
# Assessing payment adequacy and updating payments: Inpatient rehabilitation facility services

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# Inpatient rehabilitation facilities (IRFs)

- Provide intensive rehabilitation
- Medicare spending: $7.7 billion in 2016
  - Facilities: ~1,200
  - Cases:  ~391,000
  - Mean payment per case: ~$19,700
- 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

# IRF criteria

- IRFs must
  - Meet the conditions of participation for acute-care hospitals
  - Have a medical director of rehabilitation
  - Meet the compliance threshold (“60 percent rule”)
- Patients must
  - Tolerate and benefit from 3 hours of therapy per day
  - Require at least two types of therapy

# Concerns about IRF PPS

- Some case types may be more profitable than others
- Patient assessment may not be uniform across IRFs

# Analysis of 2013 data found that patient assessment may not be uniform across IRFs

- Patients in high-margin IRFs were *less* severely ill during preceding acute care hospital stay:
  - Lower hospital case mix and severity of illness
  - Less likely to spend time in ICU/CCU
  - Less likely to be high-cost outliers in hospital
- but appeared to be *more* impaired during IRF stay
  - Lower motor and cognition scores, which increased payment
- ➢ At any level of severity in the hospital, high-margin IRFs consistently coded higher impairment than did low-margin IRFs

Source: MedPAC analysis of FY2013 MedPAR, IRF-PAI data, and cost report data from CMS.

# Average IRF motor score at admission by type of stroke, for IRFs with the lowest and highest margins, 2013

| | Motor score | |
|---|---|---|
| **Type of stroke** | **Lowest margin IRFs** | **Highest margin IRFs** |
| With paralysis | 29.2 | 24.6 |
| Without paralysis | 35.3 | 29.0 |

Lower motor scores indicate greater impairment. Only IRF cases with an acute care hospital stay within 30 days of admission to the IRF were included in the analysis. IRFs were ranked by their 2013 Medicare margins and then sorted into 5 equal-sized groups (quintiles).
Source: MedPAC analysis of FY 2013 MedPAR, IRF-PAI, and Medicare cost report data from CMS.

# Previous MedPAC recommendations

- The Secretary should conduct focused medical record review of inpatient rehabilitation facilities that have unusual patterns of case mix and coding

- The Secretary should expand the inpatient rehabilitation facility outlier pool to redistribute payments more equitably across cases and providers

# Payment adequacy framework

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

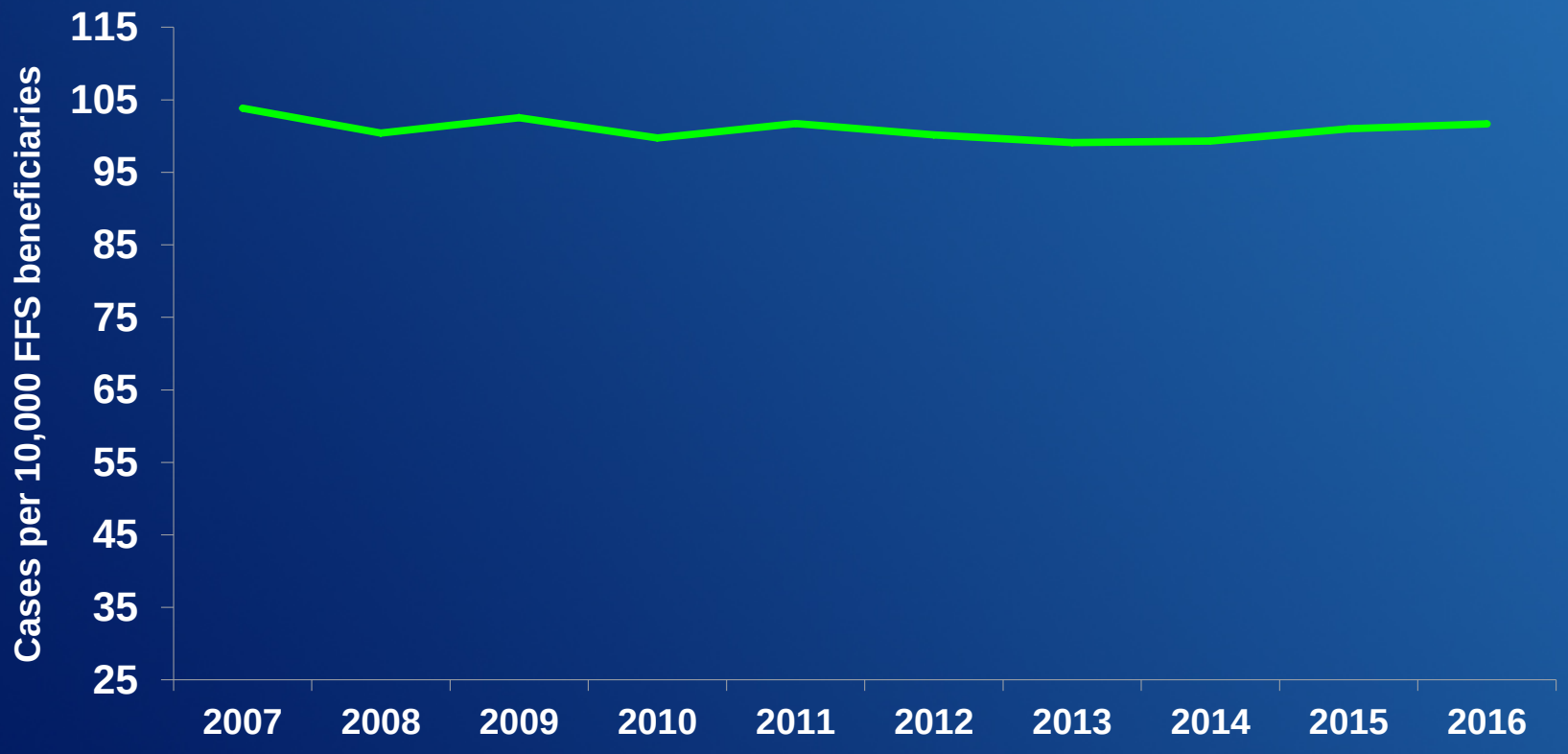
# IRF supply remained fairly steady in 2016; share of for-profits continued to increase

