Assessing payment adequacy and updating payments: Inpatient rehabilitation facility services

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Inpatient rehabilitation facilities

- Provide intensive rehabilitation
- Medicare spending: $6.8 billion in 2013
  - Facilities = 1,160
  - Cases = 373,000
  - Mean payment per case = $18,260
- Per case payments vary by condition, level of impairment, age, and comorbidity; adjusted for:
  - Rural location, teaching status, low-income share
  - 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)
    - Volume and patient mix sensitive to policy changes
- Patients must
  - Tolerate and benefit from 3 hours of therapy per day
  - Require at least two types of therapy

Payment adequacy framework

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

IRF supply remained fairly steady in 2013; share of for-profits continued to increase

			Average annual change in number of facilities	
	Facilities	Cases	2006-2012	2012-2013
All IRFs	1,161	373,000	-0.8%	-0.4%
Freestanding	21%	47%	1.6%	1.7%
Hospital-based	79%	53%	-1.4%	-1.0%
Nonprofit	58%	50%	-1.4%	-3.0%
For-profit	28%	41%	0.4%	4.9%
Government	13%	9%	-1.1%	-1.3%

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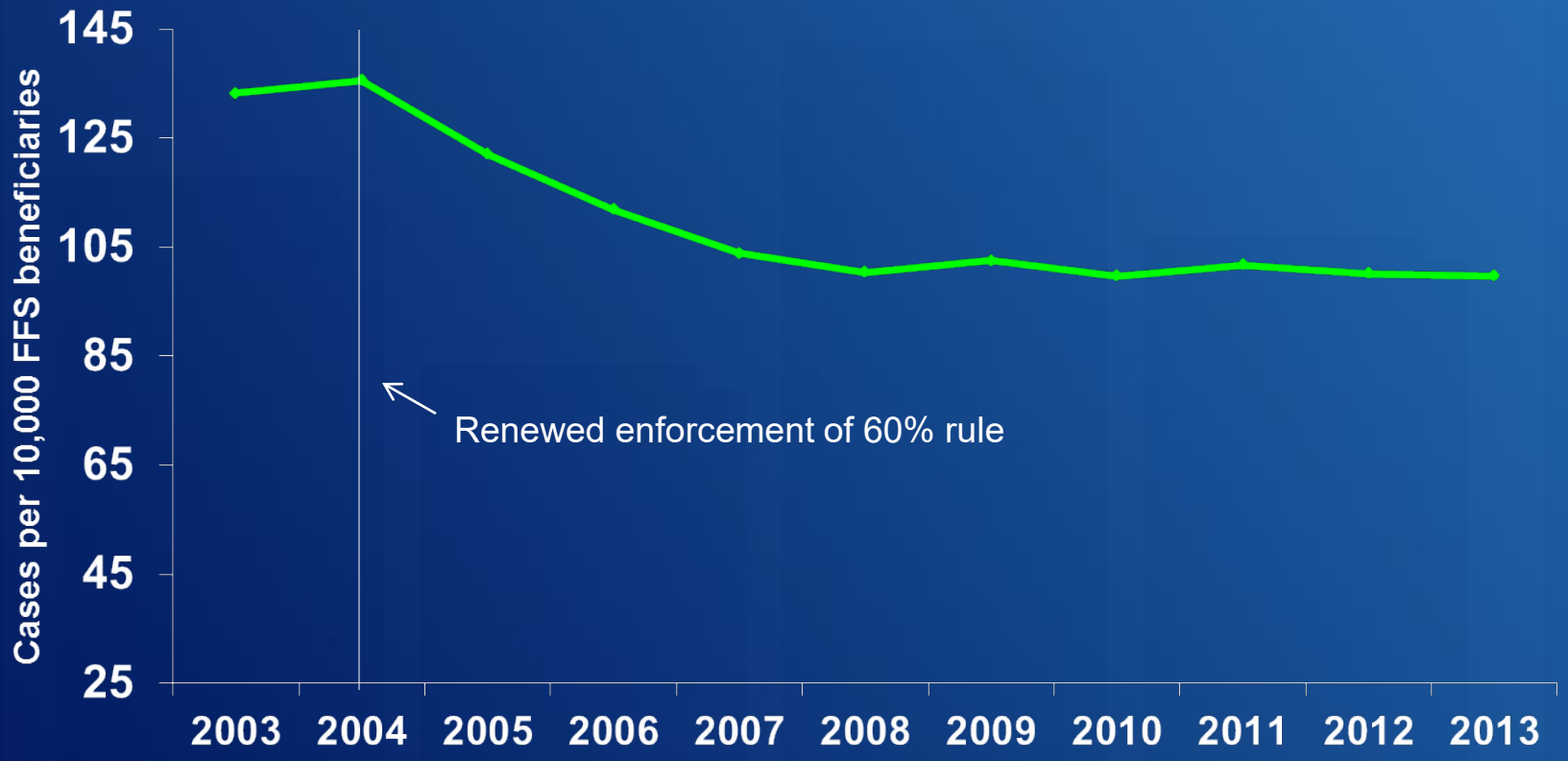
Columns may not sum to 100% due to rounding. Results are preliminary and subject to change. Source: MedPAC analysis of Provider of Services files and MedPAR and Medicare cost report data from CMS.

