SNF Opportunity/Challenge

Under 2013 Medicare Episode-of-Care Bundling
On January 1, 2013, The Centers for Medicare and Medicaid Services (CMS) will begin a pilot program that will, within five years, dramatically change referrals and reimbursement in the skilled nursing facility industry. This white paper reviews the origins of the change, and opportunities for technology-equipped SNFs to capitalize on those changes.

**Background**

Many Medicare critics believe CMS fee-for-service reimbursement creates financial incentives for excess services, because each provider in the chain of care receives a separate payment for every service. They argue fee-for-service often results in excess expenditures as seniors move between hospital stays and a host of post-acute care providers.

In response, the Medicare Payment Advisory Commission (MedPAC), Congress’ Medicare policy advisory arm, proposed that CMS test “bundled” payments similar to those of the Medicare Advantage program, to encourage acute and post-acute providers to better coordinate across a full episode-of-care for a given patient.

**Result:** The 2010 Patient Protection and Affordable Care Act (“ACA”) – popularly termed “ObamaCare” – stipulates that “The Secretary shall establish a pilot program for integrated care during an episode-of-care provided to an applicable beneficiary around a hospitalization in order to improve the coordination, quality, and efficiency of health care services under this title.”

There are several factors which strongly suggest that episode-of-care bundling is likely to remain part of CMS strategy:

- Episode-of-care bundling consideration actually began during the Bush administration.
- Medicare Advantage demonstrates that, while episode-of-care bundling may not dramatically reduce costs, it tends to cap it.
- The accountable care organizations (ACOs) that will quarterback episode-of-care bundling see it as an opportunity to control independent physician charges and to share in profits currently enjoyed by SNFs, IRFs and other post-acute providers.

This white paper will summarize the potential consequences of this change in post-acute reimbursement, and how SNFs that embrace rehabilitation technology can capitalize on that change to enhance their regional market positions.
Implementation: January 1, 2013

The law provides for implementation of the Medicare pilot program by January 1, 2013, for a period of five years. After January 1, 2016, the Secretary may extend the scope and duration of the Medicare pilot program if s/he believes expansion:

- Will reduce spending without reducing quality of care, or improve quality of care without increasing spending;
- Will not deny or limit the coverage or provision of benefits under the public insurance programs.

ACOs eligible to take part in the program may combine into their care any current providers of Medicare services and suppliers, such as an acute care hospital, a physician group, a skilled nursing facility, and a home health agency. The bundled payment to the ACO must be “comprehensive, covering the costs of applicable services and other appropriate services furnished to an individual during an episode-of-care,” such as:

- Acute care inpatient services
- Physicians’ services delivered in and outside of an acute care hospital setting
- Outpatient hospital services, including emergency department services
- Post-acute care services, including home health services, skilled nursing services, inpatient rehabilitation services, and inpatient hospital services furnished by a long-term care hospital
- Other services the Secretary deems appropriate

The “episode-of-care” that the bundled payment covers:

- The three days prior to the admission of the beneficiary to a hospital for the applicable condition
- The length of stay in such hospital
- The 30 days following the discharge from such hospital.

Prior to institution of episode-of-care bundling on January 1, the HEW secretary must choose a mix of ten chronic, acute, medical, and surgical conditions that:

- Are common in the Medicare population;
- Cause a significant number of readmissions;
- Impose a high cost to Medicare;
- Likely to reduce expenditures by improving quality of care;
- Occur in high volume, and impose high post-acute care expenditures
- Will not, under episode-of-care billing, result in a greater expenditure than if the pilot program was not implemented.
What does episode-of-care billing mean? Part A = “Managed Medicare”

Today, the Medicare Part A charges to Medicare for an acute-care admission originate not only from the hospital, and total more than the DRG prospective reimbursement payment. Separate charges for the patient’s episode-of-care come from all the private professional service providers who “touch” the patient before, during and after the associated admission: Physicians, surgeons, anesthesiologists, pharmacy, labs, and imaging.

Upon discharge to a post-acute rehabilitation provider, CMS receives a whole new series of Medicare Part A providers.

Result: Uncontrolled, unpredictable costs.

Episode-of-care billing: A simple explanation

MedPAC and CMS have concluded that the best way to cap hospital and post-acute rehabilitation is to empower ACOs to act like managed care companies.

• First (acute) providers receive one lump “bundled” sum for all services they and their partners provide related to a single episode of a condition or disease – where the unit of payment is “episode,” not individual health services.

