NORTHWEST ASSOCIATION OF REHABILITATION FACILITIES

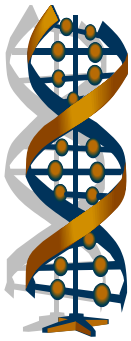
Seattle, WA

Assessing Northwest IRF/IRU Market Opportunities
Success in 2020 and Beyond!

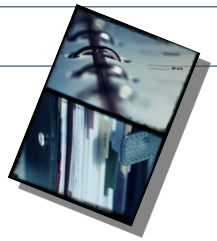
May 6, 2016

Walter CONSULTING

Focus of Today's Presentation



- Introduce Walter Consulting
- Trends in post-acute care
- ACA and future demand for IRF/IRU
- Northwest IRF/IRU opportunities
- Questions/Discussion



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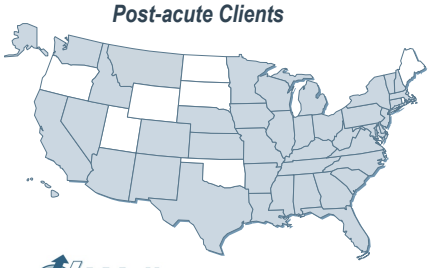
Walter Consulting

- National post-acute practice – acute and post-acute clients in 40+ states
- Community hospitals and faith-based organizations
- Major academic medical centers and integrated health systems
- Proprietary and NFP providers
- Freestanding and hospital-based SNFs, HHAs, IRFs, LTCHs, hospice
- Other

Post-acute Clients



Program Focus
Skilled care/subacute care
Acute rehabilitation
LTCH
Home health
Hospice
Assisted living
Outpatient rehabilitation
Other

Practice Areas
Strategic planning
Demand analysis
Program feasibility
Financial impact analysis
Operational improvement
CON/Regulatory Support
Board/leadership education
Other

Walter CONSULTING

National Rehab and Post-acute Consulting Experience

Clients include more than one-third of the +/- 100 NFP Rehabilitation Hospitals

	Hospital Name	City	State
1	Rancho Los Amigos Rehabilitation Center	Los Angels	CA
2	Spalding Rehabilitation Hospital	Aurora	CO
3	Shands Rehab Hospital	Gainesville	FL
4	Walton Rehabilitation Hospital	Augusta	GA
5	Rehabilitation Hospital of the Pacific	Honolulu	HI
6	Rehabilitation Institute of Chicago	Chicago	IL
7	Rehabilitation Hospital of Indiana	Indianapolis	IN
8	Southern Indiana Rehab Hospital	New Albany	IN
9	Frazier Rehab Institute	Louisville	KY
10	Rehabilitation Hospital of the Cape and Islands	East Sandwich	MA
11	Spaulding Rehabilitation Hospital	Boston	MA
12	SSM Rehabilitation at Saint Joseph Health Center	Saint Charles	MO
13	SSM Rehabilitation at Saint Mary's Health Center	Richmond Heights	MO
14	Methodist Rehabilitation Center	Jackson	MS
15	Carolinas Rehabilitation	Charlotte	NC
16	Coastal Rehabilitation Hospital	Wilmington	NC
17	Helen Hayes Hospital	West Haverstraw	NY
18	Sunnyview Rehabilitation Hospital	Schenectady	NY
19	The Rusk Institute of Rehabilitation Medicine	New York	NY
20	Allied Rehab Hospital	Scranton	PA
21	Bryn Mawr Rehab Hospital	Malvern	PA
22	Good Shepherd Rehabilitation at Easton Hospital	Easton	PA
23	Good Shepherd Rehabilitation at Pocono Medical Center	East Stroudsburg	PA
24	Good Shepherd Rehabilitation Hospital - Allentown	Allentown	PA
25	John Heinz Institute of Rehabilitation Medicine	Wilkes-Barre	PA
26	Siskin Hospital for Physical Rehabilitation	Chattanooga	TN
27	Vanderbilt Stallworth Rehabilitation Hospital	Nashville	TN
28	Gonzalez Warm Springs Rehabilitation Hospital	Gonzalez	TX
29	San Antonio Warm Springs Rehabilitation Hospital	San Antonio	TX
30	TIRR (The Institute for Rehabilitation and Research)	Houston	TX
31	Sheltering Arms Hospital South	Midlothian	VA
32	Sheltering Arms Rehabilitation Center	Mechanicsville	VA
33	St. Luke's Rehabilitation Institute	Spokane	WA
34	Sacred Heart Rehabilitation Institute	Milwaukee	WI

U.S.News & WORLD REPORT

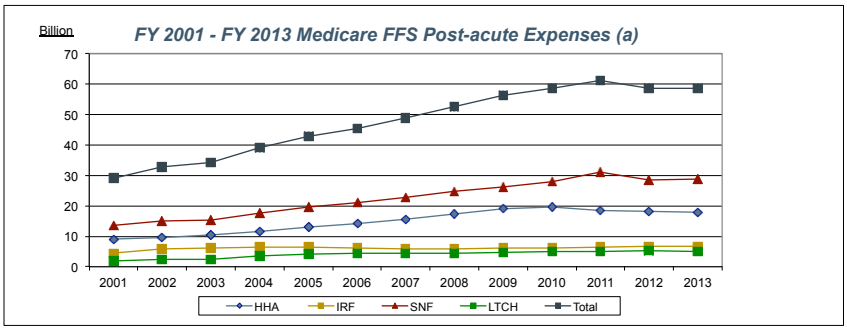
	Hospital	Beds
✔	1 Rehabilitation Institute of Chicago	155
✔	2 TIRR Memorial Hermann, Houston	119
	3 Kessler Institute for Rehabilitation, West Orange, NJ	152
	4 University of Washington Medical Center, Seattle	20
	5 Mayo Clinic, Rochester, Minn.	38
✔	6 Spaulding Rehabilitation Hospital, Boston	132
	7 Craig Hospital, Englewood, Colorado	93
	8 Moss Rehab, Elkins Park, PA	197
	9 Shepherd Center, Atlanta	152
✔	10 Rusk Institute, NYU Medical Center, New York	181

Post-acute Overview

Medicare Post-acute Definition
• Inpatient Rehabilitation (IRF, IRU)
• Skilled Nursing (SNF, subacute)
• Long-term Care Hospital (LTCH, LTACH)
• Home Health

Note: Hospice not considered post-acute by CMS, but is a close cousin to HHA

- From 2001 to 2011, CMS spending for PAC increased an average of 9 percent per year
- Over the same time period, spending for acute care increased just 3 percent per year



