American Medical Rehabilitation Providers Association
8th Annual AMRPA Educational Conference

New Orleans, LA

Health Reform and IRFs

Planning Today for Success Tomorrow

October 14, 2010

Agenda

- Introduce Walter Consulting
- Discuss potential future IRF reimbursement methodologies
- Review IRF short-term/long-term action items
- Discussion

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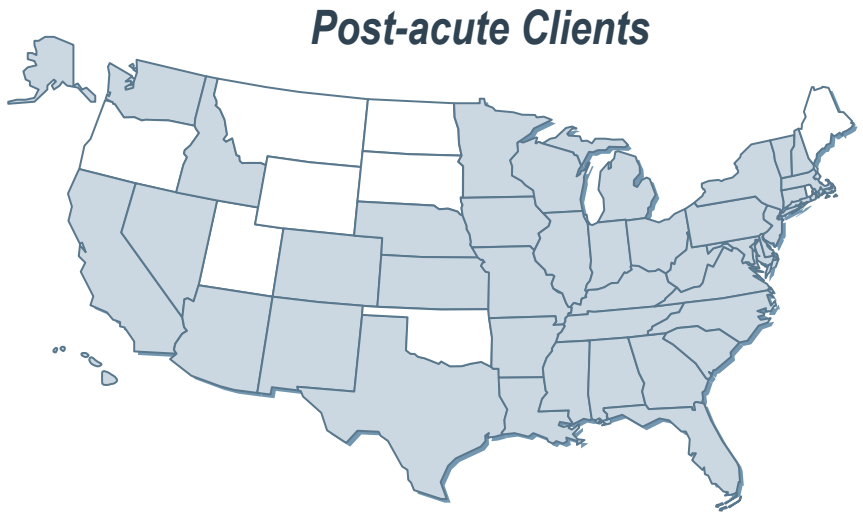
National Rehab and Post-acute Consulting Experience

- 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 CMS Initiatives Related to PAC Have Focused on Two Key Issues

1 Readmission Reduction Efforts

- 18 percent of Medicare discharges from acute care result in readmissions within 30 days of discharge
- MedPAC estimates 80 percent of its costs for readmissions ($12 billion) was potentially preventable!
- Because such a high percentage of readmissions considered preventable, reform initiatives appear to focus heavily on reducing this Medicare expenditure
- ***Part of larger strategy to link quality & outcomes to payment***

2 Aligning Financial Incentives - *a single Medicare payment for multiple providers, including acute care, post-acute care, and/or physician*

- Designed to financially incentivize better coordination of care through the full continuum of care

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Three Health Reform Initiatives With Most Significant Impact To IRFs

Program Focus	Summary
Reducing Avoidable Hospital Readmissions	■ Beginning FY 2013, hospitals with "excessive" readmissions do not receive full DRG payment ■ Initial focus on high-cost conditions ■ Implementation not intended to be budget neutral!
Bundled Payment Pilot Project	■ 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 Jan 2013 for 8 specific conditions ■ Payment made to hospital, physician group, post-acute provider, or other entity comprised of multiple providers ■ Quality measures established for participants ■ If results positive, CMS to provide implementation plan to Congress no later than Jan. 1, 2016
Continuing Care Hospital (CCH) Pilot Project	■ 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 ■ Payment not to exceed what otherwise would have been paid ■ Pilot project to start no later than Jan 2013 ■ Unlike Bundling project, no set conditions for CCH demonstration

Significant Impact on "Business As Usual"

Program Focus	Strategic Implications for IRFs
Reducing Readmissions	■ IRFs will be held to higher quality standard by acute care hospitals ■ If returns to hospital perceived to be excessive, referral sources may cut IRF out of the loop ■ Opportunity to strengthen acute relationship, however, and work collaboratively on common goal ■ IRFs and PAC providers may need to go at-risk for performance
Bundled Payment Pilot Project	■ Dollars to flow very differently if implemented; acute care hospitals could control revenue – good for HB-IRFs, potential threat for freestandings ■ Bias might be for acute care provider to duplicate IRF's services so that they do not have to share revenue ■ Freestanding IRFs and HB-IRFs that rely upon external referrals will need to demonstrate that they can provide rehab services better and cheaper than acute care hospitals in order to be preferred provider ■ Potential opportunity for some IRFs to take lead in pilot project phase – will require shared risk among parties
Continuing Care Hospital (CCH) Pilot Project	■ Potential opportunity for some providers with multiple levels of care to create cost-effective CCH ■ Will likely require greater financial risk than present reimbursement models, and increase need for case management skills

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IRF Core Planning Assumptions – Financial Environment

- ❑ Most IRFs will remain heavily dependent upon State/Federal reimbursement
- ❑ At both the State and Federal level there will be less money rather than more money

What does this mean? What are the strategic implications?