• It makes the ACO the “paymaster” for all other providers. Episode-of-care billing eliminates individual fees or charges to Medicare by MDs, imaging services, pharmacies or rehab provider in episode-of-care

• It requires post-acute inpatient rehab providers to compete for “preferred provider” status with the ACO.

• Post-acute rehab providers who don’t prove their ability to provide rapid rehab and reduced risk of readmissions won’t get referrals from the ACO

• Since the ACO is responsible for all post-acute readmissions, they pick – and pay – all post-acute care inpatient rehab providers – or decide which patients don’t need any inpatient care, and discharge them to home or outpatient rehab – which is covered by Medicare Part B.

What keeps ACOs from simply discharging all or borderline patients to Part B providers, and pocketing the CMS payment meant to also cover post-acute inpatient rehab? Their liability for readmissions, which can easily exceed any “profits” they might save.

Unlike private managed care companies, an ACO cannot compel a discharged patient to rehabilitate at a partner SNF or IRF – nor can it prevent, for now, a patient discharged to home or outpatient care from obtaining a physician referral to a SNF for inpatient rehab. And if the patient qualifies, Medicare will pay conventional charges. However, the likelihood is that most patients will comply with the ACO’s explicit discharge recommendation – and SNFs and IRFs without partnerships will be at a serious disadvantage.

Most non-ACO providers do not embrace episode-of-care bundling.

• It has received a negative response from the medical profession, because it means hospitals can set the fees they’re willing to pay – with no appeal for the doctor except to refuse to treat inpatients – which most cannot afford.
It's not embraced by many SNFs, which have their business model predicated on a minimum 20-day 100% CMS-paid Part A fee, and aren’t staffed or equipped to rehabilitate patients as aggressively as they must to compete for the shorter stays that ACOs will demand of post-acute partners.

MedPAC, CMS and the Congress all believe episode-of-care bundling will:

- Encourage cost containment and encourage collaboration between all care providers.
- Incentivize acute care hospitals to refer to providers with the best outcomes in the shortest time, and to discourage use of less competent post-acute providers that can explain high readmission rates of many DRGs.

**Post-acute readmission: Targeted by CMS with bundling**

One of the most important ways CMS expects episode-of-care bundling to cut Medicare costs will be shifting responsibility for post-acute readmission costs from CMS to the ACO and its partners.

Today, the Medicare system has no incentive for ACOs or post-acute providers to actively attempt to reduce readmissions, because – except in rare circumstances – the ACO can bill Medicare for readmission expenses.

On October 1, 2008, CMS began implementing regulations covering ten hospital-acquired conditions for which it will not reimburse:

- Stage III, IV pressure ulcers
- Fall or trauma resulting in serious injury
- Vascular catheter-associated infection
- Catheter-associated urinary tract infection
- Foreign object retained after surgery
- Certain surgical site infections
- Air embolism
- Blood incompatibility
- Certain manifestations of poor blood sugar control
- Certain deep vein thromboses or pulmonary embolisms.

This strategy presaged the Affordable Care Act provision to hold ACOs and their episode-of-care partners fully responsible for the costs of post-acute readmission. Those costs are an important part of CMS budget:

- Inpatient care accounts for 37% of Medicare costs
- 18% percent of Medicare patients discharged from the hospital have a readmission within 30 days of discharge
- Cost of readmissions average $15 billion/year
When one digs deeper into readmission statistics, the interest in ACOs finding partners that can avoid them becomes clearer: The table at left shows the 30-day readmission rate and per-episode spending by post-acute rehabilitation setting for patients with DRG 470: Major joint replacement without complications. Note the high percentage (almost 40%) of patients who received post-acute care in a SNF after total joint replacement. Their mean cost is lower than those at IRFs or LTACs – but those facilities rarely see joint replacement patients unless they have serious comorbidities, or have a serious event in their acute hospitalization that justifies admission to a more costly rehab site.

More problematic is the second table at left, illustrating the readmission rate of total joint arthroplasty patients who rehabilitated at SNFs versus home care.¹

Note that some post-acute care readmission settings are important not because of incidence alone, but more on the combination of commonality and cost – for example, joint replacement. By contrast, stroke and hip fracture readmissions are numerically lower, but they cost much more, and almost a third of all patients with a stroke or hip fracture are readmitted within 30 days of discharge into post-acute care – and those readmissions are associated with very high charges to Medicare.