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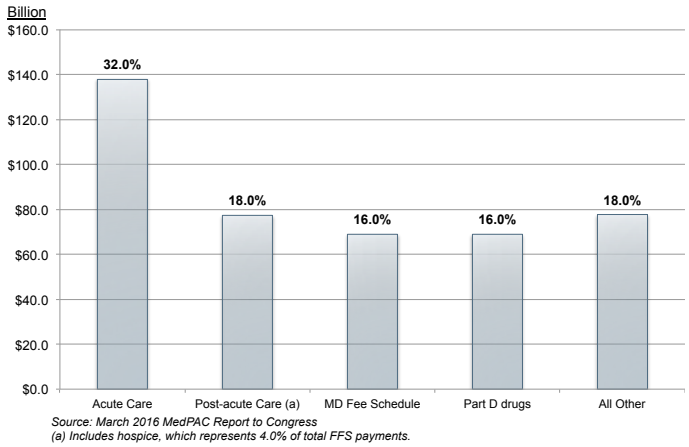
Post-acute Care a Major Component of Medicare FFS Payments

Post-acute expenses represent **18 percent** of all Medicare FFS payments and are greater than most every other major expense component



Source: March 2016 MedPAC Report to Congress
(a) Includes hospice, which represents 4.0% of total FFS payments.

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Estimated FY 2014 Post-acute Medicare Margins

Level of Care	Payment Basis	Est. 2014 Medicare Margin (a)
Skilled Nursing (SNF)	• RUG Payment • Per Diem	12.5% (b)
Inpatient Rehabilitation (IRF/IRU)	• CMG • Per Disch.	12.5%
Long-term Care Hospital (LTCH)	• LTCH-DRG • Per Disch.	4.9%
Home Care (HHA)	• HHRG • 60-day Episode	10.8%
Hospice	• Per Diem	12.0%

(a) Source: March 2016 MedPAC Report to Congress.
(b) Freestanding SNFs only; does not include HB-SNFs.

- Not only has PAC been growing but, in the aggregate, **each level of PAC is very profitable**
- FY 2014 acute care **Medicare margin -5.8%**

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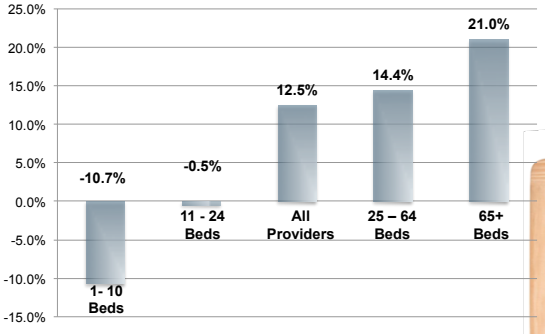
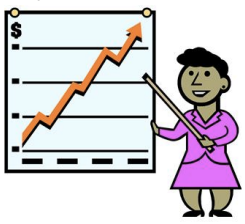
IRF Volume Has Greatest Impact to Financial Performance

2014 IRF Medicare Margin by Bed Size *(a)*



(a) March 2016 MedPAC Report to Congress



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With High Industry Margins, Minimal Updates Anticipated

Medicare Annual IRF Increases

Year	Baseline	% Increase
FY 2002	$11,838	-
FY 2003	$12,193	3.0%
FY 2004	$12,525	2.7%
FY 2005	$12,958	3.5%
FY 2006	$12,658	-2.3%
FY 2007	$12,981	2.6%
FY 2008	$13,034	0.4%
FY 2009	$12,958	-0.6%
FY 2010	$13,661	5.4%
FY 2011	$13,860	1.5%
FY 2012	$14,076	1.6%
FY 2013	$14,343	1.9%
FY 2014	$14,846	3.5%
FY 2015	$15,198	2.4%
FY 2016	$15,478	1.8%
FY 2017 (a)	$15,674	1.3%
Average		***1.9%***

(a) April 22, 2016 Proposed Rule.

- Generally, IRF expenses have been increasing **significantly more** than 1.9 percent annually
- Revenue impact offset somewhat by **increases in CMI** and **decreases in ALOS**
- However, from 2004-2014, average **occupancy has decreased** from 68 percent to an estimated 62 percent

Word to the wise

- Going forward, there will be less $$$, not more
- IRFs/IRUs and other providers PAC must be able to operate under different financial drivers

IRF Financial Pressures Likely to Continue Into The Future

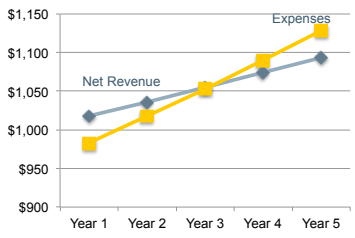
- Because Medicare is largest IRF payor, modest reimbursement increases that do not keep pace with inflation present significant challenges for provider

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	1.9%	$1,019	$1,038	$1,058	$1,078	$1,099
Expenses	$950	3.5%	$983	$1,018	$1,053	$1,090	$1,128
Net Income	$50		$36	$21	$5	-$12	-$30
Operating Margin	5.0%		**3.5%**	**2.0%**	**0.5%**	**-1.1%**	**-2.7%**

*While expense management is critical, **Top Line** revenue growth (i.e., **volume**) will be critical for long-term success*

*IRF/IRU providers must ensure that they are capturing **every possible referral** to maintain a strong financial position*



How Do You Improve Bottom Line?

- **Three Ways to Impact Financial Performance:**
  1. *Volume*
  2. *Price*
  3. *Expenses*

Revenue *(Volume x Price)*
- Expenses
Income

FY 2016 – FY 2020 should include a disciplined evaluation of **all three components**

- With >60% Medicare, however, there is less potential to impact "price"
- Efforts should primarily include documentation to ensure patients are grouped into correct CMGs and Tiers
- Should also include assessment of third-party contracts and any opportunities for improvement

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How Important is One Additional Admission?

Est. FY 2014 Impact of 1 Occupied Bed

Avg FY 2014 FFS Payment (a)	$18,632
Est. Cost (assumes 6% margin)	$17,514
Est. Variable Cost (b)	$8,757
Est. Contribution Margin	$9,875
Est. Margin PPD (c)	$771
Est. Annual Impact of 1 ADC	$281,000

(a) Source: MedPAC March 2016 Report to Congress.
(b) Assumes cost structure is 50/50, fixed/variable.
(c) Assumes 12.8 ALOS (MedPAC).

Nationally, every 1.0 increase in IRF ADC drives **$275K-$300K** to the bottom line

With a 12.8 ALOS, this equates to 28 admissions/year, or just over **2.0 admissions/month**

For smaller programs with a current margin less than 6.0 percent, the impact **likely greater** because they probably have a higher percentage of fixed costs, and the true, incremental "cost" of having 1 additional patient is not high

What could you do *TODAY* to get 2 more admissions this month?

