FY 2010 to improve acute care outcomes for stroke patients (or trauma, orthopedic, etc.)
 - ◆ Collaboratively develop admission, discharge and outcome criteria
 - ◆ Have quarterly executive sessions to review success – predominantly positive impact for referral source

IRF Strategies to Succeed Under Bundled Payment

- Become “**one with your referral source**”
 - Acute care provider will always refer out those few patients with exceptional needs requiring specific, expensive resources (SCI, TBI, etc.)
 - But, there is potential risk for the creation of competitive programs where sufficient critical mass exists for acute care hospital to create separate program (i.e., IRF bread and butter patients)
 - If they have the critical mass to support at least a 15-20-bed IRF, all things being equal, they may likely pursue that course
 - Take away the reasons they may want to create their own program...

IRF Strategies to Succeed Under Bundled Payment

- Ultimately, if acute care providers control funds, they will be most interested in accessing services that **minimize readmissions** and are the most **cost effective**
 - Over time, partnership might need to also include “at risk” relationships with major referral sources
 - Example: IRF receives 80 percent of payment if certain thresholds are met, and 100+ percent if certain thresholds are exceeded
- IRFs must be able to demonstrate **measurable outcomes** and do this less expensively than any other option, including home-grown program for acute care provider



Look For Opportunities To Strengthen Partnership Today!

- All post-acute programs are going to be more important to acute care providers as they become at financial risk for readmissions

Help acute care referral sources best manage readmission issue today, to create foundation for long-term bundled payment relationship tomorrow

- Assess their current referral patterns and opportunities for improvement
 - Are they referring as many patients to IRF as would be expected?
 - ◆ If not, and potential IRF patients are going to SNF, this might increase the likelihood of readmissions...
 - Are they referring as many patients to all levels of post-acute care as would be expected?
 - What are the outcomes for each major program? Better or worse than expected?
 - What is the plan of action for improvement?

PAC Utilization Benchmarks

PAC Program	% of Acute Discharges (Medicare Only)	Medicare % of Admissions
IRF	4% - 6%	65%
LTCH	1% - 2%	65%
SNF	10% - 14%	90%
HHA	22% - 26%	60%
Total	40% - 50%	60%-90%

- IRF ALOS 14.5 days; LTCH ALOS 27 days
- IRF market demand generally 10-12 beds/100,000 population
- LTCH market demand generally 8-10 bed/100,000 population
- SNF market demand generally +/- 25 bed/100,000 population (short-term SNF only; not inc. long-term care)
- An estimated 1,500-2,000 certified HHA referrals/100,000 population

- Assumes appropriate access

- National discharge to PAC 40 percent in 2007

Is Now The Time To Assess IRF Continuum?

- Will you make a better partner if you can say “YES” to a larger patient population than just those that meet the IRF medical criteria?
 - This will potentially avoid the need for multiple partnerships for the acute care provider and potentially strengthen relationship
 - Additionally, nationally, 55 percent of all IRF patients discharged to second PAC setting (predominantly HHA, SNF) – IRFs are going to have to bring to the table the ability to manage an “episode of care” as well
- To be a true partner, do you need to expand your continuum to accept a broader cross section of post-acute patients?
 - SNF? HHA? LTCH? Residential? Specialty outpatient programs?
 - Other?
- Clear risks involved in getting too far ahead of the curve, but greater risks in falling behind

Where Do IRFs Go From Here?

Short-term Considerations

- Ensure ability to withstand medical necessity and documentation audits
 - Including reason why IRF best placement option, physician oversight, interdisciplinary team, provision of therapy, etc.
- Top down assessment of intake/census development processes to ensure you are capturing all potential patients
 - Admission criteria, admission process, clinical competencies, medical staff involvement, etc.
- Make certain that medical staff model supports clinical needs for higher acuity patients – sufficient internal medicine, specialty coverage

Where Do IRFs Go From Here?



Long-term Considerations

- Fully demonstrate cost efficiency and quality outcomes to referral sources, patients, families, etc.
- IRFs must tie down their referral sources so that competitive programs do not emerge
 - Does this require some type of risk-sharing or alternative organizational model?
- Complete assessment of own continuum of care
- Have in place a strategic plan that addresses all of these issues to create long-term success

Parting Thoughts

- Tremendous change is likely to occur within IRF, PAC, and all other segments of healthcare
- Although it has been discussed for 10 years, some kind of bundled payment appears more likely than ever
- Both bundled payment and readmission policies will create opportunities for IRFs to more closely align with referral sources
- Nothing occurs happenstance, however, and IRFs must work proactively to evaluate its ability to meet short-term challenges (census development, audits, medical necessity, etc.) as well as to successfully create a strategic vision for its role in a post-bundled payment environment



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