Readmissions from SNFs: A concern – and a chance to differentiate

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Intuitively, one would expect that patients rehabilitated at home would have higher readmission rates. However, Kaiser Permanente prospectively studied the 90-day readmission rates for 9150 patients with a primary total hip or knee arthroplasty performed between April 2001 and December 2004. Kaiser found that, after statistically adjusting for sex, age and American Society of Anesthesiologists scores, total hip arthroplasty and total knee arthroplasty patients discharged to SNFs had higher odds of hospital readmission within 90 days of surgery than those discharged home.\(^3\)

With a nearly 12% readmission rate from all post-acute care sites in this high-volume, ACOs will be seeking partner facilities capable rapidly rehabilitating patients, to the point where they can be discharged home without the risk of readmission. Capability to meet those expectations will also help SNFs meet the expectations of managed care companies with the same aspirations for improved outcomes in shorter periods of time.

\(^3\) Total hip arthroplasty: odds ratio = 1.9; 95% confidence interval, 1.2-3.2; \(P = .008\); total knee arthroplasty: odds ratio = 1.6; 95% confidence interval, 1.1-2.4; \(P = .01\)
**Competition in the episode-of-care era: Technology is key**

Today, discharge planners at many acute-care hospitals may regard most SNFs as “about equal,” and leave the precise choice to a patient’s family. Under episode-of-care bundling, ACOs will want to solidify partnerships with a small number of providers whose superior capabilities are known – and to use their influence over patients and patient families to utilize those selected partners. The competition for patients may be greater than just other skilled nursing facilities.

Today, rehabilitation hospitals (“inpatient rehabilitation facilities” – IRFs) are blocked from accepting those Medicare Part A patients who don’t require or aren’t capable of the intensive rehab these facilities offer today under their 75% case-mix requirements. However, once episode-of-care bundling goes into effect – and a local ACO, and not CMS becomes the payer – that could change.

- **IRFs have a great deal of technology and skilled therapists.** That gives them the ability to rehabilitate patients quickly, and to document their improvement and safety for discharge.

- **Most IRFs have high-tech outpatient facilities to which they can discharge their more rapidly-rehabilitated inpatients.** Familiarity with IRF inpatient-rehab technology mirrored in their outpatient clinics – and the absence of that technology in small, local PT clinics – maximizes the likelihood that discharged IRF inpatients will “convert” to IRF outpatients.

- **IRFs are accustomed to using their inpatient/outpatient combination to gain preferred-provider contracts** from managed care companies – and so, they are very experienced in selling their efficiency under a privatized version of episode-of-care bundling.

- **Short inpatient stays plus high-tech outpatient facilities** assure ACOs that their patients are unlikely to experience a need for readmission.

  *Result:* SNFs must be prepared to compete for patients with IRFs liberated from case-mix limitations under current Medicare Part A limitations.

**Biodex helps SNFs demonstrate superior rehab capability**

Faced with the changing reimbursement and competitive landscape, SNFs must:

- **Invest now in technology and trained staff,** capable of supporting and rehabilitating more critical patients with multiple comorbidities.

- **Document their capability to safely rehab multiple-comorbidity patients** in shorter time than competing facilities.

- **Build their own outpatient rehab facilities, or partner with trusted outpatient providers** and home care providers to which they can discharge inpatients earlier/safer, without placing an ACO partner at risk of a readmission.
In building the capability to more quickly rehabilitate and document patient preparation for safe return home, Biodex Medical Systems, Inc. has proven to enhance SNF abilities to successfully rehabilitate – and compete – for Medicare and managed care referrals. Those rehabilitation systems include:

- Biodex Balance System
- Biodex Gait Trainer
- Biodex Unweighing System
- BioStep Semi-Recumbent Elliptical

In addition to its rehabilitation systems, Biodex offers a powerful portfolio of marketing/communications tools that SNFs can use to promote their capabilities to prospective partners and managed care case managers.

**The Biodex Balance System SD**

The Biodex Balance System is the world’s most widely used balance assessment and training system. Within as short a time as 2 minutes, a PT operating a Biodex Balance System

- Compares each tested patient’s balance to normative data bases, to show how his/her balance performance compares to "normals" their age
- Enables precise determination of where patient has balance issues
- Provides printed documentation of areas where rehab therapists should focus

Data from evaluation with the Biodex Balance System guides each patient’s therapy plan.

- It provides patients with large, heads-up LCD display, "games" they play by shifting weight on a dynamic platform PTs can program to each patient’s needs
- It provides evidence of patient’s readiness for discharge, need for post-discharge rehab – or requirement for extending inpatient rehab

One of the best examples of a patient group that SNFs routinely encounter – and can rehabilitate more effectively with the Biodex Balance System – is the post-op knee arthroplasty patient. Using the Biodex Balance System, PTs can more rapidly teach correct weight-shifting exercises for knee-implant patients.

