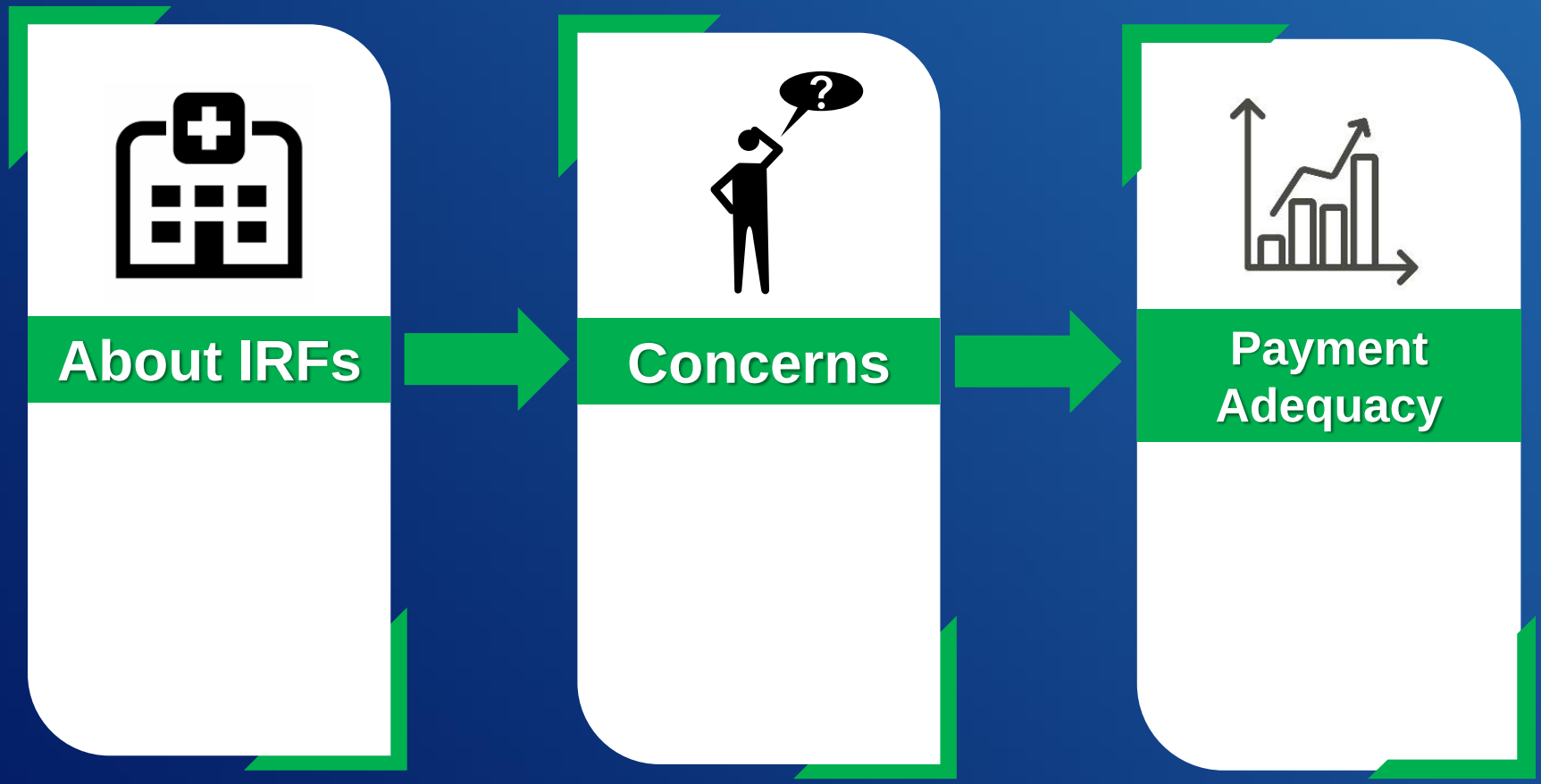
Assessing payment adequacy and updating payments: Inpatient rehabilitation facility services

Jamila Torain and Dana Kelley

December 5, 2019

MEDPAC

Overview



Inpatient rehabilitation facilities (IRFs)

About IRFs

?

