BUNDLING...ARE INPATIENT REHABILITATION FACILITIES PREPARED FOR THIS PAYMENT REFORM?

Uniform Data System for Medical Rehabilitation
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LEARNING OBJECTIVES

1. Provide an overview of the Bundling Demonstration projects, including recent Medicare Bundled Payments for Care Improvement

2. Summarize preliminary data trends regarding the CMS Bundling Demonstration projects, with particular emphasis on post-acute providers

3. Highlight the key implications for Inpatient Rehabilitation Facilities (IRFs)

4. Articulate strategies for IRFs to prepare for the future under bundled payments
BUNDLED PAYMENTS DEFINED

1. Overview

2. Data Trends

3. IRF Implications

4. Call to Action

FFS Model

Bundled Model

Acute Care Hospital

IP Rehab Hospital

OP Centers

IRF/SNF/HH

Physicians

Acute Care Hospital

IP Rehab Hospital

OP Centers

IRF/SNF/HH

Physicians
STRATEGIC CONTEXT FOR BUNDLED PAYMENTS

» CMS’ Value Based Purchasing framework defines CMS’ long-term plans to pay for outcomes (not just volume):
  › Halo effects to other lines of business could be significant, both in opportunity and risk
  › Commercial payers following CMS trend, quickly

» Bundled payment pilot focused on aligning hospital, physician, and post-acute provider interests in order to improve quality, reduce (episodic) costs:
  › Other Innovation Center pilots have similar goals targeting different populations, locations of care

» Recognize that paying for outcomes could result in lost top line revenue and margin unless the payment system and cost infrastructure are redesigned.

» External and internal payment funds flow models must align cost savings achieved with gain sharing in order for hospitals and physicians to share in savings.

» Today we’ll review initial analytics and results related to Medicare’s bundled payment initiative and potential impact to post-acute providers.
### DESIGN CONSIDERATIONS

#### 1. Overview

<table>
<thead>
<tr>
<th>Feature</th>
<th>Design A</th>
<th>Design B</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Episode Trigger</strong></td>
<td>IP Admission</td>
<td>Diagnosis</td>
</tr>
<tr>
<td><strong>Episode Window</strong></td>
<td>IP Stay Only</td>
<td>365 Days from discharge/diagnosis</td>
</tr>
<tr>
<td><strong>Reimbursement Discount</strong></td>
<td>None</td>
<td>3-4%</td>
</tr>
<tr>
<td><strong>Payment Methodology</strong></td>
<td>Retrospective</td>
<td>Prospective</td>
</tr>
<tr>
<td><strong>Outlier Protection</strong></td>
<td>Outlier carve-out</td>
<td>None, included in rate</td>
</tr>
<tr>
<td><strong>Risk Adjustment</strong></td>
<td>Risk adj. impacts annual price update</td>
<td>None</td>
</tr>
<tr>
<td><strong>Conditions</strong></td>
<td>IP focused</td>
<td>Any All</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>None</td>
<td>User Defined</td>
</tr>
</tbody>
</table>

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Imagine a bundle where hospitals will collect single payment from Medicare and be responsible for paying post-acute providers for services.
**BUNDLING CONTEXT – INITIAL RESPONSE**

**Reasons Payers Will Adopt Bundling:**
- Drives cost effectiveness and provides stronger outcomes (52%)
- Drives the ACO model to make providers more accountable for care quality (40%)
- Belief that payment bundle pricing would reduce medical cost (35%)

**Reasons Providers Will Adopt Bundling:**
- Government will mandate it (72%)
- Would increase quality and coordination of care (46%)
- Knowledge that it will be used selectively with predictable costs (38%)

**Payer Concerns:**
- 40% providers do not want to do payment bundling
- 40% providers cannot distribute payment bundling
- 33% no ability to recognize and adjudicate payment bundles

**Provider Concerns:**
- 52% puts the provider at risk
- 49% difficult to determine how to share gains/losses

*2010 Gantry Group quantitative study findings*
FIVE DATA TRENDS WORTH DISCUSSING