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Volume Is Critical To Maintain Profitability

But…

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Washington PAC Use Rates Significantly Less Than National Rates

*Nationally, approximately **45 percent** of all Medicare FFS acute care patients are discharged to some level of post-acute care*

*PAC use rates have shown **consistent annual increases** for the last 10+ years*

*"Best Practices" for effective systems is in the **46 – 55 percent range***

National Post-acute Utilization Rates (a,b)

Discharge Disposition	Nat'l Medicare FFS 2006	2009	2012	2013	Washington 2014 (c)	Best Practices Low	High
SNF	18.8%	19.8%	20.3%	20.6%	18.5%	16.0%	18.0%
HHA	13.8%	15.2%	15.9%	16.7%	9.7%	22.0%	24.0%
IRF	3.4%	3.3%	3.5%	3.5%	1.3%	4.0%	6.0%
LTCH	0.9%	1.1%	1.2%	1.2%	0.3%	1.5%	2.0%
Hospice	1.6%	2.1%	2.7%	2.8%	2.4%	3.0%	3.5%
Total	**38.5%**	**41.5%**	**43.6%**	**44.8%**	**32.2%**	**46.5%**	**53.5%**

(a) National rates - June 2015 MedPAC Data Book, pg 71.
(b) Best Practices – Walter Consulting
(c) CHARS data. Please note CHARS data includes Medicare FFS and Medicare Advantage.

*CHARS data includes FFS and Medicare Advantage, so actual FFS rates likely lower for HHA and SNF, and slightly higher for IRF and LTCH - **FFS IRF rate estimated at 1.8%***

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PAC Use Rates for Northwest Region Generally Low

- Washington not only State in region with **low PAC use rates**
- All three states have some of the lowest PAC use rates in the country **for all levels of PAC care**

FY 2012 –FY 2013 USA & Northwest PAC Use Rates

	SNF Admits/1,000 Beneficiaries (a)		HHA Admits/1,000 Beneficiaries (a)		Hospice Admits/1,000 Beneficiaries (a)		% Acute Discharges to IRF (b)	
State	*Use Rate*	*Rank*	*Use Rate*	*Rank*	*Use Rate*	*Rank*	*Use Rate*	*Rank*
USA	*103*	*-*	*93*	*-*	*26*	*-*	*3.5%*	*-*
WA	53	42nd	52	44th	22.6	37th	1.8%	44th
OR	52	44th	54	42nd	28.5	15th	1.0%	49th
ID	40	48th	67	37th	27.9	19th	2.7%	29th

(a) Source: Kaiser State Health Facts
(b) Walter Consulting est. from provider Medicare Cost Report data.

*In addition to IRF/IRU discussion, Northwest health systems should assess utilization and growth opportunities for **the entire continuum** of post-acute care*

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Low IRF/IRU Use Rates in Northwest

Although the national rate of Medicare FFS acute discharges to IRF/IRU is 3.5%, Oregon and Washington are **less than half this use rate**, with Idaho twenty-five percent less

- Oregon and Washington among the **lowest use rates in the country**
- Lower than other Western states**,** including **California, Arizona, and Nevada**

FY 2013 Estimated Medicare FFS Acute Care Discharges to IRF/IRU

State	Rate	Rank	State	Rate	Rank	State	Rate	Rank
AK	1.1%	48	KY	3.1%	24	NY	1.9%	43
AL	4.3%	12	LA	5.5%	6	OH	2.5%	31
AR	6.9%	4	MA	2.8%	26	OK	3.4%	21
AZ	5.1%	7	MD (a)	0.8%	51	OR	1.0%	49
CA	2.1%	39	ME	3.7%	16	PA	5.7%	5
CO	3.6%	18	MI	2.1%	38	RI (b)	2.1%	40
CT (a)	0.8%	50	MN	1.4%	47	SC	4.8%	8
DC (b)	3.9%	15	MO	3.4%	20	SD	2.1%	37
DE	2.5%	32	MS	2.3%	33	TN	3.7%	17
FL	3.5%	19	MT	2.1%	36	TX	7.0%	2
GA	2.3%	34	NC	2.2%	35	UT	3.3%	23
HI	2.0%	41	ND	2.7%	28	VA	3.1%	25
IA	1.7%	45	NE	2.6%	30	VT	1.6%	46
ID	2.7%	29	NH (b)	7.0%	3	WA	1.8%	44
IL	2.8%	27	NJ	3.3%	22	WI	2.0%	42
IN	4.0%	14	NM	4.6%	10	WV	4.2%	13
KS	4.7%	9	NV	9.4%	1	WY	4.5%	11

Source: Kaiser Foundation and American Hospital Directory.
(a) May be understated due to out-migration to neighboring states.
(b) May be overstated due to in-migration from neighboring states.

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Washington IRF/IRU and PAC Rates Low Across State

Not one WA county **approaches national PAC use rates**, and Benton, Columbia, Franklin, Spokane, and Walla Walla counties with an **IRF use rate of > 2.0%** *(use rates include Medicare Advantage, so Medicare FFS likely slightly higher)*

2015 Washington PAC Use Rates by County

	Acute Discharges		Medicare Discharges by Disposition					
County	Medicare	Total	IRF	SNF	LTCH	HHA	Hospice	Total
Adams	526	1,660	**1.0%**	11.8%	0.4%	4.4%	2.3%	**19.8%**
Asotin	690	1,082	**0.7%**	24.3%	1.4%	4.1%	1.3%	**31.9%**
Benton	8,021	22,238	**2.4%**	14.6%	0.4%	7.7%	2.4%	**27.5%**
Chelan	3,943	9,012	**1.3%**	13.1%	0.1%	9.0%	3.9%	**27.4%**
Clallam	4,349	8,227	**0.7%**	21.3%	0.6%	15.5%	1.3%	**39.5%**
Clark	11,458	33,024	**0.5%**	16.4%	0.3%	7.8%	3.5%	**28.6%**
Columbia	298	531	**2.7%**	23.2%	0.0%	8.1%	1.0%	**34.9%**
Cowlitz	3,679	9,300	**0.4%**	14.1%	0.2%	9.5%	4.6%	**28.8%**
Douglas	1,757	4,418	**0.9%**	11.2%	0.1%	9.4%	3.2%	**24.9%**
Ferry	428	786	**1.6%**	13.8%	0.7%	3.3%	0.7%	**20.1%**
Franklin	2,232	9,223	**2.8%**	12.9%	0.2%	5.7%	1.7%	**23.3%**
Garfield	116	211	**0.0%**	12.1%	0.0%	6.0%	1.7%	**19.8%**
Grant	3,057	8,644	**1.1%**	13.2%	0.3%	6.4%	2.7%	**23.8%**
Grays Harbor	4,509	9,871	**1.1%**	17.8%	0.2%	10.9%	1.1%	**31.0%**
Island	3,977	8,104	**0.7%**	16.4%	0.3%	8.5%	1.6%	**27.5%**
Jefferson	1,900	3,142	**0.7%**	19.3%	0.2%	11.9%	2.8%	**34.8%**
King	59,223	185,393	**0.9%**	21.4%	0.3%	10.5%	2.5%	**35.6%**
Kitsap	8,467	23,300	**0.9%**	23.2%	0.1%	4.6%	1.8%	**30.6%**
Kittitas	2,059	4,669	**0.9%**	13.3%	0.0%	13.1%	2.0%	**29.3%**
Klickitat	740	1,256	**0.1%**	10.0%	0.0%	2.8%	1.1%	**14.1%**
Lewis	4,905	10,770	**1.2%**	13.4%	0.2%	5.4%	2.0%	**22.2%**
Lincoln	852	1,512	**1.5%**	16.4%	0.1%	5.0%	1.3%	**24.4%**

