Advising the Congress on Medicare issues

Assessing payment adequacy: Inpatient rehabilitation facility services

Sara Sadownik and Craig Lisk

January 10, 2013

MEDPAC

Inpatient rehabilitation facilities

- Provide intensive rehabilitation
- IRFs are hospital-based or freestanding
  - Hospital-based IRFs represent 55% of Medicare IRF discharges; 45% are in freestanding IRFs
- Medicare FFS is the largest payer
  - 62% of IRF cases (~ 371,300 cases)
  - ~ $6.5 billion in spending
- IRF PPS established in 2002 (BBA)

Inpatient rehabilitation facilities: Commissioner questions

- Regional variation in utilization
  - Rural areas generally have fewer beds, lower occupancy
- Virtually all beneficiaries live in a county with at least one PAC option
  - 31% live in a county that does not have an IRF; of these counties, 86% have both a SNF and home health
- Hispanic beneficiaries less likely to have joint replacements, but more likely to be discharged home rather than to institutional care

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

Access to care measures summary

- Number of facilities and beds continued to decline slightly in 2011
  - 1,165 facilities (1.2% decrease); 35,249 beds (0.8% decrease)
  - Supply trend of hospital-based decreasing, freestanding increasing
- Spending increased 5.2% in 2011 due to growth in number of cases and payment per case (~$6.5 billion in FFS spending)
- Occupancy rate grew 1.4% (average ~ 63%)
  - Commissioner question: most hospital-based IRFs need patient referrals from other hospitals

Note: Data is preliminary and subject to change

Quality of care: risk-adjusted measures show relative stability

	2009	2010
FIM gain	**26.7**	27.4
Discharge to community	70.6%	71.1%
SNF admission within 30 days after discharge to community	3.6%	4.0%
Discharge to acute care hospital	10.4%	10.3%
Hospital readmission within 30 days after discharge to community	12.0%	12.0%

Note: Figures preliminary and subject to change. Estimates developed from risk-adjustment models. FIM gain (the difference between the Functional Independence Measure on the IRF-Patient Assessment Instrument between admission and discharge).

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

Quality of care: Commissioner questions

- Hospital-based vs freestanding: outcomes comparable overall
- Variation: among the five measures, difference between 25th and 75th quartiles ranged from 20% to 2-fold
- Decline in FIM score on admission over time
- Comparability of outcomes between different post-acute care providers
- Share of conditions treated by different PAC providers
  - 3% of all acute hospital discharges are to IRFs, but varies by condition: IRFs treat 19% of stroke discharges and 12% of hip and knee replacements
- Impact of hospital readmission penalty

Adequate access to capital

- Hospital-based units
  - Access capital through their parent institutions: hospitals maintaining reasonable access to capital but are shifting capacity to outpatient
- One major freestanding IRF chain
  - Ability to borrow increased, largely due to improving credit markets and the chain's strong operating performance

Note: Data is preliminary and subject to change

Medicare margins increased in 2011, but vary by type of facility

	Percent of discharges	2009	2010	2011
Margins				
All IRFS	**100%**	**8.4%**	**8.7%**	**9.6%**
Hospital-based	55%	0.3%	-0.3%	-0.8%
Freestanding	45%	20.3%	21.4%	22.9%
Nonprofit	48%	2.3%	2.0%	2.0%
For-profit	45%	19.0%	19.7%	21.3%
Government	8%	N/A	N/A	N/A

Note: Figures preliminary and subject to change. Totals may not sum to 100 due to rounding. Margins for government facilities are not presented separately but are included in the margins for other groups, where applicable.

Source: MedPAC analysis of Medicare hospital cost reports from CMS

MEDPAC

Margins in 2011 by facility type and ownership

	Percent of discharges	Margin
Freestanding		**22.9%**
Nonprofit	9%	14.8%
For-profit	36%	25.3%
Government	1%	N/A
Hospital-based		**-0.8%**
Nonprofit	40%	-0.9%
For-profit	8%	3.9%
Government	7%	N/A

Note: Figures preliminary and subject to change. Totals may not sum to 100 due to rounding. Margins for government facilities are not presented separately but are included in the margins for other groups, where applicable.

Source: MedPAC analysis of Medicare hospital cost reports from CMS

Hospital-based IRFs: factors that impact margins

- Tend to be smaller with lower occupancy
  - Average number of beds (vs freestanding): 25 vs 63
  - Occupancy (vs freestanding): 60% vs 68%
- Higher costs per case than freestanding IRFs
  - 30% higher direct costs; 11% higher indirect costs
  - Contained cost growth less than freestanding IRFs
- More likely to have Medicaid patients, but non-profits drive difference
- Able to cover their direct costs
  - 2010 direct cost margin: 34.4%
- Total acute hospital Medicare margins are 2.1 percentage points higher for acute hospitals with an IRF

Note: Data is preliminary and subject to change

Policy changes for modeling 2013 margins

	2011	Projected 2013
All IRFs' margin:	9.6 %	8.5%

- 2012: Market basket plus outlier adjustment (CMS); minus 0.1% (PPACA), minus 1.0% for productivity (PPACA)
- 2013: Market basket plus outlier adjustment (CMS); minus 0.1% (PPACA), minus 0.7% for productivity (PPACA)

Note: Figures preliminary and subject to change

Summary

- Beneficiary access
  - Capacity remains adequate to meet demand
- Risk-adjusted quality remains stable
- Access to credit appears adequate
- 2011 margin is 9.6%
- 2013 projected margin is 8.5%

Note: Figures preliminary and subject to change