IRFs and Health Reform: Planning Today for Success Tomorrow

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IRFs and other post-acute providers have been operating in a changing environment for as long as most people remember. The BBA in 1997, the implementation of PPS in 2002, the 75 Percent/60 Percent Rule changes in 2004 and 2007 and beyond, medical necessity reviews, and the RAC audits, to name just a few things, have kept the field in a constant state of change in many ways. Change has become the norm.

And, as much as those within the industry would like things to stabilize for a while, it appears that the tsunami of health reform is going to prevent that from happening! The changes being driven by the Patient Protection and Affordable Care Act (PPACA) will impact the flow of patients to IRFs, the way providers are paid, the quality standards utilized and, ultimately, the strategic positioning of IRFs within the community. While many of these dynamics may extend beyond the control of the IRF field, resulting in nervousness among providers, in fact this should be looked at as an *exciting time* with *great opportunity* for those willing to embrace the future.

PPACA Overview From an IRF Perspective

First, a quick review of several of the key elements of the PPACA that are most likely to impact IRF providers is in order. (See Figure 1.)

Health Reform IRF Highlights

Initiative	Start Year	IRF Impact
Market Basket Updates	FY 2010	Negative offsets to market basket updates; lower reimbursement
Productivity Adjustments	FY 2012	May result in lower payment
Accountable Care Organizations	Jan. 2012	Providers must demonstrate low cost/high quality to receive incentive
Acute Readmission Penalty	FY 2013	Decreased referrals if readmission rate higher than industry/peers
Quality Reporting for IRF	FY 2014	Increased quality pressure; decreased revenue for non-reporting
Bundled Payment Pilot Project	Jan. 2013	Significant change in patient flow; potential lower reimbursement
Continuing Care Hospital Pilot Project	Jan. 2010	Significant change in patient flow; potential lower reimbursement

Although the complete detail of each of these initiatives is too extensive to discuss within the space constraints of this article, there are some common themes running through these and other initiatives that must be recognized. Specifically, these include:

There Will Be Less Money Rather Than More Money for Rehab Providers – Given that a major emphasis of the PPACA is cost reduction, it is clear that over time IRFs can expect lower reimbursement, either from Medicare or from other third parties that assume financial risk for an episode of care.

Payment Will Be Tied to Quality – This has been a growing trend in recent years in Medicare programs, and this approach appears to be reaching its logical conclusion with several elements of the PPACA. That is, the market is rapidly moving towards:, "Do a good job and we will pay you fairly. Do a bad job and you will suffer financial consequences."

Acute Care Systems Will Also Experience Increased Financial Pressures – IRFs are not alone in this boat, and as a result many systems that do not provide IRF or other post-acute programs may choose to do so if it will improve their bottom line, *unless existing providers can offer the same service at a lower cost…*

What Can IRFs Do Now?

Each IRF, whether hospital-based or freestanding, must first decide where it wants to be in five years. Inaction and inertia today will certainly create failure

in the long run. Having stated that, regardless of the desired "future state" for any provider, there are several key elements to success that must be included in any strategic plan.

1. **Focus with laser-like intensity on the cost of care!**

Starting yesterday, IRFs need to prepare for tough financial times. As such, program managers need to look at both the revenue and expense side of the financial equation. First, recognize that, for most providers, an increase in daily census of just one occupied bed typically results in an additional $200,000-$300,000 to the bottom line. Given this, providers need to ask themselves, "Am I doing everything possible today to fill as many beds as I can?" Very often, internal processes or screening criteria are limiting admissions, or insufficient resources are dedicated to census development. It may cost money to generate additional admissions, but in the end, it will be worth it.

Second, and even more important, IRF providers must ensure that they operate "lean and mean," and that there is no fat in their system. As payment systems evolve to more risk sharing models, including bundled payment models, those entities that carry the financial risk of patient care will only contract with IRF and post-acute providers that can deliver low cost services.

2. **Ensure quality of care and measureable outcomes that are at least as good, if not better, than other providers.**

Starting with the upcoming initiative to penalize acute care providers with "excessive" readmissions, IRFs and other "down stream" providers will be required to demonstrate that their outcomes, particularly readmission rates, are lower than industry levels and lower than local competitors. If this is not demonstrated, the IRF will likely see its referrals dry up, as they are directed to other providers that can show better performance, even if the referral source is an affiliated entity.

In addition, in order to "stay in the game" over the long-term, IRFs must stay current on the quality indicators that CMS and other payors are tracking. Both the national bundled payment pilot project and the CCH pilot project require participants to achieve certain quality indicators, and successful IRFs must ensure that they remain ahead of the curve on these measures as well.

3. **Evaluate existing continuum of care.**

Given the trend towards patient management for an episode of care, it appears that those providers that can manage a patient through multiple levels of care might be best positioned to emerge as the community leaders. Hospitals and health systems that offer IRF services, or freestanding IRFs with a limited continuum of care, might find that they are the less desirable healthcare partner, unless they can broaden their scope of services and manage patients across a full post-acute continuum. It will be very hard to tell the market that they can only use you for one specific patient population, when the payment might be for a full episode of care. As such, now is the time to begin to assess which programs might be needed, keeping in mind the continued drum beat to always manage patients in the *least costly setting.*

4. **Develop and embrace alternative business models**

Finally, all IRFs must embrace new business models that share financial risk with referral sources, as well as potentially other post-acute providers. IRFs should be creative as to what type of business model they pursue, but recognize that the days of saying, "Send us your patient and we will do a good job" are likely coming to an end. All providers will have to assume partial risk, and IRFs may need to give up some return to make sure that they remain a preferred provider. The trick, however, will be to strike a deal such that the whole is greater than the sum of the parts.

Conclusion

While the health reform changes are not occurring over night, it does appear that IRFs have only two to three years to make significant headway in their financial, quality, and strategic efforts to avoid being left behind. IRF managers and leaders should begin their planning process now and develop a comprehensive action plan that lays out specific steps over the next several years to ensure that they create the future they envision.

Despite uncertainty in the environment, this truly is an exciting time for the healthcare industry. And, for those IRFs that embrace change and demonstrate an ability to adapt to this new world, their long-term success will become clear as emerge as leaders in their field.

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