Advising the Congress on Medicare issues

Assessing payment adequacy and updating payments: Inpatient rehabilitation facility services

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Inpatient rehabilitation facilities (IRFs)

- Provide intensive rehabilitation
- Medicare FFS spending: $7.9 billion in 2017
  - Facilities: ~1,180
  - Cases: ~380,000
  - Mean payment per case: ~$20,300
- Per case payments vary by condition, level of impairment, age, and comorbidity; adjusted for:
  - Rural location, teaching status, low-income share, short stays
  - Outlier payments for extraordinarily costly patients

Concerns about IRF PPS

- Some case types may be more profitable than others
- Patient assessment may not be uniform across IRFs
  - Patients in high-margin IRFs were *less* severely ill during preceding acute care hospital stay
  - But patient assessment indicated they were *more* impaired during IRF stay
  - At any level of severity in the hospital, high-margin IRFs consistently coded higher impairment than did low-margin IRFs
- How IRFs code patient's level of impairment affects payments

Payment adequacy framework

- Access
  - Supply of providers
  - Volume of services
  - Marginal profit
- Quality
- Access to capital
- Payments and costs

IRF capacity stable in 2017; share of for-profits continued to increase

	Facilities	Cases	Average annual change in number of facilities 2013-2016	2016-2017
All IRFs	1,178	380,000	0.8%	-0.8%
Freestanding	24%	52%	4.0%	2.2%
Hospital-based	76%	48%	-0.1%	-1.7%
Nonprofit	56%	39%	0.0%	-2.2%
For-profit	33%	54%	4.7%	5.9%
Government	11%	7%	-5.0%	-6.0%

- Aggregate number of beds increased; average occupancy rate 65%

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Results are preliminary and subject to change.
Source: MedPAC analysis of Provider of Services files and MedPAR and cost report data from CMS.

FFS volume down but payments increasing; marginal profit provides incentive to expand

	2013	2016	2017
Medicare cases	373,000	391,000	380,000
Cases per 10,000 FFS beneficiaries	99.1	100.9	98.5
Payment per case	$18,258	$19,714	$20,322
Medicare expenditures (in billions)	$6.9	$7.7	$7.9
Marginal profit:			
Freestanding	39.9%	41.2%	40.9%
Hospital-based	19.0%	19.1%	19.4%

Results are preliminary and subject to change.

Source: MedPAC analysis of MedPAR data and Medicare cost reports from CMS.

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Quality: Small improvement since 2012

Risk-adjusted measure	2012	2017
Potentially avoidable rehospitalizations:		
During IRF stay	2.8%	2.6%
Within 30 days after discharge from IRF	4.8%	4.7%
Discharged to community	74.3%	76.0%
Discharged to SNF	6.9%	6.8%
Gain in motor function	22.1	24.0
Gain in cognitive function	3.5	3.9

Results are preliminary and subject to change.
Source: Analysis of IRF-PAI data from CMS.

Access to capital appears adequate

- Hospital-based units
  - Access capital through their parent institutions
  - Hospitals maintain good access to capital markets
  - Hospitals with units have higher relative Medicare inpatient and overall Medicare margins
- Freestanding facilities
  - Almost half owned by one company
    - Access to capital appears strong; new construction reflects positive financial health
  - Little information available for others
  - All-payer margins strong at 10.4 percent

