Eli's Rehab Report

Inpatient Insights: Brace for Change: Post-Acute Bundling Could Bring You Big Business Snafus

See what experts are predicting for your rehab setting.

Heads up, rehab providers in skilled nursing facility, inpatient rehab facility, home health agency, and long-term acute care hospital settings: plans are afoot to bundle post-acute Medicare payments. MedPAC and the feds have been talking about bundling post-acute payments for years without it coming to fruition, but experts say that this policy -- now sitting in the Senate Finance Committee's health reform option papers -- could realistically take effect during the Obama Administration.

Here's the deal: In essence, Medicare would pay hospitals a bundled rate for services (including rehab) within the first 30 days a patient is discharged. That means the post-acute venue, whether it's an LTACH, SNF, IRF, or HHA, would share payment with the hospital for those 30 days. And the hospital would receive a payment even if the patient discharged does not receive post-acute services.

The kicker: "Preventable" hospital readmissions would dip into the bundled payment funds. In fact, policymakers have emphasized monitoring readmission rates and penalizing those venues with rates above the 75th percentile, according to a whitepaper by McGuire Woods titled, "To Bundle or Not to Bundle: Lawmakers Explore the Question."

"It will clearly, for post-acute providers, be as dramatic as DRGs were for hospitals back on Oct. 1, 1983," says **Tom Clarke,** president and CEO of Kissito Post Acute.

Is the Sky (the IRF) Going to Fall?

With hospitals slated to be the gatekeepers for bundled payments, many predict that hospitals will want to share their cash packages with the least-expensive postacute venues -- HHAs and SNFs. And that could hang IRFs and LTACHs out to dry in short order.

After all, SNFs get paid an average of $400 to $500 per day for a Part A stay and HHAs get about $100 a visit, while IRFS and LTACHs are bringing in between $1100 and $1500 per day for a single patient, Clarke points out.

Another view: "People are saying that the IRF is falling, or the sky is falling, and I don't see it that way," says **Lyndean Brick, JD,** senior vice president of Murer Consultants, Inc. in Joliet, Ill. "If you can demonstrate your outcomes, and you're really restoring that person to function, then you're going to be the venue of choice."

Remember, the hospital's bundled payment would take a hit if the patient were readmitted within 30 days. And SNFs and HHAs have much higher readmission rates than IRFs and LTACHs, experts point out.

Another comfort to IRFs and LTACHs is that without the details of post-acute bundling written into law, it's too early to tell how everything will pan out.

For example: "One question that remains unanswered is, how will the CARE tool, which RTI is currently testing in a CMS pilot project, play into the bundling policy?"posits **Fran Fowler, FAAHC,** managing director of Health Dimensions Group in Atlanta. "Hospitals may not have a choice in where they send a person if the tool becomes the indicator of where the patient should go."

Resources: For more information on CMS' post-acute pilot study, see Physical Medicine & Rehab Coding Alert, Vol. 8, No. 9. or email the editor for the article at lindseyr@eliresearch.com. You can also check out CMS' Web site at

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www.cms.hhs.gov/DemoProjectsEvalRpts/MD/list.asp. Click on "Post Acute Care Payment Reform Demonstration."

For more information on the developing post-acute bundling policy, go to the following link http://finance.senate.gov/sitepages/legislation.htm, and click on the 4-28-09 entry. Also check out http://cbo.gov/doc.cfm?index=9925 and www.medpac.gov/documents/20090310_EandC_Testimony_DeliveryReform.pdf.

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