Source: CHARS

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Washington IRF/IRU and PAC Rates Low Across State

The variations in IRF/IRU use rate across the State, however, do highlight volume **growth opportunities** for most parts of the State – i.e., ***WA Best Practices***

2015 Washington PAC Use Rates by County

	Acute Discharges		Medicare Discharges by Disposition					
County	Medicare	Total	IRF	SNF	LTCH	HHA	Hospice	Total
Mason	3,418	7,297	**1.1%**	17.2%	0.2%	5.6%	1.7%	**25.8%**
Okanogan	2,334	5,182	**0.7%**	15.5%	0.2%	4.9%	1.5%	**22.8%**
Pacific	1,039	1,806	**1.2%**	11.9%	0.0%	4.9%	1.4%	**19.4%**
Pend Oreille	792	1,513	**1.8%**	16.5%	0.4%	9.5%	1.4%	**29.5%**
Pierce	29,933	91,588	**1.4%**	18.1%	0.2%	7.5%	1.8%	**29.0%**
San Juan	731	1,374	**1.9%**	19.8%	0.3%	4.4%	2.2%	**28.6%**
Skagit	6,247	14,652	**0.7%**	20.2%	0.3%	6.5%	1.3%	**29.1%**
Skamania	184	379	**0.0%**	13.0%	0.0%	4.3%	2.7%	**20.1%**
Snohomish	22,573	70,970	**1.4%**	18.0%	0.4%	14.3%	2.8%	**36.8%**
Spokane	20,518	53,929	**2.4%**	18.0%	0.6%	16.0%	2.9%	**39.9%**
Stevens	2,620	4,973	**1.7%**	16.8%	0.2%	7.0%	1.5%	**27.1%**
Thurston	9,766	25,002	**1.5%**	18.6%	0.4%	6.0%	2.1%	**28.7%**
Unknown	56	265	**0.0%**	1.8%	0.0%	0.0%	0.0%	**1.8%**
Wahkiakum	160	280	**0.0%**	10.6%	0.0%	5.0%	3.8%	**19.4%**
Walla Walla	2,611	6,152	**3.4%**	19.3%	0.5%	13.6%	2.0%	**38.7%**
Whatcom	8,957	21,055	**1.3%**	18.8%	0.0%	6.8%	2.6%	**29.6%**
Whitman	1,460	3,279	**1.3%**	23.8%	0.1%	9.4%	2.0%	**36.6%**
Yakima	8,444	28,209	**0.9%**	17.1%	0.1%	9.5%	3.5%	**31.1%**
Total	249,029	694,278	**1.3%**	18.5%	0.3%	9.7%	2.4%	**32.1%**
Count – Medicare Only			**3,145**	**45,966**	**778**	**24,039**	**5,955**	
Count - Total (All Payors)			**5,696**	**56,579**	**1,076**	**36,766**	**8,057**	

Source: CHARS

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Washington State Hospital-based IRUs

- **11 of 18 Washington HB-IRUs** have Medicare use rates **less than the national rate of 3.5 percent**, so access to beds is not the only reason State use rates are low
  - Because the 3.5 percent national rate includes all Medicare patients and all locations, regardless of access, those providers and communities with sufficient access to beds generally have **use rates in the 4.0% - 6.0% Best Practice** range identified
  - **Only 5 of the 18 providers** appear to have use rates in the 4.0% - 6.0% target range
- The presence of "higher performing" IRUs does suggest that barriers to admission (at least Medicare FFS) are **not generally regulatory**, since the higher performing IRUs had various MACs (Highmark, WI Physicians, National Heritage, etc.)
- Several WA IRUs should likely consider **bed expansion** due to current high occupancy

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FY 2013 – FY 2014 Washington HB-IRU Utilization

	Acute Discharges		IRU		Est. IRU Admissions (a)		Est. Internal IRF Admissions (85%)		% Medicare Acute Discharges
Hospital	Medicare	Total	Beds	Occupancy	Medicare	Total	Medicare	Total	to IRU
HB-IRF 1	3,697	19,144	14	50.4%	94	188	79	160	2.2%
HB-IRF 2	3,804	17,333	24	86.7%	89	554	76	471	2.0%
HB-IRF 3	2,020	7,812	12	34.5%	56	110	47	94	2.4%
HB-IRF 4	5,334	14,540	12	63.2%	148	202	126	172	2.4%
HB-IRF 5	1,729	6,191	14	57.5%	121	215	103	182	5.9%
HB-IRF 6	5,173	15,615	25	91.4%	317	609	270	517	5.2%
HB-IRF 7	5,340	29,383	12	67.8%	142	217	121	184	2.3%
HB-IRF 8	5,501	19,232	14	59.8%	100	223	85	189	1.5%
HB-IRF 9	5,709	28,034	19	77.9%	155	394	131	335	2.3%
HB-IRF 10	1,771	3,969	8	45.2%	70	96	60	82	3.4%
HB-IRF 11	6,034	19,721	19	85.2%	241	431	205	366	3.4%
HB-IRF 12	5,370	25,239	33	81.8%	283	719	241	611	4.5%
HB-IRF 13	3,212	8,160	36	44.4%	180	426	153	362	4.8%
HB-IRF 14	4,427	17,847	16	72.0%	73	307	62	261	1.4%
HB-IRF 15	4,509	16,108	18	32.7%	64	157	54	133	1.2%
HB-IRF 16	1,994	4,090	15	59.7%	164	238	139	203	7.0%
Other (2 small IRUs w/ missing data)			*16*		*148*	*225*			
Subtotal HB	**61,927**	**252,418**	**307**		**2,445**	**5,311**	**1,873**		**3.0%**
Freestanding 1			102	55.1%	891	1,530			
Total			**409**		**3,336**	**6,841**			

Source: American Hospital Directory
(a) Assumes 12.8 Medicare ALOS and 13.7 Total ALOS.

