



Advising the Congress on Medicare issues

Updating Payments for Inpatient Rehabilitation Facilities

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Inpatient rehabilitation facilities

- Provide intensive rehabilitation (physical, occupational, speech therapy)
- \$6.0 billion in Medicare FFS spending in 2007
- Medicare FFS accounts for over 60% of IRF patients
- PPS established for IRFs in 2002, pursuant to BBA

IRF criteria

- Patients generally must meet 3-hour rule
- IRFs must:
 - Meet acute hospital COPs
 - Meet other conditions
 - Medical director must provide care full-time
 - Preadmission screening
 - Multidisciplinary team approach
 - Nurses must specialize in rehabilitation
 - 75% rule (now 60%)

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- Historically, to be paid as an IRF, 75% of all patients were required to have certain specific diagnoses
- 2004 change meant that most hip and knee replacement patients would not count toward the 75% rule going forward
- Phase-in of renewed enforcement of the 75% rule:
 - 50% July 2004-June 2005
 - 60% July 2005-June 2007
 - scheduled to be 65% July 2007-June 2008
 - scheduled to be 75% beginning July 2008
- In December 2007, the MMSEA permanently capped the threshold at 60% retroactive to July 2007

Assessing adequacy of Medicare payments for IRF services

- Supply of facilities and beds
- Volume of services / access to care
- Quality of care
- Access to capital
- Payments and costs

Supply of IRFs has declined modestly since 2005 after increasing in the early years of PPS

	2002	2005	2007	Annual change 2002-05	Annual change 2005-07
All IRFs	1,188	1,231	1202	1.2%	-1.2%
Urban	988	1,000	953	0.4	-2.4
Rural	200	231	249	4.9	3.8
Nonprofit	755	765	740	0.4	-1.6
For profit	277	305	288	3.3	-2.8
Freestanding	215	217	219	0.3	0.5
Hospital-based	973	1,014	983	1.4	-1.5

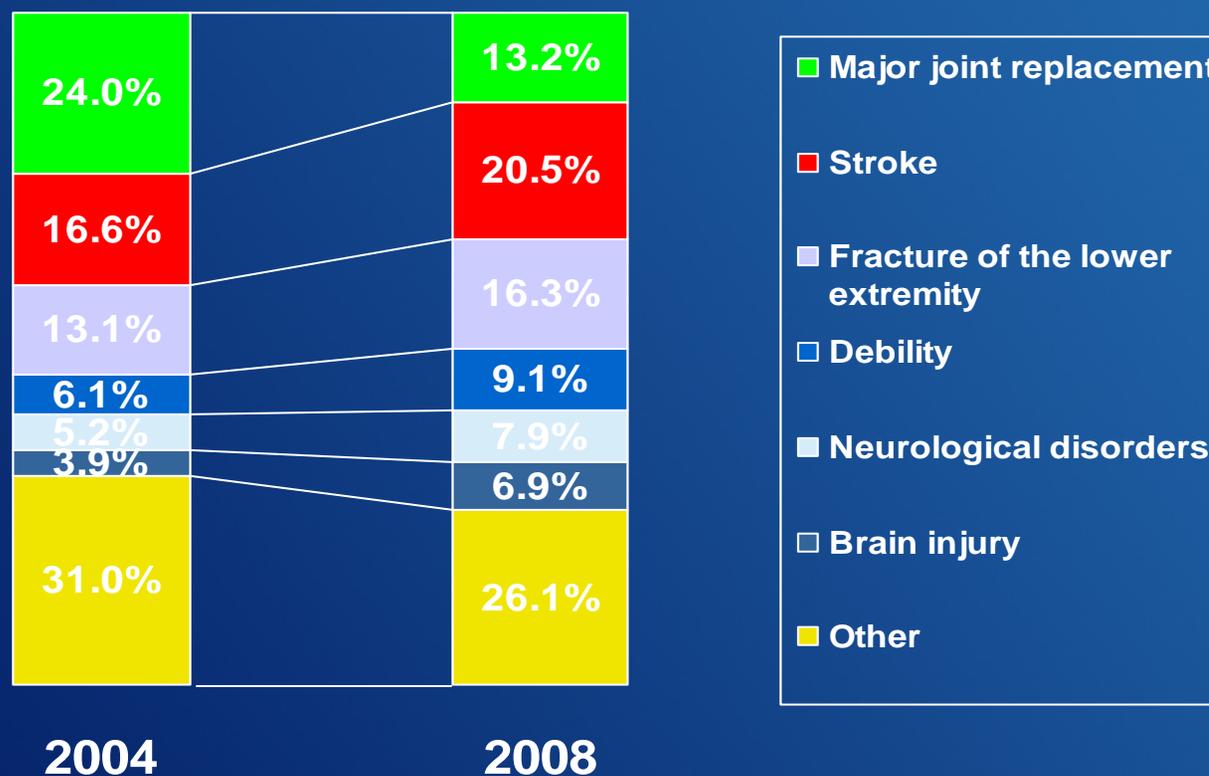
Supply of IRF beds has declined modestly since 2004

	2002	2004	2007	Annual change 2002-04	Annual change 2004-07
Total beds	36,453	37,549	36,187	1.9%	-1.2%
Freestanding	13,355	13,523	12,917	2.1	-1.5
Provider-based	23,098	24,026	23,270	1.8	-1.1

Medicare volume and spending rapidly increased after PPS, followed by volume declines

	2002	2004	2007	Annual Change 2002-2004	Annual Change 2004-2007
Unique patients per 10K FFS Beneficiaries	114	124	98	4.4%	-7.5%
Payment per case	\$11,152	\$13,275	\$16,143	9.1%	6.7%
Unique Medicare Patients	398,000	451,000	338,000	6.5%	-9.2%
Spending (billions)	\$5.7	\$6.4	\$6.0	6.7%	-2.6%

Change in composition of Medicare IRF cases, 2004 – 2008



Source: MedPAC analysis of IRF-PAI data from CMS, 2004 - 2008.

Implications for FFS beneficiaries' access to care: hip and knee replacement example

Percent of hospital patients in hip and knee replacement DRG by discharge destination

Hospital discharge destination	2004	2005	2006	2007	% point change, 04 – 06	% point change, 06 – 07
IRF	28%	24%	20%	16%	-8	-4
SNF	33%	34%	35%	36%	2	1
Home health	21%	25%	27%	29%	6	2
Other	18%	18%	18%	19%	0	1
Total	100%	100%	100%	100%		

Quality of care: increase in functional gain, 2004-2008

Medicare patient type	2004	2006	2008
All patients			
FIM™ Admission	68.0	63.6	61.2
FIM™ Discharge	90.4	87.1	85.5
FIM™ Gain	22.4	23.5	24.3
Discharged home			
FIM™ Admission	71.9	68.0	65.7
FIM™ Discharge	97.1	94.9	93.8
FIM™ Gain	25.3	26.9	28.1

Source: MedPAC analysis of IRF-PAI data from CMS, 2004 – 2008.
 Note: “All patients” includes patients discharged to other inpatient settings, other post-acute care, outpatient care, and home.

Access to capital tightened in 2008

- Economy-wide issues in the credit markets may result in increased capital costs or delayed capital investments for IRFs
- Changes in the credit markets are broad and not related to specific changes in Medicare payment policy

Cumulative changes in IRFs' payments and costs per case, 1999-2007