Pre-surgery patients typically have balance issues due to osteoarthritis pain post-op. That pain can dissuade patients from following surgeon’s rehab orders. The Biodex Balance System challenges residents to shift and control their center of gravity, measured between parameter-set parallel lines on the display – front-to-back and side-to-side. Postural stability training helps patients resist falling on unstable surfaces, and identifies each patient’s musculoskeletal balance deficiencies.
Programs in the Balance System emphasize specific movement patterns or strategies that develop resident response to balance challenges. As patients shift their weight on the Balance System platform, aiming for targets on the screen, the computer scores their performance – how many times a target is hit.

After each therapy session, the Balance System generates a hard-copy report, showing how a patient performed on each protocol. It compares how a patient performed compared to an age-matched group of normal, and provides guidance for areas where patient needs to focus on subsequent sessions.

**Biodex Gait Trainer**
The Biodex Gait Trainer is an ambulation tool that documents and compares performance, useful in rehabilitating a wide range of inpatients and outpatients in the episode-of-care era.

Many SNFs attempt to rehabilitate patients with gait issues using parallel bars and walkers – both inefficient for rehab in the episode-of-care era.

- Few elderly, especially women and the obese, have the necessary arm strength to use either device.
- Both methods are fundamentally useless – even dangerous – for most hemiparetic stroke patients.
- Neither enables proper arm swing, and neither allow unweighing or objective documentation – and neither provide repetitive stride cycles replicating over ground walking – essential for safe discharge to home.

For patients with gait issues or fear of long, smooth strides, the Biodex Gait Trainer is not just another treadmill. Footfall sensors beneath the belt detect each patient’s step. A large visual display shows patient target versus actual foot placement, which compares where a patient’s foot should strike (and where it actually did). Audio pacing helps patients – especially those with Parkinson’s disease – step more regularly.

Like the Biodex Balance System, the Gait Trainer compares and documents patient performance to age- and gender-matched normals. Thus, the Gait Trainer enables the SNF to show ACOs when their patients are safe to return home – or need more rehab. Together, the Biodex Gait Trainer and Biodex Balance System form a complete mobility assessment and training package that documents patient improvement.
**Biodex Unweighing System**
The Biodex Unweighing System supports patients who may be too weak or unstable to stride confidently on a treadmill or over ground. Its harness and dynamic suspension mechanism allows anatomically correct vertical displacement and hip pivoting, critical to recovery of normal gait.

The Unweighing System may be used on the Biodex Gait Trainer, on ordinary treadmills, or over ground walking. It encourages safe, aggressive rehab, critical to successful ACO partnering under episode-of-care billing.

**Biodex BioStep semi-recumbent elliptical**
Non-weight-bearing mobility exercise is an important component of physical rehabilitation for virtually all patients.

Under current Medicare Part A regulation, all rehab must be one patient per PT or group equivalent. However, under episode of care, **best results in shorter time are key to successful partnering**. The BioStep encourages independent cardiovascular exercise and joint movement, critical to ambulation skills when patients aren’t PT-managed on the Balance System or Gait Trainer. Even hemiparetic stroke patients can productively use the BioStep, applying as much force as possible with affected limb(s).
Conclusion: Biodex can help you attract patients – and profit

To compete for partnerships and patients under episode-of-care bundling, and to enhance your ability to compete for managed care assignments, SNFs can benefit from the documentation and rehabilitation capabilities of Biodex systems. Biodex works with the management and therapists of SNFs to design system packages customized to each facility’s patient flow and partnership potential.

Beyond hardware, Biodex provides:

- SNF PTs with training needed to rapidly deploy and capitalize on Biodex equipment.
- A complete range of promotional tools to help you market your Biodex rehab/maintenance systems to ACOs and the public – to ACO management, discharge planners, managed care case managers, as well as patients and patient families – useful for building partnerships and referrals – and for maximizing the likelihood that families follow your ACO partner’s post-acute referral, and will select your SNF.

Medicare reimbursement under episode-of-care bundling unquestionably represents a significant challenge to the skilled nursing facility industry. However, it also represents an opportunity for technology-prepared SNFs to differentiate themselves from competition and obtain a larger share of regional referrals from partner ACOs. Biodex rehabilitation systems can help SNFs better prepare to meet the challenges – and capitalize on the opportunities – that this reimbursement change offers.