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Northwest IRF/IRU Market Summary

1. Washington, Oregon, and Idaho all have **low PAC levels** compared to national norms and Best Practices

2. Each of these states also have **IRF/IRU use rates significantly less than national levels**, suggesting opportunities for volume growth

3. Although most IRUs in Washington have **lower conversion rates for Medicare patients from acute-to-IRU norms**, several providers are within the Best Practice target range identified, suggesting **limited barriers** to achieving these volume levels
   - **Access to services** is also not a major driver for low utilization, since even hospitals with their own IRUs have low utilization

4. **Volume growth strategies should likely be initiated** in many locations in each of the Northwest states

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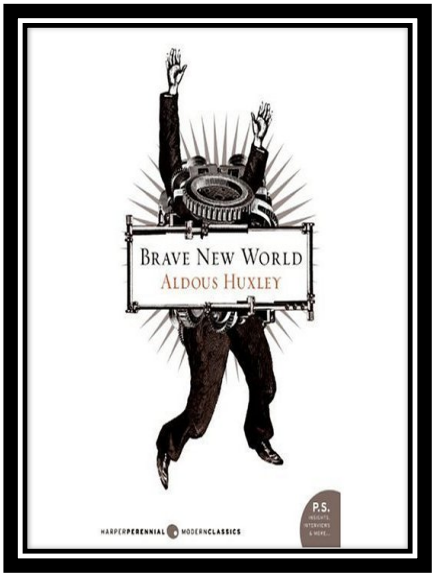
What Next??
The Affordable Care Act – *Welcome to a Brave New World!*

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



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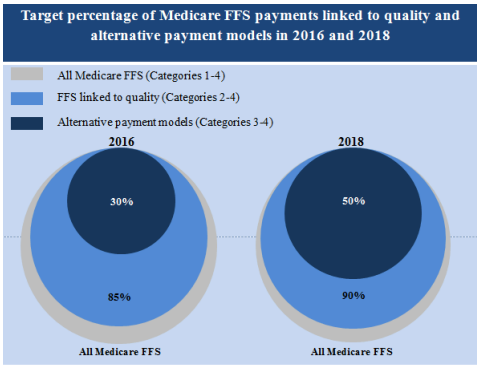
Post-acute Strategic Landscape Shifting Post-ACA

Shifts in Medicare payment away from FFS are driving major changes in **post-acute utilization** and in **strategic positioning** among health systems as it relates to their post-acute continuum



Source: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html

Category 1	Volume based, FFS, no link to quality
Category 2	FFS with link to quality (readmission penalties, etc.)
Category 3	Alternative payment, built on FFS model (Bundled Payments, Medical Homes, etc.)
Category 4	Population Health Management

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Growing Support For Bundled Payments (Episode of Care)

The ACA created opportunity for hospitals to voluntarily participate in a **Bundled Payment Demonstration Project**, in which one option includes a single payment for the acute care stay and 30-90 days of post-acute care, depending upon the risk desired by the provider

- Approximately **10 percent of hospitals** nationally participating, with **1,500 total providers** (SNFs, IRFs, etc.)

For the last two years, the **President's Budget** has proposed a bundled payment for post-acute care that covers **50 percent** of all post-acute payments

In April 2016, MedPAC voted to recommend that CMS develop a **single payment system for post-acute care** that would reimburse providers by diagnosis/condition rather than site of care

In April 2016, CMS implemented the **Comprehensive Joint Replacement Model**, that is mandatory in 67 geographic markets, and includes one payment for hospitals, physicians, and 90-days of post-acute care for most Medicare Joint Replacement patients

At least two separate bi-partisan Congressional bills recommending Bundled Payments for acute care

Many **other payors** beginning to create bundled payments as well

*If everyone is headed in the **same direction**, that's probably where you will end up…*

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Where is IRF Utilization Headed Post-Healthcare Reform?

When bundled payments or other shared-risk financial models are in place, IRF utilization likely to mimic **Medicare Advantage** health plans that are currently at full financial risk…

2014 Post-acute Utilization – Three Sample Markets and Health Systems

		Discharge Disposition					
Market	Discharges	SNF	IRF	LTCH	HHA	Hospice	Total
Health System A - Texas							
Medicare	35,000	12.4%	**5.1%**	10.2%	13.4%	3.1%	**44.2%**
Medicare HMO	12,000	11.0%	**3.2%**	3.9%	16.9%	3.2%	**38.2%**
Health System B - Arizona							
Medicare	8,700	12.8%	**5.6%**	1.0%	16.6%	7.4%	**43.4%**
Medicare HMO	8,000	12.9%	**3.0%**	0.5%	17.7%	5.5%	**39.6%**
Health System C - Illinois							
Medicare	12,000	23.4%	**6.5%**	2.0%	18.6%	3.3%	**53.8%**
Medicare HMO	3,000	21.1%	**4.0%**	0.5%	22.2%	3.2%	**53.0%**

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Northwest Rehab Call To Arms

Medicare Fee-for-service IRF/IRU admissions **WILL decline**

If results continue to support Bundled Payments, CMS **could fast-track** additional payment changes to the industry

These payment changes WILL change IRF/IRU and PAC referral patterns, **shifting many current IRF patients to SNF and HHA**

It is imperative that Northwest rehab providers **work TODAY on increasing volume**, so that the impact of any future reductions are mitigated

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What Now?

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Sustaining and Growing Referrals Requires Planning and Discipline

	IRF Initiative	Success Criteria
Know where to go for patients	**Market Assessment**	• Know what the referral potential is within your market or hospital, and where to go to increase census
Ensure effectiveness with "getting them in the door"	**Admission criteria**	• Have clear message to the market • Evenly applied by all liaisons and medical staff
	Admissions process	• Open referral funnel as wide as possible • Deploy sufficient clinical liaisons • Set response times and stick to them • Assess "risk tolerance" for potential admissions
Manage them well once they are there	**Medical staff coverage**	• Different issues for IRFs and IRUs • Access to medical specialties • Minimize returns to acute
	Clinical staff competencies	• May require infusing more med/surg skills into nursing staff in order to admit higher acuity patients • Medically complex patients may also require challenges from therapy perspective
Pulling it all together…	**Delivering on your promise**	• "Sicker" patients means that your program is living up to "hospital" level of care • A program is only as good as its weakest link…

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What Can I Do TODAY To Increase Census?