**Trend 1:** Significant percentage of episode allowed amount driven by post-acute providers

**Trend 2:** Significant variation in (perceived) performance within post-acute providers

**Trend 3:** Readmission rates vary drastically by post-acute provider

**Trend 4:** Outlier payment variation compared to non-outlier cases driven by post-acute care

**Trend 5:** Hospital post-acute utilization varies dramatically by market, even within a specified service
Analysis of over 12 markets indicates that post-acute care accounts for 25-50% of allowed for key episodes (joints, CHF, pneumonia, etc.).
Joint Replacements Sample

<table>
<thead>
<tr>
<th>Market Average</th>
<th>HH</th>
<th>SNF</th>
<th>IRF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent Discharged Initially To</td>
<td>37%</td>
<td>43%</td>
<td>12%</td>
</tr>
<tr>
<td>HH Visits Per Episode</td>
<td>13.9</td>
<td>7.4</td>
<td>11.3</td>
</tr>
<tr>
<td>HH Spend Per Episode</td>
<td>$3,061</td>
<td>$1,635</td>
<td>$2,401</td>
</tr>
<tr>
<td>SNF Days Per Episode</td>
<td>0.2</td>
<td>21.5</td>
<td>5.9</td>
</tr>
<tr>
<td>SNF Spend Per Episode</td>
<td>$119</td>
<td>$10,597</td>
<td>$2,834</td>
</tr>
<tr>
<td>IRF Days Per Episode</td>
<td>0.0</td>
<td>0.2</td>
<td>11.4</td>
</tr>
<tr>
<td>IRF Spend Per Episode</td>
<td>$31</td>
<td>$182</td>
<td>$11,360</td>
</tr>
<tr>
<td>Total Post-Acute Spend Per Discharge</td>
<td>$3,211</td>
<td>$12,414</td>
<td>$16,596</td>
</tr>
<tr>
<td>Readmission Rate</td>
<td>3.1%</td>
<td>6.1%</td>
<td>6.0%</td>
</tr>
<tr>
<td>Allowed Per Readmission</td>
<td>$6,698</td>
<td>$7,886</td>
<td>$8,905</td>
</tr>
<tr>
<td>Total Readmission Allowed Per Episode</td>
<td>$205</td>
<td>$485</td>
<td>$533</td>
</tr>
</tbody>
</table>

- Joint replacement patients discharged to IRF result in approximately $4k higher PAC spend than SNF discharges, with no significant difference in readmission rate.
- Initial IRF stay on average is 11.4 days, and costs are $800 higher than the average initial SNF stay of 21.5 days.
For stroke patients, the significantly higher IRF spend translates to lower readmission rates, and lower costs per readmission.

IRF stays were half as long on average as SNF stays (15.6 days vs. 31.9 days), but still had 10.9 SNF days per discharge after discharge to IRF.

How can IRFs differentiate their quality of care and clinical outcomes for stroke patients (or other conditions) compared to a SNF post-acute stay?
Hospitals are evaluating readmission trends in selecting post-acute partners for bundled payments (and ACOs).

Higher costs are loosely correlated with lower readmission rates (more so for IRF than SNF). Hospitals are seeking best performing, lowest cost providers in the market for partnerships.
TREND #4: OUTLIER ALLOWED VARIATION DRIVEN BY POST-ACUTE CARE

Analysis of **20% of highest cost cases reveals variation in allowed in post-acute rather than inpatient care setting.**

Most clients agreed that **predictively identifying, then managing outliers before they become outliers** is key to driving significant savings.
Discharge trends for stroke are relatively consistent by market (more so than for other conditions), based on current affiliations and relationships.

What volume shift opportunity/risk exists as IRFs differentiate their value offering to hospitals?
Increased focus on post-acute spending and utilization:

A. Improved data collection

B. Management of care transitions

C. Prevention of readmissions

D. Integrated post-acute organizational structure

E. Outcomes Management/Quality
Data needs to be *collected and reviewed on a continuous basis* to measure costs and financial impact.

