American Medical Rehabilitation Providers Association
9th Annual AMRPA Educational Conference

Miami, FL

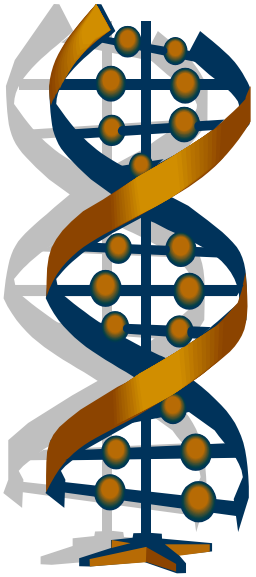
Health Reform and IRFs

Achieving Long-term Success!

September 27, 2011

Walter CONSULTING

Focus of Today's Session



- Introduce Walter Consulting
- Discuss environmental factors impacting IRFs
- Review IRF short-term & long-term action items
- Discussion

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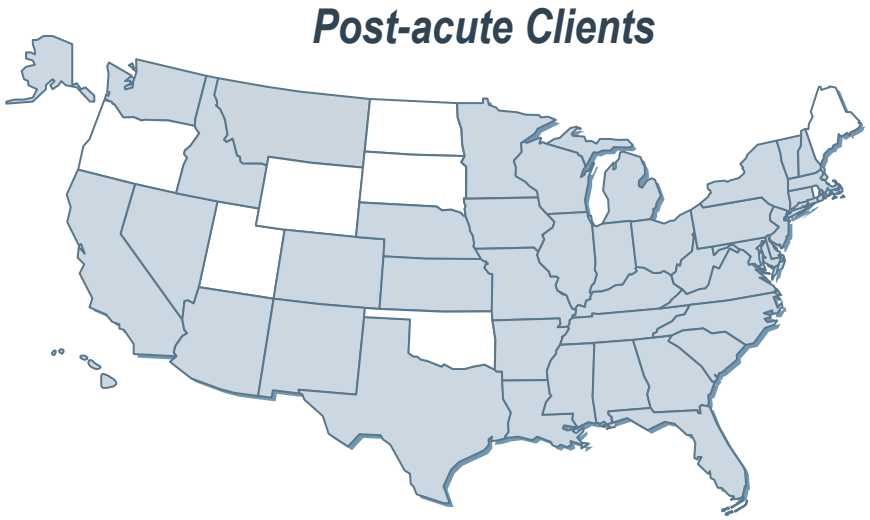
National Rehab and Post-acute Consulting Experience

- Over one-third of the +/- 100 freestanding NFP IRFs nationally
- Multiple proprietary IRFs and systems
- Major academic medical centers and integrated health systems
- Community hospitals and faith-based organizations
- Freestanding and hospital-based SNFs
- Freestanding and hospital-based HHAs
- Proprietary and NFP LTCHs
- Clients in 40+ states
- Other



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Recent Changes to IRF Landscape

Change	Impact to IRFs
FY 2012 payment update of 1.8%	Payment increases not keeping up with expenses increases erode bottom-line performance
Re-admission penalties	Less direct impact to IRFs immediately due to CHF, MI and Pneumonia as initial diagnoses, but longer term consequences
IRF quality reporting requirements	Initial steps for Pay-for-Performance
Bundled Payment Demonstration	Big potential opportunities; challenges, however, for IRFs without other levels of care
Continuing Care Hospital	Potential opportunity but lots of unknowns

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Modest Revenue Adjustments (e.g., 1.8%) Likely to Increase Financial Pressure on IRFs