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Top Three Reasons For Missing IRF/IRU Patients

1. No volume targets established

- There must be specific **annual, quarterly, and monthly** IRF/IRU **admission targets** by referral source and diagnosis
- Targets should be based upon the **actual acute care population of each referral source**, and reflect both **diagnostic and payor mix** of current patient population
- Someone must have **direct responsibility and accountability** for achieving IRF/IRU volume targets – incentive compensation should be tied to achieving targets
  - Too often, **everyone and no one** is responsible for patient volume
- If additional resources are required to achieve targets (FTEs, marketing collateral, etc.), these **investments should be made if the total ROI is still positive**

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Sample Internal IRF Demand Model

"That Which Is Measured Improves" – Karl Pearson

Community Hospital
FY 2014 Sample Internal IRF Demand Projections

Diagnosis	Admits	ALOS Low	ALOS High	ADC Low	ADC High	Bed Need (a) Low	Bed Need (a) High
Neurology	304	16	18	13.3	15.0	16	18
Orthopedics	207	10	14	5.7	7.9	7	9
Brain Injury	46	17	20	2.1	2.5	3	3
Non-Traumatic SCI	38	17	19	1.8	2.0	2	2
Traumatic SCI	35	25	28	2.4	2.7	3	3
Mjr Mltp Trm	34	20	23	1.9	2.2	2	3
Cardiology	39	10	12	1.1	1.3	1	2
Pulmonology	28	10	14	0.8	1.1	1	1
Other Medical	116	12	14	3.8	4.4	4	5
Total	**847**	**14**	**17**	**32.8**	**39.1**	**39**	**46**

(a) Assumes 85% occupancy.

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Sample External IRF Demand Model

- Also helpful to understand the **total service area** IRF demand
  - Are there potential referrals outside of your hospital?
  - Are there enough (surplus) of IRF beds in the area?

Community Hospital – External Market IRF Demand Projections

County	Ortho Admits	Ortho Beds	Neuro Admits	Neuro Beds	SCI Admits	SCI Beds	BI Admits	BI Beds	Other Medical Admits	Other Medical Beds	Total Admits	Total Beds
PSA												
County 1	151	6	210	11	36	2	47	2	190	8	634	29
County 2	225	9	319	16	54	3	72	4	287	12	957	44
PSA Total	***376***	***15***	***529***	***27***	***90***	***5***	***119***	***6***	***477***	***20***	***1,591***	***73***
SSA												
County 3	101	4	125	7	30	2	33	2	124	5	413	20
County 4	40	2	55	3	11	1	12	0	51	2	169	8
County 5	30	1	40	2	7	0	9	0	37	2	123	5
County 6	39	2	56	3	9	1	12	0	50	2	166	8
County 7	19	1	24	1	5	0	6	0	23	1	77	3
SSA Total	**229**	**10**	**300**	**16**	**62**	**4**	**72**	**2**	**285**	**12**	**948**	**44**
Total	**605**	**25**	**829**	**43**	**152**	**9**	**191**	**8**	**762**	**32**	**2,539**	**117**

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Sample Dashboard Report

Dashboard should be customized to reflect volume targets from **each major referral source**, as well as agreed upon **Quality and Financial metrics**

IRF/IRU Dashboard Report

Measure	Target	Caution	Alert	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	YTD
Utilization																
1 Total Admissions	50	45	40													
2 Stroke/Neurology	20	15	10													
3 Orthopedic	15	10	5													
4 SCI/TBI	5	3	1													
5 Other Medical	10	6	4													
Quality																
6 Returns to acute	TBA	TBA	TBA													
7 Days Onset																
8 Total FIM Gain	TBA	TBA	TBA													
9 Total FIM Efficiency	TBA	TBA	TBA													
10 Case Mix Index	TBA	TBA	TBA													
Financial																
11 Net Revenue Per Case	>22%	15%-22%	<15%													
12 Direct Cost Per Case	<$650	$700-$750	>$750													
13 Contribution Margin Per Case	=>50%	45-50%	<50%													
14 Net Income Per Case																

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Top Three Reasons For Missing IRF/IRU Patients

2. IRF/IRU screens patients Out and not In

- Many providers are so **highly risk adverse** that the screening process is designed to uncover any potential reason to deny admission
  - *"The patient may not have a discharge disposition"*
  - *"We've been retroactively denied on patients like this before"*
  - *"We stopped taking patients with that diagnosis"*
  - *"We don't take patients with those comorbidities"*
  - *"We don't take patients on those meds or with those lab results"*
- **Do some homework:** If your IRF/IRU **volume is low** and there are other providers in your region with **higher conversion rates** to rehab, they have figured out a way to admit these patients and receive payment
  - This may require **greater risk tolerance** and/or **operational changes** such as improved documentation or increased medical support (i.e., physician consults, nursing, ancillary services, etc.)

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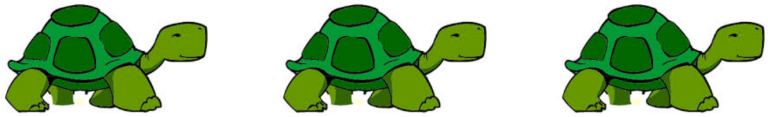
Top Three Reasons For Missing IRF/IRU Patients

3. IRF/IRU is too slow to respond and admit patient

- Many rehab providers have **lengthy screening processes** that include multiple chart and bedside assessments by Intake Coordinators, physicians and others that can take one or more days to complete
- **Over 50 percent** of these potential patients will be admitted into a nursing home or competitive IRF because the referring hospital will not wait for a lengthy process to be completed
- 80 percent of referrals should receive a response **within 4 hours** – all others within a day



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Top Three Reasons For Missing IRF/IRU Patients[(a)]

[(a)] Just one more…

4. Difficult payors drive admission process to the exclusion of others

- Although growing, Medicare Advantage currently represents **just 31 percent** of all Medicare covered lives in the country and 30 percent in Washington – Oregon with one of highest Medicare Advantage penetrations
- Strategies should be pursued to maximize appropriate Medicare Advantage admissions, but the Medicare Advantage denials **should not prevent an IRF/IRU from focusing on similar Medicare Fee-For-Service patients**