1. **Requires IRFs to be "lean and mean"; highly efficient; no fat; *expense reduction critical***
2. **Requires efficiency and cost effectiveness at all levels**
3. **IRFs need to "make hay while the sun shines" before reimbursement tightens – 2 to 3 year planning horizon**
4. **May challenge some providers to rethink their book of business, i.e., *Can we afford to remain in all service lines even if some operate at loss?***
5. **Do we need to "right size" certain programs?**
6. **Despite financial constraints, providers will still face capital investment needs for facilities, EMR, etc.**

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IRF Core Planning Assumptions – Quality

IRF reimbursement will be tied to quality outcomes, including returns to acute care, etc.

What does this mean? What are the strategic implications?

1. **IRFs define/be current on "Quality" reporting requirements**
2. **Technology will be critical success factor**
3. **Progressive IRFs will continually push the envelope to improve quality**
4. **In addition to clinical quality standards, the most successful IRFs will target quality improvement for non-clinical areas as well (patient satisfaction, billing, documentation, etc.)**
5. ***"That which is measured improves"***

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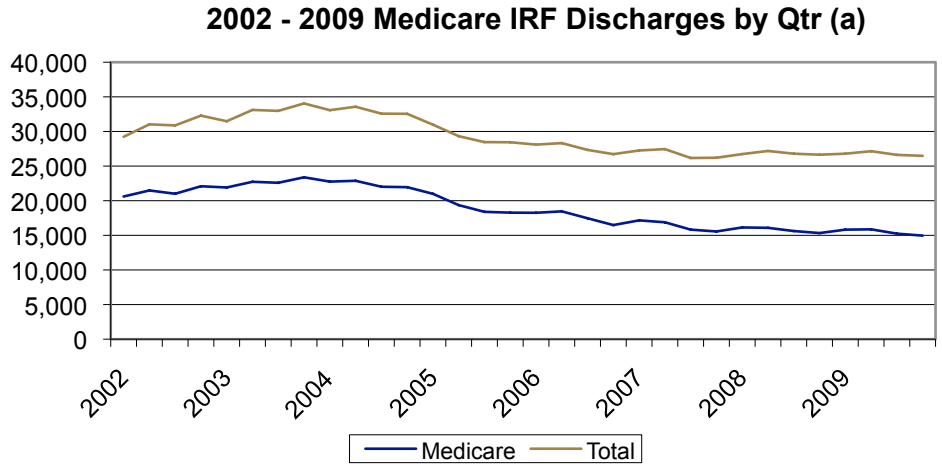
IRF Core Planning Assumptions – Demand for IRF Services

Probably will not see significant growth in most markets

What does this mean? What are the strategic implications?

1. **Must make sure IRF is capturing every possible referral today – most IRFs leaving potential referrals "on the table"**
2. **Meaningful growth may have to come through developments of new markets, program development, and/or program merger/acquisitions**



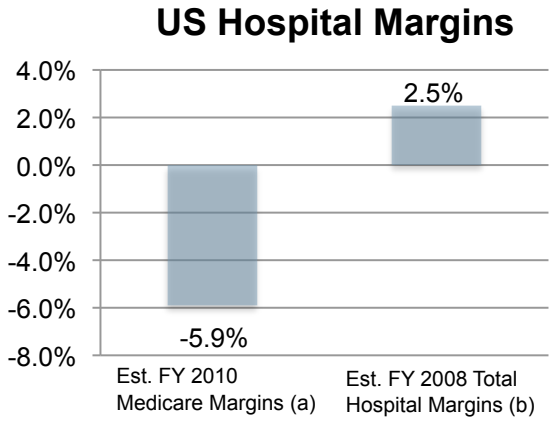
(a) Source: e-rehab AMRPA reports.

IRF Core Planning Assumptions – Acute Care Hospitals

Will continue to experience financial challenges

What does this mean? What are the strategic implications?

1. **If financially viable, acute care systems may choose to provide their own IRF and PAC services**
2. **IRFs dependent upon unrelated referral sources will need to create at-risk financial arrangements that are a win-win for both sides**



(a) Source: 12/09 MedPAC Report to Congress
(b) 11/09 AHA Report

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Short-term Priorities

Financial

- If financial performance less than industry, alarms should be going off
- Each additional occupied bed represents $200,000-$300,000+ bottom-line Net Income (industry average), so every effort should be made to fill beds now
- If target operating margin cannot be achieved through revenue growth, it ***must be achieved through efficiencies***
- Each IRF should operate for the next several years as if they currently had a negative 30 percent margin!
- What would you do to turn this around?