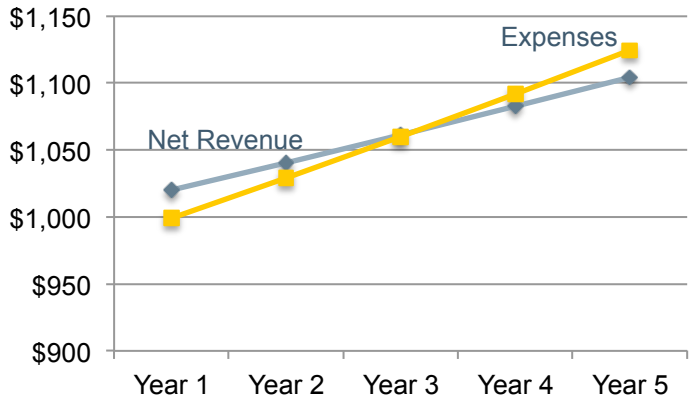
- Because Medicare is largest IRF payor, modest reimbursement increases that do not keep pace with inflation present significant challenges for providers
  - *Medicaid adjustments likely less than Medicare*

Impact of Revenue Adjustments Remaining Lower Than Expense Adjustments

	Base Year	Annual Inflation	Projections				
			Year 1	Year 2	Year 3	Year 4	Year 5
Net Revenue	$1,000	2.0%	$1,020	$1,040	$1,061	$1,082	$1,104
Expenses	$970	3.0%	$999	$1,029	$1,060	$1,092	$1,124
Net Income	$30		$21	$11	$1	-$9	-$20
Operating Margin	3.0%		2.0%	1.1%	0.1%	-0.9%	-1.8%

Any volume decreases over this same period would accelerate the negative trend

Regardless of current financial performance, status-quo operations and strategic initiatives are not an option



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2011-2012 Priorities to Mitigate Financial Impact

*Key priority is to look at both the **revenue** and expense side of the equation*

On average, an ADC increase of 1.0 will increase Operating Income by $250,000

This is only approximately 26 new admissions annually, or +/- 2 admissions per month

- *What is the **universe** of IRF potential in your hospital or in your market?*
- *Many providers have not fully transitioned from the changes in the 75 Percent Rule, and often do not effectively target certain **neurology** and other higher acuity patients*
  - *How comfortable are the clinical staff and medical staff in taking and managing **higher acuity patients**? Can the therapy staff effectively adapt?*
- *Regardless of written admission criteria, what have we **trained our referrals sources** about patients we will accept and will not accept?*
  - *Is this consistent among all admitting physicians?*
- *What are the resources we are applying towards **census development** activities?*

Two IRF Planning Benchmarks

Approximately 4% to 6% of Medicare acute care discharges
Approximately 10 beds/100,000 population at 85% occupancy

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2011-2012 Priorities to Mitigate Financial Impact

*Key priority is to look at both the revenue and **expense** side of the equation*

Expense management is not simply about reducing staff or cutting costs

- *The single biggest opportunity for expense management is to implement **"best practices"** operational practices*
  - *For similar diagnosis, look at various practices and outcomes by physician or by location*
    - ✓ *Length-of-stay*
    - ✓ *Therapy/other ancillary utilization*
    - ✓ *Pre-admission/admission processes and days on-set prior to admission*
    - ✓ *Other*
- *Consider implementation of **Dash Board** planning tools for expense management, productivity, staffing, etc.*
- *Ensure appropriate **IT systems** for effective resource utilization*
- *Do we need to **"right-size"** certain programs?*
- *Can we afford to stay in all **existing business** lines?*
- *Other – try to think **outside of the box**…*

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Re-admission penalties

- Beginning FY 2013 (Oct. 1, 2012), acute care hospitals penalized for "excessive" readmissions
  - Initial diagnostic categories of CHF, MI, and Pneumonia not generally high volume patients for IRFs, although IRFs will certainly be held to a higher standard on a go-forward basis for these populations

IRF quality reporting requirements

- Also beginning FY 2013 (Oct. 1, 2012), IRFs will need to report both percent of patients with new/worsened pressure ulcers and with catheter associated UTIs
  - A potential third item includes readmission measure

The biggest issue is not the immediate impact of these two new rules

Instead it is the constant drum-beat signifying the CMS's intent to continue it's move toward Pay-for-Performance reimbursement models for IRFs

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Prepare For Payment Linked to Demonstrated Quality

- Clearly, it will not be enough to simply say “We provide excellent quality” without **measureable indicators** comparing your performance to industry and local competitors
- The information reported will also need to go far beyond FIM gain and/or Return to the Community

- Every IRF must be able to demonstrate effectiveness on these measures **without sacrificing performance** on other measures
  - Admission Days Onset, FIM score, CMI and discharge FIM must remain as good or better than both the industry and local competitors
  - Cannot afford to be risk-adverse in order to achieve quality targets – if this is being done, then program content needs to be evaluated
    - Staffing
    - Competencies
    - Medical staff coverage
    - Etc.

