Advising the Congress on Medicare issues

Assessing payment adequacy and updating payments: Inpatient rehabilitation facility services

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Inpatient rehabilitation facilities

- Provide intensive rehabilitation: 1,166 IRFs treated 373,000 FFS cases in 2012
- IRFs are hospital-based or freestanding
  - Hospital-based IRFs represent 80% of facilities, but only 55% of Medicare IRF discharges
- Medicare FFS is the largest payer
  - 60% of IRF cases
  - $6.72 billion in expenditures (2012)
- Payment rates per discharge vary by condition and level of impairment, among other factors

Note: Data is preliminary and subject to change

IRF criteria

- Patients must
  - Tolerate 3 hours of therapy per day
  - Require at least two types of therapy
- IRFs must
  - Meet the conditions of participation for acute care hospitals
  - Have a medical director of rehabilitation
  - Meet the compliance threshold (60 percent rule)
    - Volume and patient mix sensitive to policy changes
    - Major joint replacement cases shifted to SNFs and HHAs

Assessing adequacy of IRF payments

- Access to care
  - Supply of facilities and occupancy rates
  - Patient volume
- Quality of care
- Access to capital
- Payments and costs

IRF supply remained steady in 2012, share of for-profits continued to increase

Facilities	2008	2011	2012	Share of discharges	Average annual change '08-'11	Average annual change '11-'12
All IRFs	**1,202**	**1,165**	**1,166**	**100%**	**-1.0%**	**0.1%**
Freestanding	221	234	239	45.3%	1.9%	2.1%
Hospital-based	981	931	927	54.7%	-1.7%	-0.4%
Nonprofit	738	711	698	46.9%	-1.2%	-1.8%
For-profit	291	294	307	45.8%	0.3%	4.4%
Government	173	158	157	7.3%	-3.0%	-0.6%

Note: Data ispreliminary and subject to change

Source: Medicare Provider of Service files from CMS

Occupancy rates suggest capacity adequate to meet demand

				Average annual change	
	2008	2011	2012	’08-’11	’11-’12
Occupancy rates					
All IRFs	**62.1%**	**63.3%**	**62.8%**	**0.6%**	**-0.8%**
Freestanding	66.2%	67.8%	67.3%	0.8%	-0.7%
Hospital-based	59.8%	60.1%	59.7%	0.2%	-0.7%

2012 occupancy rates

- Urban higher than rural (63.9% vs 50.2%)
- Nonprofit and for-profit the same (about 63%)

Note: Data ispreliminary and subject to change

Source: Medicare hospital cost report data from CMS

Volume and payment increasing

				Average annual change	
	2008	2011	2012	’08-’11	’11-’12
FFS Spending ($ billions)	$5.93	$6.46	$6.72	+2.9%	+4.0%
Number of cases	356,000	371,000	373,000	+1.4%	+0.5%
Unique patients per 10,000 beneficiaries	92.2	93.1	92.4	+0.3%	-0.8%
Payment per case	$16,646	$17,398	$17,995	+1.5%	+3.4%

Note: Data is preliminary and subject to change

Source: MedPAC analysis of Medicare MEDPAR from CMS (number of cases and payment per case)

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Access to capital appears adequate

- Hospital-based units
  - Access capital through their parent institutions: hospitals maintain adequate access to capital overall
- Freestanding facilities
  - Access to capital in one major chain remains very good; acquisitions and construction reflect positive financial health
  - Little information available for others

Note: Data is preliminary and subject to change

Quality of care improved slightly

- Performance on quality measures improved slightly from 2010 to 2011
  - Functional improvement (FIM gain) increased by 3%
  - Rates of discharge to the community increased by 1%
- Analysis of a broad set of measures over earlier years found improvement in quality of care over time

Note: Data is preliminary and subject to change. FIM gain (the difference on the Functional Independence Measure on the IRF-Patient Assessment Instrument between admission and discharge).

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

Medicare margins increased in 2012

	Percent of industry	Percent of spending	2010	2011	2012
Margins					
All IRFS	**100%**	**100%**	**8.7%**	**9.8%**	**11.1%**
Freestanding	20.5%	44.7%	21.3%	22.9%	23.8%
Hospital-based	79.5%	55.3%	-0.4%	-0.1%	0.8%

2012 margins

- Freestanding IRFs:
  nonprofits = 13.8% vs for-profits = 26.5%
- Hospital-based IRFs:
  nonprofits = -0.2% vs for-profits = 8.3%

Note: Data is preliminary and subject to change. Margins for government-owned IRFs are not presented separately, but are included in the margins for other applicable groups. Source: MedPAC analysis of Medicare hospital cost reports from CMS

Hospital-based IRFs: factors that impact margins

- 80% of facilities, but 55% of Medicare IRF discharges
- Tend to be smaller with lower occupancy
  - 58% have fewer than 22 beds
- Higher costs than freestanding IRFs
  - 30% higher direct costs per case; 11% higher indirect costs per case (2010)
- Overall Medicare margins are 1.9 percentage points higher for acute care hospitals with an IRF

Note: Data is preliminary and subject to change

Efficient IRFs maintain high margins with above-average quality

2011 Analysis	Relatively efficient providers	All other providers
Share of IRFs	16.7%	83.3%
Medicare margins (median)		
All	24.8%	-3.0%
Freestanding	*27.4%*	*14.2%*
Hospital-based	*13.3%*	*-4.8%*

Compared to other IRFs, relatively efficient providers were larger, disproportionately freestanding and had (median):

- Costs per discharge that were 28 percent lower
- Patients with higher case mix and longer lengths of stay, but lower average costs per day
- FIM gain scores that were 5 points higher
- Rates of discharge to the community that were 8 percentage points higher

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Note: Data is preliminary and subject to change. FIM gain (the difference on the Functional Independence Measure on the IRF-Patient Assessment Instrument between admission and discharge).

Payment adequacy indicators are positive, similar to results from recent years

- Beneficiary access
  - Capacity remains adequate to meet demand
  - Share of users relatively stable
- Quality remains stable
- Access to capital appears adequate
- 2012 margin is 11.1%

Note: Data is preliminary and subject to change