On a FFS basis, steady volume of IRF cases since 2008



Results are preliminary and subject to change.

Source: MedPAC analysis of MedPAR data from CMS.

Gains in IRF patients' motor & cognitive function were maintained

Risk-adjusted measure	2012	2013
Gain in motor function	22.7	23.1
Gain in cognitive function	3.7	3.8

Gain in function is the difference between the motor/cognitive function score at discharge and admission. Results are preliminary and subject to change.
Source: Analysis of IRF-PAI data conducted by Kramer et al. 2015.

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Rates of community discharge & potentially avoidable rehospitalizations remained stable

Risk-adjusted measure	2012	2013
Discharged to community	75.3%	75.9%
Discharged to SNF	6.6%	6.7%
Potentially avoidable rehospitalizations		
During IRF stay	2.6%	2.5%
Within 30 days after discharge from IRF	4.6%	4.5%

Results are preliminary and subject to change.
Source: Analysis of IRF-PAI data conducted by Kramer et al. 2015.

Variation in risk-adjusted quality measures indicates opportunities to improve

Risk-adjusted measure	25th percentile	75th percentile
Gain in motor function	20.7	25.3
Gain in cognitive function	3.0	4.6
Discharged to community	72.8%	79.1%
Discharged to SNF	4.3%	8.9%
Potentially avoidable rehospitalizations		
During IRF stay	1.5%	3.3%
Within 30 days after discharge from IRF	3.2%	5.7%

Gain in function is the difference between the motor/cognitive function score at discharge and admission. Results are preliminary and subject to change.
Source: Analysis of IRF-PAI data conducted by Kramer et al. 2015.

Access to capital appears adequate

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

IRF Medicare margins, 2013

	% of IRFs	% of cases	Margin
All IRFs	100%	100%	11.4%
Freestanding	21%	47%	24.1%
Hospital-based	79%	53%	0.3%
Nonprofit	58%	50%	1.5%
For-profit	28%	41%	23.4%

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 affect the margins of hospital-based IRFs

- Higher routine, ancillary & indirect costs than freestanding IRFs
  - Hospital-based IRFs' routine costs were 70% higher
- Higher standardized costs:
  - Hospital-based = $17,627
  - Freestanding = $12,474
- Tend to be smaller with lower occupancy
  - 67% have fewer than 25 beds

➢ *Acute care hospitals with an IRF unit have an average Medicare margin that is almost 1 percentage point higher than acute care hospitals without an IRF unit*

Standardized costs control for differences in the price of inputs across geographic areas and in case mix. Results are preliminary and subject to change.
Source: MedPAC analysis of Medicare cost report and claims data from CMS.