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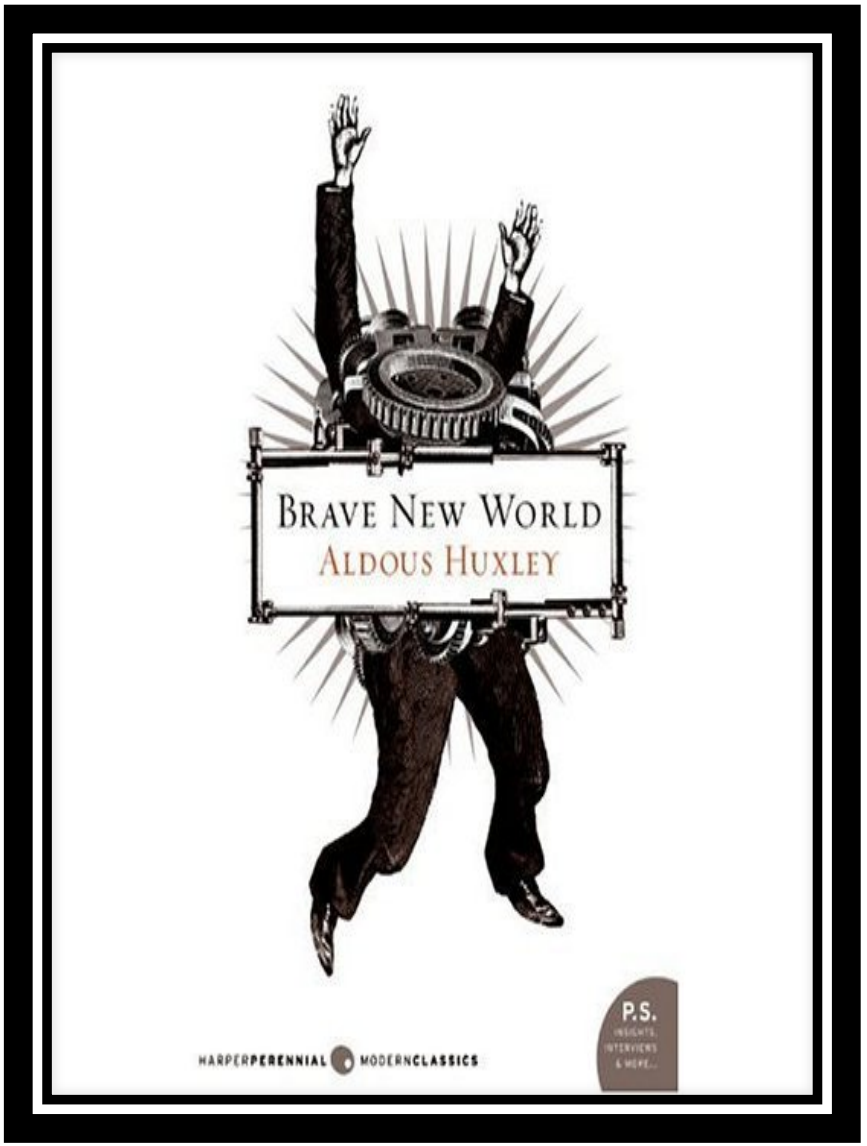
Bundled Payments – *Welcome to a Brave New World!*

Definitely a game-changer because Medicare is clearly moving away from Fee-For-Service



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Bundled Payments – The Mechanics

