Assessing payment adequacy: Inpatient rehabilitation facility services

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Inpatient rehabilitation facilities

- Provide intensive rehabilitation
- IRFs are hospital-based (80%) or freestanding (20%)
- Medicare FFS is largest payer
  - 60% of IRF cases
  - $6.32 billion in expenditures (2010)
- IRF PPS established in 2002 (BBA)

IRF criteria

- Patients must
  - Require at least two types of therapy
  - Tolerate 3 hours of therapy per day
- IRFs must
  - Have a medical director of rehabilitation
  - Have an interdisciplinary team approach
  - Screen patients within 48 hours prior to admission
  - Initiate therapy within 36 hours after admission
  - Meet the compliance threshold (60 percent rule)

Assessing adequacy of IRF payments

- Access to care
  - Supply of facilities, number of rehabilitation beds, and occupancy rates
  - Volume of services
- Quality of care
- Access to capital
- Payments and costs

IRF capacity and supply are relatively stable in 2010

	2008	2009	2010	Annual change '08-'09	Annual change '09-'10
Number of beds					
All IRFs	35,762	35,767	35,440	0%	-0.9%
Hospital-based	22,670	22,267	21,907	-1.8%	-1.6%
Freestanding	13,092	13,500	13,533	3.1%	0.2%
Occupancy rates				% point change	% point change
All IRFs	62.1%	62.9%	62.4%	0.7	-0.5
Hospital-based	59.8%	60.2%	59.4%	0.4	-0.8
Freestanding	66.1%	67.3%	67.2%	1.2	-0.1

Note: Figures preliminary and subject to change

Source: Medicare hospital cost report data from CMS

Volume remains relatively stable in 2010

	2008	2009	2010	Annual change '08-'09	Annual change '09-'10
FFS Spending ($ billions)	$5.95	$6.03	$6.32	+1.3%	+4.8%
Number of cases	356,000	364,000	359,000	+2.2%	-1.3%
Payment per case	$16,646	$16,552	$17,085	-0.6%	+3.2%

Note: Figures preliminary and subject to change

Source: CMS Office of the Actuary (FFS spending), MedPAC analysis of Medicare MEDPAR from CMS (number of cases and payment per case)

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IRF patient mix has changed since 2004

- Increases in share of IRF cases that meet the compliance threshold (stroke, brain injury, neurologic disorders)
- Increases in share of IRF cases that do not meet the compliance threshold (debility, orthopedic conditions)
- Decline in share of major joint replacement cases
- Fewer share of hospital discharges for major joint replacements sent to IRFs; increase in share sent to home health and SNFs
- Changing patient mix results in an increasing average patient severity

Note: Data is preliminary and subject to change

Small improvement in risk-adjusted quality since 2004

	FIM gain	Discharge to community	Discharge to acute hospital	Hospital readmission within 30 days after discharge to community	SNF admission within 30 days after discharge to community
Preliminary risk-adjusted estimates					
2004	25.3	77.8%	8.7%	10.8%	3.1%
2006	26.3	78.1%	7.6%	9.7%	2.9%
2008	27.2	78.4%	7.6%	9.4%	2.9%
2009	27.9	78.9%	7.2%	9.3%	2.9%

Note: Figures preliminary and subject to change. Estimates developed from risk-adjustment models and by holding the 2004 Medicare IRF patient cohort constant through 2009.

Source: RAND analysis of IRF-PAI, MedPAR, denominator file, and provider of services file

Access to capital appears adequate

- Hospital-based units
  - Access capital through their parent institutions
- One major freestanding IRF chain
  - Cost of accessing capital under equity and debt markets increased in 2011; however able to access capital markets because of positive revenue growth

Note: Data is preliminary and subject to change

Medicare margins increased in 2010, but vary by type of facility

	Percent of spending	2008 margins	2009 margins	2010 margins
All	100%	9.5%	8.4%	8.8%
Hospital-based	58.4%	4.1%	0.4%	-0.2%
Freestanding	41.6%	18.2%	20.3%	21.4%
Bed size				
1-10	2.5%	-5.0%	-11.6%	-10.9%
11-21	19.6%	0.7%	-2.6%	-3.2%
22-59	40.9%	8.5%	6.6%	7.0%
60+	36.9%	17.1%	18.3%	18.5%

Note: Figures preliminary and subject to change

Source: MedPAC analysis of Medicare hospital cost reports from CMS

Characteristics of hospital-based IRFs

- 80% of facilities, but 57.8% of Medicare IRF discharges
- Tend to be smaller facilities
  - More than half have less than 21 beds
- Higher costs than freestanding IRFs
  - 30% higher direct costs per case; 11% higher indirect costs per case
- Are able to cover their direct costs
  - 2010 direct cost margin: 34.4%

Note: Data is preliminary and subject to change

Low volume impacts rural and urban IRFs' Medicare margins

Total (all payer) volume	Urban IRF median Medicare margin	Rural IRF median Medicare margin
Lowest quintile	-16.1%	-28.7%
Second quintile	-5.4%	-8.8%
Third quintile	1.4%	-3.4%
Fourth quintile	9.3%	2.4%
Fifth quintile	18.6%	16.0%

Note: Figures preliminary and subject to change

Source: MedPAC analysis of Medicare hospital cost reports from CMS

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Payment adjustment for rural IRFs does not have a uniform impact

	Urban	Micropolitan	Rural adjacent to urban	Rural nonadjacent to urban
Margin	9.0%	4.3%	-5.6%	16.1%
Cost per case	$15,517	$16,098	$21,963	$14,630
Payment per case	$17,046	$16,828	$20,801	$17,445

Note: Figures preliminary and subject to change; Cost and payment per case are unadjusted for wages, case-mix, and outliers

Source: MedPAC analysis of Medicare hospital cost reports from CMS

Summary

- Beneficiary access
  - Supply, capacity, and volume are relatively stable in 2010
- Small improvement in risk-adjusted quality since 2004
- Access to credit appears to be adequate
- 2010 margin is 8.8%

Note: Figures preliminary and subject to change

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