How do you compare to industry benchmarks?

Industry Averages
Est. FY 2009 Medicare Margins

IRF	4.5%
SNF	6.1%
HHA	12.2%

Source: MedPAC 2009 Report to Congress.

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Short-term Priorities

Quality

- Returns to acute clearly most critical quality imperative for short-term performance – ***always room for improvement***
- But, IRF must demonstrate effectiveness on this measure 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.

Long-term Priorities

- ***Continuum of care and strategic alignments***

  - For all IRFs, it will be harder to be a “one-trick pony” in the future environment
  - Particularly under a bundled payment, but also with readmission penalties, those providers than can manage a patient through multiple levels of care will likely emerge as the strongest competitors
    - Need to determine what is the least expensive way to provide rehab services, and it might be in an SNF bed, home care, or outpatient
    - Multiple levels of care may be provided internally, or through collaboration with other community providers
  - 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 providers

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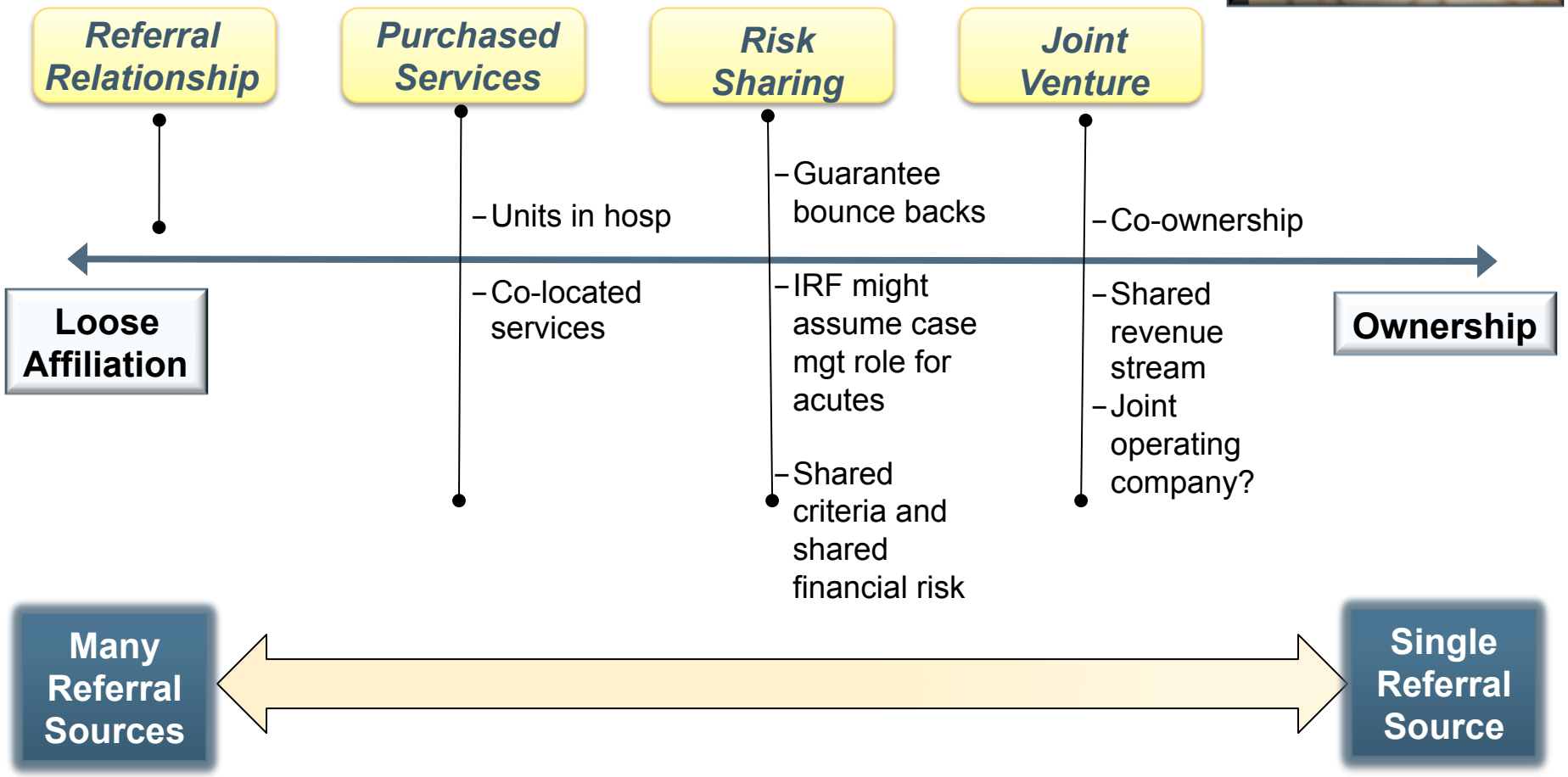
Strategic Alignments