Feature	Model 1 Inpatient Only	Model 2 Inpatient + post-acute	Model 3 Post-acute Only	Model 4 Inpatient Only
Period covered	Acute care stay	Acute care stay and 30-89 or 90+ days post-discharge	Admission into post-acute for minimum of 30 days	Acute care stay
Patients covered	All Medicare FFS patients	Specific MS-DRGs proposed by applicant		
Payment	Discounted FFS with gain-sharing for reduced expenses; inc. Part A only	• Discounted Fee-for-Service with proposed target • Participants receive any additional gains after reconciliation • Includes Part A & B		Prospective payment, inc. MD
Financial Risk	Discounted amount	Discounted amount AND payback if FFS payments exceed targets		FFS – new payment
Quality	All models will have quality indicators			
Duration	Three years with potential to extend two additional years			
Process	LOI due 9/22/11 Application due 10/21/11	LOI due 11/4/11 Application due 3/15/12		

Note: Acute care stay inc. 3 days prior for related services.

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CMS Goals

- CMS expects these payment models will be successful through:
  - Care redesign
  - Reengineered care pathways
  - Standardized care using checklists
  - Care Coordination
  - Gainsharing
- In its notices, CMS makes clear that this the first in a series of activities designed to redefine an episode of care

CMS Vision of the Progression of Bundled Payments

Payment of Bundle	Acute Care Hospital Stay Only	Acute Care Hospital Stay plus Post-Acute Care	Post-Acute Care Only	Chronic Care
"Retrospective" (Traditional FFS payment with reconciliation against a predetermined target price after the episode is complete)	Model #1	Model #2	Model #3	Model #7
"Prospective" (Single prospective payment for an episode in lieu of traditional FFS payment)	Model #4	Model #5	Model #6	Model #8

Source: Bundled Payment Request for Application

= Current = Future

Why Now?

- Two reasons
  1. Cost
  2. Quality

CMS prior experience suggests positive results with bundled payment concept

Program	Focus	Results
Heart Bypass Center Demonstration (1986-1991)	Bypass surgery	10% Medicare savings; lower beneficiary copayments
Cataract Alternative Payment Demonstration	Cataract surgery	2%-5% Medicare savings
Geisinger ProvenCare	CABG	Decreased costs by 5%; readmission rate decreased by 44%; ALOS decrease by .5 days

Additionally, ACE Demonstration project underway since 2009 for cardiac and orthopedic diagnoses beginning to show favorable results in both cost management and quality improvement

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Two Biggest Questions for IRFs

1. Do we participate in the Bundled Payment Demonstration project?

- ***Yes***
- ***Assuming economic incentives in place, it provides an opportunity to learn emerging payment model with less risk, and with limited target populations***
- ***If part of a health system, you might not have a choice***

2. If we do participate, what will it take to succeed?

- ***Low cost – if you are not low cost, you may be bypassed for alternative programs (e.g. SNFs)***
- ***Demonstrable high quality – without it, business will go to your competitors***
  - ***Quality = readmissions, medical management, functional gains, etc.***
- ***Tight integration with both upstream and downstream providers***
  - ***Handoffs will be critical – timing, exchange of information, expectations, etc.***

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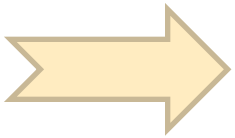
Two Options At This Time for IRFs and Other PAC Providers

	Model 2 - Inpatient + PAC	Model 3 - PAC Only
Pros	• Acute care partner controls the patient • If part of a system, there may not be a choice	• May be easier for freestanding IRFs with multiple levels of care to implement (SNF, HHA, other)
Cons	• IRF and PAC providers will likely be smaller piece of overall pie	• At mercy of acute care provider to refer patient



- *Because the number one problem for many IRFs has been patient flow (i.e., volume), **swimming upstream** and becoming part of the bundled payment is likely the **desired position***
- *A PAC-only bundled payment may have all of the system in place, but **no patients…***

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Successfully managing risk under a bundled payment begs the question of the continuum of care

- Especially for freestanding IRFs, it will be hard to be an **equal partner** with program expertise in only one level of care
- For both hospital-based and freestanding IRFs, the ability to manage patients across multiple levels of the post-acute continuum will place providers in the **strongest position**
- **Hospital-based IRFs** may better positioned strategically for bundled payment than freestanding IRFs, but these providers still have to demonstrate the efficiencies and specialized program outcomes typically associated with larger IRFs