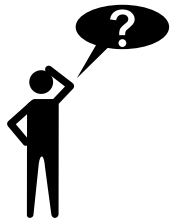
- Provide intensive rehabilitation
- Patient must be able to tolerate intensive therapy
- Per case payments vary by condition, level of impairment, age, and comorbidity; adjusted for:
  - Rural location, teaching status, low-income share, short stays
  - Outlier payments for extraordinarily costly patients
- Medicare accounted for:
  - 59% of IRFs' discharges
  - Average length of stay in an IRF was 12.7 days

MEDPAC

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

Results preliminary; subject to change

Concerns about providers' coding of patients' function



Concerns

- **Variation in patient assessment**
- **Profitability of some case types**

- How IRFs code patients' level of impairment affects payments
- Patient assessment may not be uniform across IRFs
- Some case types may be more profitable than others

IRF payment adequacy framework

Beneficiaries' access to care	Quality of care	IRFs' access to capital	Medicare payments and IRFs' costs
• Supply of IRFs • Volume of services • Marginal profit	• Readmissions • Discharge to SNF • Discharge to community • Change in function	• All payer profitability • Hospitals' access to capital • New construction	• Payments and costs • Medicare margins and efficient IRFs • Projected Medicare margins

Update recommendation for IRF PPS

IRF capacity stable in 2018; share of for-profits continued to increase

			Average annual change in number of facilities	
	Facilities	Cases	2013-2017	2017-2018
All IRFs	1,170	408,000	0.4%	-0.7%
Freestanding	25%	52%	3.5%	**3.9%**
Hospital-based	75%	45%	-0.5%	-2.1%
Nonprofit	55%	37%	-0.8%	-2.0%
For-profit	34%	56%	5.0%	**2.0%**
Government	10%	7%	-5.2%	-3.2%

- Aggregate number of beds increased; average occupancy rate 66%

Source: MedPAC analysis of Provider of Services data and Medicare Provider Analysis and Review data from CMS.

Results preliminary; subject to change

FFS volume up and payments increasing

	2010	2016	**2018**
Medicare cases	365,000	396,000	**408,000**
Cases per 10,000 FFS beneficiaries	101.3	103.2	**105.7**
Payment per case	$16,814	$18,931	**$20,124**
Medicare expenditures (in billions)	$6.1	$7.7	**$8.0**
Marginal profit:			
-Freestanding:			**41%**
-Hospital-based			**20%**

MEDPAC

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS, Office of the Actuary 2019 and Medicare cost report data from CMS.

Results preliminary; subject to change

Quality: Small improvement since 2012

Measure	2012	2018
Potentially avoidable rehospitalizations		
-During IRF stay	2.8%	2.6%
-During 30 days after discharge from IRF	5.0%	4.8%
Discharged to a SNF	6.7%	6.6%
Discharged to the community	74.4%	76.4%
Gain in motor score	22.1	24.3
Gain in cognitive score	3.5	4.0

Source: MedPAC analysis of Inpatient Rehabilitation Facility–Patient Assessment Instrument data from CMS.