- Trade-off between depth of relationship and ability to partner with more than one acute care system



Potential Key Planning Initiatives

Initiative	Potential Action Steps	Rank
Strengthen Financial Position	❑ Establish financial targets ❑ Ensure operational efficiencies ❑ Implement staff accountabilities ❑ Identify, stretch, and reward staff with leadership and growth potential ❑ Other	
Ensure Quality Services	❑ Define quality measures/targets ❑ Develop "best practice" ❑ Eliminate barriers between programs/functions (e.g., admitting, finance, clinical staff, etc.) ❑ Evaluate reporting relationships/organizational structure? ❑ Implement TQM ❑ Other	
Strategic Alignments	❑ Assess need for potential new alignments – may not be able to remain "Switzerland" ❑ Determine the relationships that will secure future viability – may include more than IRF (OP, SNF, other PAC) ❑ Develop at-risk model for consideration ❑ Be prepared to give up as much as you get….	

Clear overlap among Initiatives and Potential Action Steps, but priorities need to be determined.

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Develop Measureable Action Plan

- Step 1: Establish quality targets

Function	Strategic Target				
	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015+
Quality	–Reduce readmissions by 10 percent –Define and implement “best practice” protocols for high volume diagnoses (> two-thirds admissions) –Ensure days onset equal to or better than nat’l average for two-thirds patient population –Ensure tiers/comorbidities equal to or better than nat’l average for two-thirds patient population –Ensure patient satisfaction at least 75th percentile –Other				
Finance	–Reduce direct operating expense per patient day by 3 percent –Reduce administrative/overhead expenses by 10 percent over three year period –Ensure that denials decrease by 3 percent annually –Improve billing/revenue cycle function by 5 percent				

Action items need to have responsible party, timelines, and financial incentives for completion (i.e., rewards and penalties)

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Potential Quality Work Plan

Initiative	Impact on Quality Targets Greatest Impact = 1	Ease of Implementation Easiest = 1	Impact on Financial Targets Greatest Return = 1	Comment
Implement "Best Practices"	1	3	1	Does this require program consolidation? What kind of tools might be required to determine "best practice?
Address internal operational barriers	1	2	2	What is the appropriate structure to achieve long-term goals?
Implement TQM process	1	3	1	How do we prioritize initiatives?
Implement EMR	2	3	2	What is the timing? Cost of implementation?
Ensure MD contractual financial incentives have measureable quality targets	1	2	1	How do we do this when physicians are not employees?
Other_____				
Other_____				
Other_____				

Potential Financial Work Plan

Initiative	Impact on Financial Performance *Greatest Return = 1*	Ease of Implementation *Easiest = 1*	Impact on Quality *Greatest Impact = 1*	Comment
Implement staff accountabilities	1	3	1	How deep in organization? Are current management tools sufficient? Impact to performance evals/HR?
Ensure efficient use of clinical resources (staff, ancillary, etc.)	1	2	2	Appropriate productivity targets & staffing levels Share staff among programs? Appropriate use of ancillary services (best practices)
Ensure efficient overhead services	1	3	3	Outsource any back office functions? Consolidate back office function with other provider?
Right size certain core (or secondary) services	2	2	3	Community programs? Low payor mix services? Other?
Eliminate negative services	2	1	3	How does this impact IRF role in community?
Other_____				
Other_____				

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 any non-fee-for-service model, successful IRFs must be able to demonstrate lower total cost than competitors or than acute care can do with their own program
Measureable Outcomes	• IRFs must demonstrate outcomes equal to or better than the industry: FIM, readmissions, new CMS criteria included in demonstration projects – and, ideally with fewer days/visits, etc. to also improve bottom line
Alternative Business Models	• Freestanding IRFs must embrace alternative business models that are likely to emerge, including multiple shared risk scenarios (bundled payment, chronic care capitated amount, 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

Questions?

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