Many Freestanding IRFs May Be Facing A "Moment of Truth"

- As much as the preference is to remain "Switzerland" in the community, that reality may not last much longer…
- It will be much better to be on the **front-end** of this process rather than the back-end

Freestanding
- Multiple referral sources
- Independent
- Weak upstream linkages

Part of System
- Fewer referral sources
- Part of a system
- Strong upstream linkages

Freestanding IRFs will likely always receive the catastrophic referrals, but the bread and butter orthopedic and neurology referrals may be in jeopardy in the new world without tighter relationships with the referral sources

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Enter The Continuing Care Hospital

Regulatory Summary

- Defined as an entity capable of meeting the requirements/skills of IRF, LTCH, and SNF
- Provider to receive a single payment for inpatient stay and all care 30 days following discharge, including HHA
- Payment not to exceed what otherwise would have been paid
- Quality measures will apply
- Pilot project to start no later than Jan 2013

- Although there are a lot of unknowns (such as the 60 Percent Rule, payment & whether all beds need to be in same location) this may be an opportunity to significantly extend continuum of care
- In general, the ability to provide multiple levels of care will strengthen an IRF in the market place
- CCHs may, however, open the door for additional IRF competition from SNFs and/or LTCHs
- IRFs, particularly those not part of a system or without multiple levels of care, should follow this closely and apply for participation in the demonstration if the dollars are there

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Bottom Line on Health Reform For IRFs
Four Critical Success Factors

Criteria	Strategic Implication
Low Cost	• There will clearly be less revenue under the current fee-for-service model in future years, so economic efficiencies imperative • Additionally, under a bundled payment model, successful IRFs must be able to demonstrate lower total cost than competitors or than an acute care provider can do on its own
Measureable Outcomes	• IRFs must demonstrate outcomes equal to or better than the industry, ideally with fewer days/visits, etc. to improve bottom line – FIM, readmissions, any new CMS quality measures
Alternative Business Models	• Freestanding IRFs must embrace alternative business models that are likely to emerge, including multiple shared risk scenarios (bundled payment, capitated amounts, etc.)
Continuum of Care	• Freestanding IRFs and some hospital-based IRFs must evaluate continuum and determine how they will provide all levels of care required under bundled payment (CCH? Partnerships? Other?)

Next Steps: Four Priorities for FY 2012

1. Bring in every IRF admission today that is possible

- *Every **incremental admission** strengthens your organization for the short-term, and better positions you for the long-term*
- *Complete a **demand assessment** to make sure you are capturing all potential referrals and admissions*
- ***Assess marketing and admissions processes** to ensure effectiveness in developing referrals and converting referrals to admissions*

2. Make sure you are the low cost provider

- *Evaluate your **cost of care** and compare to local providers as well as "best in class"*
- *Look at operations, staffing, and productivity, but also **support and overhead functions** that make up a large component of total cost*
- *Evaluate not just IRF program, but OP and **any part of the continuum** that might be included in a bundled payment*

Next Steps: Four Priorities for FY 2012

3. Develop plan for Continuous Quality Improvement

- *Evaluate **all components** of organization, not just readmissions or those included in FIM score (e.g., billing, housekeeping, transport, etc.)*
- *If overall performance compares favorably to industry (such as readmissions), identify those areas of lower performance **and develop plan for improvement***
- *Link **performance to compensation** if possible*

4. Complete Strategic Plan

- *Begin to decide today where your organization would like to be in 2015-2016 – **develop a vision***
- *Evaluate alternatives and decide how to **best achieve** that vision*
- *Be proactive as to where you would like your IRF to be **strategically** as systems consolidate and organizations assume greater financial risk under bundled payments*
- *Develop a written **strategic plan** to serve as your road map for the future*

There will be lot of opportunity for forward-thinking IRFs, but the work needs to start today to ensure long-term success in this dynamic environment!

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Questions?

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