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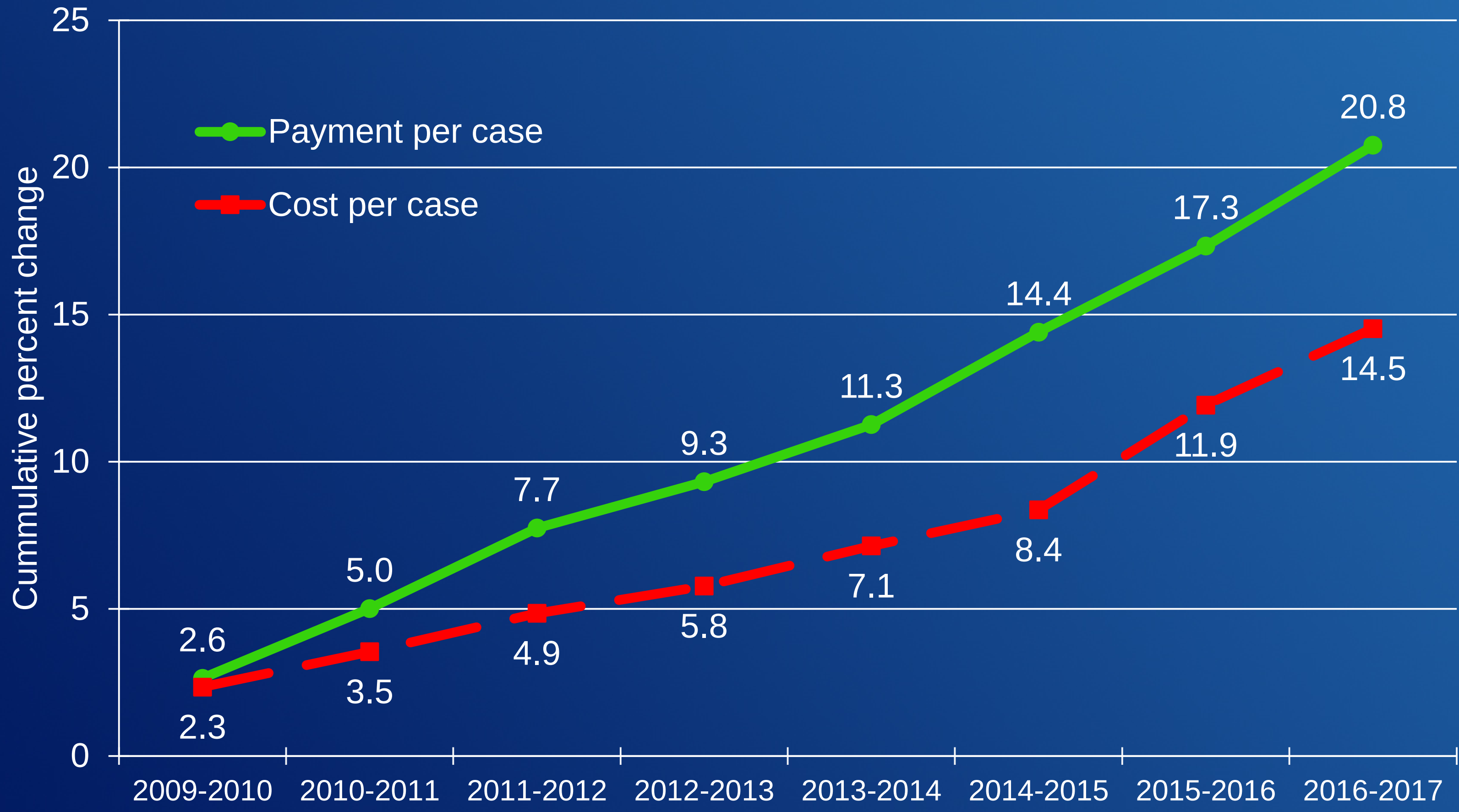
Medicare payments have been rising faster than costs since 2009



Results are preliminary and subject to change.
Source: Analysis of Medicare cost report data from CMS.

With payments rising faster than costs, Medicare margins have been increasing

Results are preliminary and subject to change.
Source: Analysis of Medicare cost report data from CMS.

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IRF Medicare margins vary substantially

	% of IRFs	% of cases	2017 Margin
All IRFs	100%	100%	13.8%
Freestanding	24%	52%	25.5%
Hospital-based	76%	48%	1.5%
Nonprofit	56%	39%	2.2%
For-profit	33%	54%	23.8%

Government-owned IRFs are not shown but are reflected in the aggregate margin. Results are preliminary and subject to change.

Source: MedPAC analysis of Medicare cost report data from CMS.

Factors that contribute to lower margins in hospital-based IRFs

- Majority are nonprofit; may be less focused on cost control
  - From 2009-2017, costs up 21% vs. 10% in freestanding
- Tend to be smaller with lower occupancy
  - 67% have fewer than 25 beds
- Tend to have a different mix of patients
  - 24% admitted for stroke vs. 17% in freestanding
  - 10% admitted for “other neurological” conditions vs. 19% in freestanding
- May assess and code their patients differently

Results are preliminary and subject to change.
Source: MedPAC analysis of Medicare cost report and claims data from CMS.

Examining relatively efficient IRFs

- Examine IRFs with consistently low costs and high quality
- Use three years of data (2014-2016) to categorize IRFs as relatively efficient
  - Must be in top third performance on costs or quality metrics every year
  - Provider cannot have poor performance (bottom third) on cost or quality metrics in any year
- Assess performance in 2017

Relatively efficient IRFs compared to other IRFs in 2017

- Relatively efficient IRFs had better performance on quality metrics
  - Readmission rate 9% lower
  - Discharge rate to SNFs 35% lower
- Relatively efficient IRFs were larger and had higher occupancy rates leading to lower costs (18% lower)
  - Payment rates similar
  - Medicare margin 16.5% for relatively efficient IRFs
- Mix of cases differed
  - Relatively efficient IRFs had smaller share of stroke cases and higher share of other neurological condition cases
- Freestanding and for-profit facilities disproportionately represented in relatively efficient group

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Results are preliminary and subject to change.
Source: MedPAC analysis of Medicare cost report and claims data from CMS.

Summary of payment adequacy

- Access: Capacity appears adequate to meet demand; strong marginal profits
- Quality: Risk-adjusted outcome measures improved slightly since 2012
- Access to capital: Appears adequate
- 2017 Medicare margin: 13.8%