*IT system integration should support ongoing tracking* of key metrics.

In the absence of technology solutions, resources need to be devoted to data and metrics management.

Data must be analyzed for active and *ongoing process improvement*.

*Telemedicine options* should also be used as a technology tool to enhance access to clinical resources and monitoring of patient status.

**IRF Take-Away**

- Know your cost per case for key diagnostic groups.
- Consider options for EMR integration.
- Work collaboratively with referring health system to identify and report key performance metrics.
Currently, the discharge process to post-acute care is fragmented.

Multiple resources are likely involved (both from the acute and post-acute providers) prior to a post-acute discharge decision.

Many times, a pre-admission assessment is completed by multiple providers; competition for patients can be fierce in some markets.

Effective management of care transitions will:

- Reduce personnel involved in the transition
- Enhance patient and family satisfaction
- Improve information flow from acute to PAC
- Reduce the cost of the transition
- Improve patient and family education
- Engage collaboration between physicians

IRF Take-Away

- Meet with the referral sources to identify opportunities for improvement to expedite the transition process.
- Make the transition easier than your competitors, including SNFs.
- Provide clinical outcome feedback to referring physicians and discharge planners.
Nearly 20% of Medicare patients discharged from the hospital were readmitted within 30 days, and 34% were readmitted within 90 days. Return trips cost the healthcare system more than $17 billion in 12 months. Medicare will begin penalizing hospitals for excessive readmission rates. Managing patients who are discharged to post-acute care can have a significant impact on reducing acute readmission rates. Many health systems are considering designated physicians to follow patients from acute to post-acute care as an investment in care coordination and readmission prevention.

IRF Take-Away

- Is your IRF readmission rate better than regional and national benchmarks?
- Do you know your readmission rate within 30 days? 60 days?

Frequently, *post-acute organization structures* within health systems are *siloed*.

Regulations are frequently used as the excuse to segment post-acute leadership – need to consider *creative solutions*.

*Post-acute services need to have a “common boss”* who is knowledgeable and accountable for the performance of the entire post-acute continuum.

*Physician leadership is key*, particularly related to coordination/collaboration across venues of care.

**IRF Take-Away**

- Consider proposing an integrated post-acute organizational structure.
- Organize a “post-acute steering committee” of preferred providers.
- Convene the medical directors to discuss opportunities for improvement for post-acute care.
Post-acute programs must be willing to measure clinical outcomes to quantify “quality”.

Whenever possible, industry benchmarks should be utilized to assess performance.

Providers and strategic partners should be selected based on outcomes—both financial and patient satisfaction.

Implement quality scorecards for post-acute providers to demonstrate positive performance expectations.

A culture of quality improvement, including action plans for performance improvement, is imperative (not just tracking the required metrics).

IRF Take-Away

- Ensure your IRF team understands and can share your outcomes “report card”.
- Develop a report card reflecting key outcome measurements.
- Disseminate your report card to referrals regularly.
WHY SHOULD IRFs ACT NOW?
POST-ACUTE MEDICARE SPENDING

Source: CMS, Office of the Actuary
Post-Acute Care Case Study • November 11, 2011
WHY SHOULD IRFs ACT NOW?

» SNFs already appear to be winning based on Medicare post-acute spending trends over the last ten years.

» In the absence of an IRF value proposition, SNFs will continue to drive more volume under bundled payments and ACOs.

» Providers are evaluating their partnerships now to succeed with bundled payments and ACOs:
  › More than 150 Medicare ACOs already exist
  › Expected that more than 100 Medicare bundled payment pilots will go-live in January 2013

» Patients should receive the most appropriate level of care for inpatient rehabilitation.
“YOU SNOOZE, YOU LOSE”

An expression which states that anyone will miss out on a great opportunity if they don’t remain aware or open to communication.

Source: urbandictionary.com
PLEASE LEAVE A BUSINESS CARD
AND WE WILL SEND YOU OUR
BUNDLING READINESS IRF SELF-ASSESSMENT
THANK YOU!

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