High margins for hospital-based and freestanding IRFs with low costs, 2013

Median	Lowest-cost IRFs	Highest-cost IRFs
Standardized cost per discharge	$11,227	$21,934
Hospital-based	12,127	21,848
Freestanding	10,632	22,514
Medicare margin	26.2%	-26.0%
Number of beds	44	17
Occupancy rate	70%	47%
% hospital-based	41%	95%
% nonprofit	31%	63%

Costs are standardized for differences in the price of inputs across geographic areas and in case mix. 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 are stable
- Access to capital: Appears adequate
- Estimated margin for 2013: 11.4%

Results are preliminary and subject to change.

Site-neutral payments for select conditions treated in inpatient rehabilitation facilities and skilled nursing facilities

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Medicare's requirements for IRFs and SNF differ

	SNF	IRF
MD oversight	Seen by MD day 14; then every 30 days	At least 3 times a week
RN coverage	8 hours a day	24 hours a day
Therapy provided	Varies; ¾ of days have at least 2.4 hours per day	"Intensive" Often interpreted as 3 hours per day
PPS	Day-based No add-on payments	Discharge-based Add-on payments
Other	No requirement regarding mix of cases	Must meet compliance threshold

Criteria considered to evaluate conditions for site-neutral payment

- Consistent with approach taken in Commission's other site-neutral work
  - Frequently treated in SNFs
  - Similar risk profiles
  - Similar outcomes

Conditions considered for a site-neutral policy

- In June, we reported on our analysis of 5 orthopedic and 3 stroke conditions
- In November's discussion
  - Given the large variation in stroke cases, the stroke conditions were set aside for now
  - Examined 17 additional conditions
- 22 (17 + 5) conditions are a mix of orthopedic, pulmonary, cardiac, and infections
  - Comprise 30% of IRF cases and spending

Conditions are frequently treated in lower-cost setting

- Given that many markets do not have IRFs, we looked at the frequency of cases treated in IRFs and SNFs in markets with both types of facilities
- The majority of cases are treated in SNFs
- On a per stay basis, Medicare payments to IRFs are considerably higher than payments to SNFs

Risk profiles of patients treated in IRFs and SNFs are similar

- For each of the 22 conditions, the risk scores were similar
- SNF patients tended to be older
- Most comorbidities were either more common in SNF users or comparable between the two settings
- From CMS's PAC demonstration: Considerable overlap in the functional status at admission of all IRF and SNF users

Outcomes for patients treated in IRFs and SNFs are similar

- CMS's PAC demonstration (all conditions, not our selected 22)
  - Risk-adjusted readmission rates and changes in mobility were similar
  - Risk-adjusted changes in self care were higher in IRFs
- MedPAC analysis of the 22 conditions
  - Observed mortality rates were higher in SNFs in part because their patients are older and sicker
  - 30-day spending higher in IRFs

Site-neutral policy for qualifying conditions has several components

- IRF base rate would be the average SNF payment per discharge
- All add-on payments to IRFs would remain at current levels
- IRFs would get relief from certain regulations regarding how care is furnished—examples:
  - Provision of 3 hours of therapy a day
  - Face-to-face physician visits 3 times/week
- Revise the 60 percent rule requirement

Effect of IRF site-neutral policy on Medicare spending

- Medicare spending would be lower by $497 million (7.1% of IRF spending)
- Impact dampened by: share of IRF cases affected and add-on payments remain intact
- Assumes no behavioral change

Data are preliminary and subject to change.

How will IRFs respond to site-neutral payment for IRFs?

- Policy reduces IRF's regulatory requirements for site-neutral conditions
  - IRFs can lower their costs
  - IRFs can reduce the intensity and mix of services
- IRFs may continue to treat these patients
  - SNF PPS is highly profitable
- Or, IRFs may no longer treat these patients
  - IRF industry contracts or shifts their mix of patients

Effect of site-neutral policy on beneficiaries

- If IRFs continue to admit beneficiaries:
  - No change in liability
    - Hospital deductible met with prior hospital stay. Copayment begins on day 60 of hospital + IRF stay
    - Copayments for subsequent PAC and outpatient care
- If cases are shifted to SNFs:
    - Hospital deductible met with prior hospital stay Copayment begins on day 60 of hospital stay
    - Copayment begins day 21 of SNF stay
    - Copayments for outpatient care
- Most beneficiaries have supplemental coverage