2015 Medicare Advantage Penetration by State

State	% MA	State	% MA	State	% MA
Alabama	24.9%	Kentucky	24.9%	North Dakota	17.0%
Alaska	0.2%	Louisiana	29.7%	Ohio	38.1%
Arizona	38.4%	Maine	21.9%	Oklahoma	16.7%
Arkansas	19.4%	Maryland	8.3%	**Oregon**	**43.9%**
California	38.3%	Massachusetts	19.4%	Pennsylvania	39.9%
Colorado	36.9%	Michigan	31.7%	Rhode Island	35.3%
Connecticut	25.2%	Minnesota	53.4%	South Carolina	22.7%
Delaware	7.8%	Mississippi	13.8%	South Dakota	17.6%
DC	12.6%	Missouri	27.7%	Tennessee	33.8%
Florida	40.0%	Montana	18.0%	Texas	30.8%
Georgia	30.8%	Nebraska	13.2%	Utah	34.5%
Hawaii	45.8%	Nevada	34.2%	Vermont	6.9%
Idaho	**32.4%**	New Hampshire	6.6%	Virginia	15.5%
Illinois	18.1%	New Jersey	15.1%	**Washington**	**29.9%**
Indiana	23.2%	New Mexico	31.1%	West Virginia	24.0%
Iowa	14.6%	New York	36.6%	Wisconsin	37.5%
Kansas	13.4%	North Carolina	29.5%	Wyoming	2.9%

Source: Kaiser Family Foundation

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Other Check Points

Medical Director

- Is Census Development a responsibility **specifically identified** in the contract?
- Where does the Medical Director and other PM&R physicians **bonus/ incentive compensation** come from?

Job Descriptions

- What are you asking the IRF Marketing Director, Liaison Staff and Medical Director to do? What are you **paying them to do**? Are **Census Development activities** clearly articulated in the Job Description and is at least some of their compensation directly tied to performance goals?

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Case Study #1

- Large multi-hospital system in the Midwest – approximately 60,000 total discharges
- One freestanding IRF and one HB-IRF unit
- Non-CON state, many LTCHs in service area (none within health system)

FY 2014 Potential IRF admissions by Hospital and Diagnosis

	Neurology/BI			Orthopedics			SCI/MMT			All Other			Total			
	Admits			Admits			Admits			Admits			Admits			
Hospital	Potential	Actual	Percent	Potential	Actual	Percent	Potential	Actual	Percent	Potential	Actual	Percent	Potential	Actual	Percent	Variance
Hospital 1	122	51	41.4%	102	120	118.2%	12	4	30.4%	45	52	115.6%	280	226	80.7%	-54
Hospital 2	54	32	58.3%	48	68	143.2%	9	4	47.1%	20	26	127.5%	130	129	99.2%	-1
Hospital 3	71	30	42.3%	34	57	166.2%	5	5	90.0%	33	41	126.2%	143	132	92.6%	-11
Hospital 4	284	219	77.1%	76	110	144.9%	134	85	63.7%	137	145	106.2%	630	559	88.7%	-71
Hospital 5	55	48	87.3%	57	128	223.7%	17	13	73.5%	17	20	117.6%	146	208	142.5%	62
TOTAL	**586**	**379**	**64.7%**	**316**	**482**	**152.6%**	**176**	**110**	**62.4%**	**251**	**284**	**112.9%**	**1,328**	**1,254**	**94.4%**	**-74**

Findings

1. Although system doing a good job of capturing Ortho and Debility/Misc. patients, there was significant opportunity to improve capture of **Neurology and Trauma patients**
2. An additional 275 admissions would increase IRF ADC by 12.0 patients, and improve Net Income by **$3.0+ Million annually**
3. These patients **MUST** be targeted to "Backfill" empty beds as ACA changes are implemented

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Case Study #2

- Mid-size acute care hospital in Southwest with 20-bed IRU
- IRU ADC = 12.0
- 90+ percent of IRU admissions come from host hospital
- High compliance, with relatively few "Other Medical" or Miscellaneous cases

Community Hospital – FY 2014 IRF Market Assessment

Current Admissions	300
Compliant Cases	225
Compliance Percent	**75%**
Target Compliance	65%
Potential Admissions	345
Potential Increase	**45**
Percent Increase	15.4%
Increase ADC (a)	1.7
Incremental Operating Income	**$450,000**

(a) Assumes 13.5 day ALOS

Findings

Opportunity identified to admit 40 – 50 non-ortho/ neuro patients, mostly cardiac and pulmonary patients with general debility, with **significant financial impact**

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Case Study #3

- Three-hospital health system in Midwest – 750 total beds (all 15-20 min apart)
- 40-bed IRU in 400-bed academic medical center
- IRU program historically had very low risk tolerance for potential denials

University Hospital – FY 2013 IRF Market Assessment

	% of Acute Pts Discharged to PAC	
PAC Program	**Medicare**	**Medicare Advantage**
IRF	2.0%	3.1%
SNF	21.0%	18.0%
LTCH	1.3%	0.7%
HHA	19.5%	18.8%
Hospice	4.0%	3.7%

Medicare and Medicare Advantage population similar diagnostically, but MA Case Managers actually utilizing IRU at a higher rate than Medicare FFS patients,

Findings

Market Assessment showed potential to double Medicare IRU admissions, increasing ADC by 8.0 - 10.0 patients, and Operating Income by > $2.0 million

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A Good Place To Start Is A Review Of Annual FIM Report

A review of **FIM/Outcomes report** can tell you how your FIM changes and outcomes compare to your peers, but can also potentially identify marketing opportunities

FIM Measure	Facility	Reg'l	Nat'l	Potential Opportunity
Days Onset	13.1	11.4	11.7	• Days Onset **longer than peer group** suggests: 1. Your acute care hospital is incurring **unnecessary LOS** 2. You are **losing IRU referrals** to other providers – probably SNF programs
CMI	1.23	1.28	1.30	• CMI that is too low suggests possibility to pick up **add'l stroke or other higher acuity** patients • CMI that is too high suggests potential to admit **add'l orthopedics and/or debility patients**
Admit FIM	61.0	58.4	59.4	• Admit FIM higher than average suggests not admitting patients quickly enough & **possible losses to SNF** or other providers
ALOS	12.5	13.7	13.5	• ALOS lower than peer group suggests potential to admit **more high acuity patients** • ALOS significantly higher than peer group suggests potential to admit lower acuity patients (if CMI also high)
60% Compliance	88.5%	64.0%	65.0%	• High compliance suggests ability to **increase additional medically appropriate non-compliant admissions**

All FIM data must be reviewed simultaneously, however, so that any single item is not misinterpreted

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Referral Log May Also Provide Clues