| | | | Average annual change in number of facilities | |
|---|---|---|---|---|
| | Facilities | Cases | 2006-2013 | 2013-2016 |
| All IRFs | 1,188 | 391,000 | -0.8% | 0.8% |
| Freestanding | 23% | 50% | 1.6% | 4.0% |
| Hospital-based | 77% | 50% | -1.3% | -0.1% |
| Nonprofit | 57% | 41% | -1.6% | 0.0% |
| For-profit | 31% | 52% | 1.1% | 4.7% |
| Government | 11% | 7% | -1.1% | -5.0% |

- Average occupancy rate: 65%

Columns may not sum to 100% due to rounding. Results are preliminary and subject to change.
Source: MedPAC analysis of Provider of Services files and MedPAR and cost report data from CMS.

# On a FFS basis, steady volume of IRF cases since 2007




Results are preliminary and subject to change.

Source: MedPAC analysis of MedPAR data from CMS.

# Quality: Improvement since 2011

| Risk-adjusted measure | 2011 | 2016 |
|---|---|---|
| Potentially avoidable rehospitalizations | | |
| During IRF stay | 2.8% | 2.5% |
| Within 30 days after discharge from IRF | 5.0% | 4.4% |
| Discharged to community | 74.1% | 76.9% |
| Discharged to SNF | 6.9% | 6.7% |
| Gain in motor function | 22.2 | 24.4 |
| Gain in cognitive function | 3.6 | 4.0 |

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 strong access to capital markets
- Freestanding facilities
  - Almost half owned by one company
    - Access to capital appears strong; new construction reflects positive financial health
  - Little information available for others

➢ Post-acute care companies continue to pursue vertical integration

# IRF Medicare margins, 2016

| | % of IRFs | % of cases | Margin |
|---|---|---|---|
| All IRFs | 100% | 100% | 13.0% |
| Freestanding | 23% | 50% | 25.5% |
| Hospital-based | 77% | 50% | 1.2% |
| Nonprofit | 57% | 41% | 2.0% |
| For-profit | 31% | 52% | 23.9% |

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 higher costs in hospital-based IRFs

- Majority are nonprofit; may be less focused on cost control
  - From 2009-2016, costs up 17.9% vs. 7.4% in freestanding
- Tend to be smaller with lower occupancy
  - 66% 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. 18% in freestanding
- May assess their patients differently

➢ Marginal profit: Hospital-based = 19.3%
Freestanding = 40.9%

MEDPAC

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

# Summary

- Access: Capacity appears adequate to meet demand
- Quality: Risk-adjusted outcome measures improved since 2011
- Access to capital: Appears adequate
- 2016 estimated margin: 13.0%
- 2016 estimated marginal profit:
  - Hospital-based = 19.3%
  - Freestanding = 40.9%



Results are preliminary and subject to change.

# How should Medicare payments to IRFs change in 2019?

- MedPAC recommended no payment increase for FY2009–2017
- MedPAC recommended 5% reduction in payment rate for FY2018
- CMS has been required to increase payments each year
- Payments to IRFs remain well above the costs of caring for beneficiaries