Results preliminary; subject to change

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 10.7 percent

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

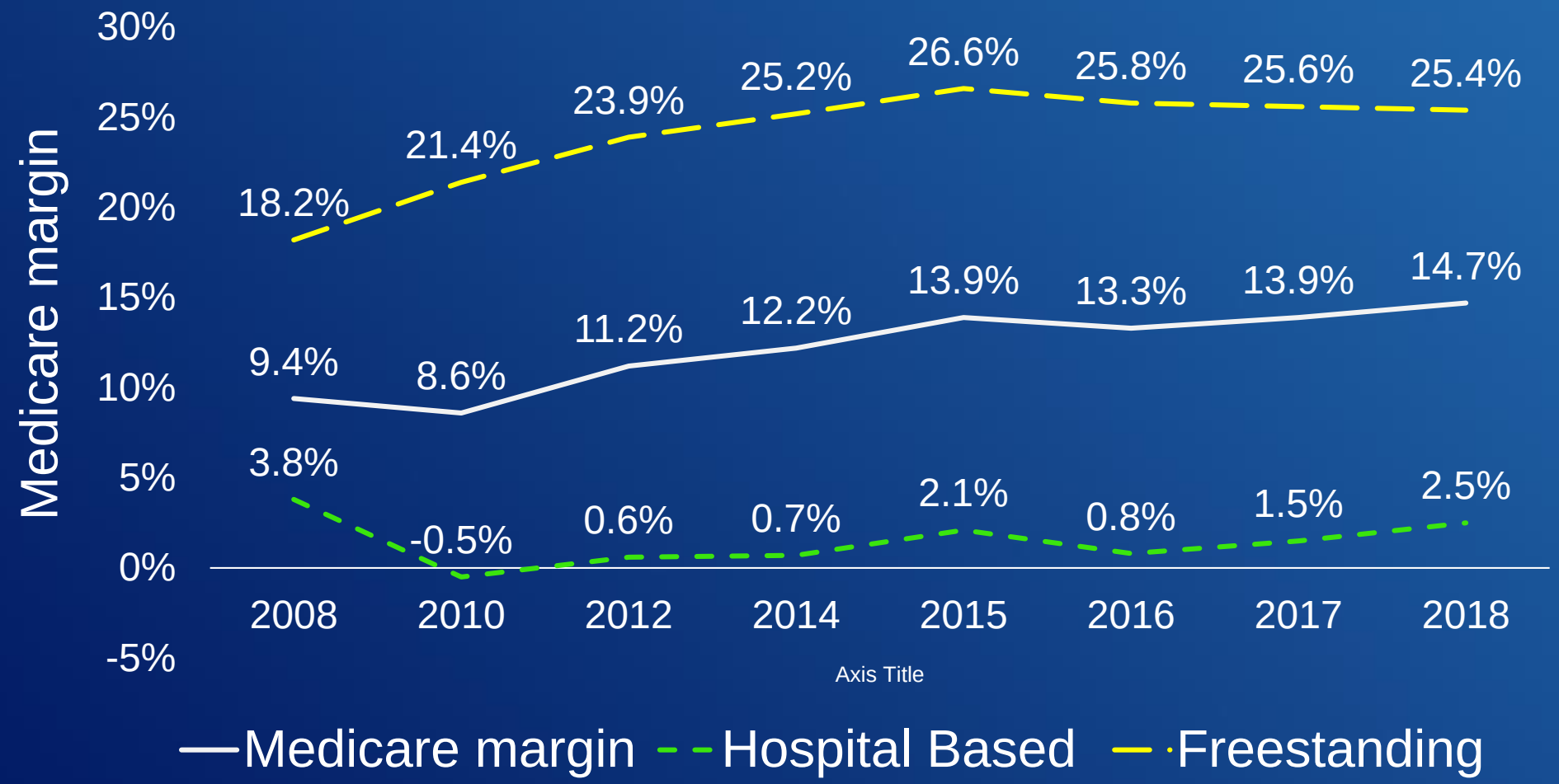
Results preliminary; subject to change

Medicare payments have been rising faster than costs since 2010

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

Results preliminary; subject to change

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



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

Results preliminary; subject to change

Factors that contribute to lower margins in hospital-based IRFs

- Majority are nonprofit; may be less focused on cost control
  - From 2010-2018, costs up 19% vs. 10% in freestanding
- Tend to be smaller with lower occupancy
  - 67% have fewer than 25 beds
  - In 2018, hospital-based IRFs' occupancy rate: 61% vs. 69% in freestanding
- 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

Source: MedPAC analysis of Medicare cost report data, Medicare Provider Analysis and Review data, and Inpatient Rehabilitation Facility–Patient Assessment Instrument data

Results preliminary; subject to change

Relatively efficient IRFs compared to other IRFs in 2018

	Relatively Efficient IRFs	Other IRFs
Readmission rate	2.3%	2.6%
Discharge to SNF	4.8%	6.6%
Number of beds	30	23
Occupancy rate	69%	63%
Medicare margin	**17.8%**	**1.1%**
Case types	More neurological	More strokes
Facility types	Freestanding, for-profit	Hospital-based, nonprofit

MEDPAC

Source: MedPAC analysis of Medicare cost report data, Medicare Provider Analysis and Review data, and Inpatient Rehabilitation Facility–Patient Assessment Instrument data from CMS for 2015 to 2018.

Results preliminary; subject to change

Summary: IRF payment adequacy indicators are positive

Beneficiaries' access to care	Quality of care	IRFs' access to capital	Medicare payments and IRFs' costs
• Capacity appears to be adequate to meet demand • Increase in volume • High marginal profit	• Risk-adjusted outcome measures have improved slightly over time	• IRFs maintain good access to capital markets • The all-payer margin for freestanding IRFs is a robust 10.7 percent	• In 2018, the aggregate Medicare margin was 14.7 percent
Positive	Positive	Positive	Positive