- Nationally, about **50% - 60**% of all IRF/IRU referrals are converted into an admission
- Providers should strive to maintain this level, and **not have** a conversion rate that is much higher
  - A conversion rate higher than 60% suggests that the referral source (MD, case manager, etc.) is already **deciding in their own mind** what is medically appropriate for an IRF/IRU, and you are likely missing many potential admissions
- Too low of a conversion rate may also be a problem, as **additional education** may be necessary to avoid spending too much time on inappropriate referrals

Referral Source	Referrals	Admissions	Denials	Admit %
Hospital 1	200	100	100	50.0%
Hospital 2	200	175	25	87.5%
Hospital 3	200	150	50	75.0%
Hospital 4	200	75	125	37.5%
Hospital 5	200	100	100	50.0%
Total	**1,000**	**600**	**400**	**60.0%**

A 50% conversion rate also suggests that for each **1.0 increase** in ADC, you will need **2 new admissions**, and **4 new referrals** each month

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Expense Management Critical Element As Well

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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Case Study #4 – Evaluating Cost Structure

- Rehabilitation system in the Southwest that includes, among many other programs and services, **two freestanding IRFs** – (a/k/a IRF-North and IRF-South)
- IRFs relatively **similar in size and scope of services**; same geographic market
- **Similar FIM scores** and other outcome measures
- Very **different financial performance** at a CMG and RIC level
- Same corporate services, so cost structure variances **not due to overhead**
- **Operated separately**, however, with two administrators, separate DONs, medical staff, etc.

- Project focus was a five-year strategic plan, and one of the primary initiatives was a **financial analysis** to identify those existing opportunities to improve financial performance
- A **"Best Practices"** analysis was completed that evaluated on a CMG-level
  - FIM scores
  - CMI
  - ALOS
  - Cost PPD
  - Revenue PPD
  - Other
- **Clear differences emerged** that suggested the system would be better off to implement the Best Practices represented from both IRFs across the system

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Case Study #4 – Evaluating Cost Structure

FY 2013 Estimated Impact of IRF Best Practices Model of Care

		Case Weight (a)		ALOS (b)		Direct Cost PPD (c)		
RIC	RIC Description	Best Practice	Financial Impact	Best Practice	Financial Impact	Best Practice	Financial Impact	Total
01	Stroke	IRF-North	$187,000	IRF-South	$172,000	IRF-North	$494,000	$853,000
02	TBI	IRF-North	$97,000	IRF-South	$100,000	IRF-North	$16,000	$213,000
03	BI, Non-Traumatic	IRF-North	$54,000	IRF-South	$131,000	IRF-North	$46,000	$231,000
04	SCI, Traumatic	IRF-North	$60,000	IRF-North	$63,000	IRF-South	$6,000	$129,000
05	SCI, Non-Traumatic	IRF-South	$2,000	IRF-South	$25,000	IRF-South	$15,000	$42,000
06	Other Neuro	IRF-North	$189,000	IRF-South	$149,000	IRF-North	$136,000	$474,000
07	Lower Ex. Fracture	IRF-North	$135,000	IRF-South	$18,000	IRF-North	$86,000	$239,000
08	Lower Ex. Jt. Replace	IRF-North	$202,000	IRF-South	$269,000	IRF-North	$116,000	$587,000
09	Ortho Orthopedic	IRF-North	$130,000	IRF-South	$53,000	IRF-North	$27,000	$210,000
10	Amputation, Lower Ex.	IRF-North	$12,000	IRF-North	$5,000	IRF-North	$63,000	$80,000
12	Osteoarthritis	IRF-North	$29,000	IRF-South	$46,000	IRF-North	$88,000	$163,000
13	Rheumatoid/Other Arthritis	IRF-North	$14,000	IRF-South	$7,000	IRF-South	$9,000	$30,000
14	Cardiac	IRF-North	$8,000	IRF-South	$4,000	IRF-South	$4,000	$16,000
15	Pulmonary	IRF-North	$24,000	IRF-North	$11,000	IRF-South	$29,000	$64,000
17	MMT w/o BI/SCI	IRF-South	$2,000	IRF-South	$7,000	IRF-North	$17,000	$26,000
18	MMT w/ BI/SCI	IRF-North	$16,000	IRF-North	$5,000	IRF-South	$3,000	$24,000
19	Guillain-Barre	IRF-South	$42,000	IRF-North	$13,000	IRF-South	$3,000	$58,000
20	Miscellaneous	IRF-North	$25,000	IRF-South	$31,000	IRF-North	$15,000	$71,000
	Total		**$1,228,000**		**$1,109,000**		**$1,173,000**	**$3,510,000**

- The assessment revealed over **$3.5M in financial opportunity** by creating a Best Practices model of care, adopting the best of each IRF with documentation (impacting CMI), LOS management, and resource utilization

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FY 2016 – FY 2017 Action Plan

- Complete a **tactical one-year census development plan** for IRF/IRU program
  - Develop **admissions targets** by hospital and diagnosis
  - Create **Dashboard Report** that is updated monthly
  - **Ensure accountability** from all IRF/IRU leadership
- More importantly, complete a five-year organizational **post-acute strategic plan**
  - **Current and five-year demand** by program by diagnosis – IRF, SNF, LTCH, HHA, hospice
  - **How will we get there?** *Targets, resources, accountabilities, etc.*
  - Ideally, all PAC in a system should **report up to same manager** – creates more seamless continuum and reduces internal competition

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FY 2016 – FY 2017 Action Plan

- It is critical that the post-acute strategic plan ensure access to **all PAC programs**, including those not provided by the health system
  - *Partnerships with community providers*
  - *Acquisition*
  - *Start-up development (likely CON issues)*
  - *Other*
- If no one in your organization is taking the lead, rehab managers should **step up to the plate** – without at least a seat at the table, it may get left behind
  - Very often, hospital leaders do not understand PAC dynamics and it is critical that these voices be heard

Are we in the rehabilitation business, or are we in the post-acute business?

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NWARF IRF/IRU Strategic Planning Conclusions

Although the overall demand for IRF/IRU services will likely decline as Bundled Payments and other shared-risk financial models continue to emerge, the low use rates in the Northwest states suggest **significant opportunities for volumes increases today** for many providers

Rehabilitation will remain a **critical part of the health continuum in the future** because its patients represent some of the costliest and high-risk patients that health systems will manage – IRFs/IRUs help manage that risk by increasing patient independence, which is critical

The most successful IRF/IRU providers in Washington, Oregon and Idaho in 2020 and beyond, however, will be those providers that focus aggressively on **census development activities TODAY** so that they can survive and thrive in the new healthcare landscape

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Questions?

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Contact Information

Daniel B. Walter
Senior Principal
Walter Consulting
404.636.9700
dan.walter@walterconsulting.com
www.walterconsulting.com

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