Assessing payment adequacy and updating payments: Inpatient rehabilitation facility services

Dana Kelley

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Inpatient rehabilitation facilities

- Provide intensive rehabilitation
- Medicare spending: $7.0 billion in 2014
  - Facilities = 1,180
  - Cases = 375,000
  - Mean payment per case = $18,600
- 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

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

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IRF supply remained fairly steady in 2014; share of for-profits continued to increase

	Facilities	Cases	Average annual change in number of facilities	
			2006-2013	2013-2014
All IRFs	1,180	375,000	-0.9%	1.4%
Freestanding	21%	48%	1.9%	3.3%
Hospital-based	79%	52%	-1.5%	0.9%
Nonprofit	58%	43%	-1.9%	0.6%
For-profit	29%	50%	1.2%	5.0%
Government	13%	7%	-1.3%	-3.9%

- Average occupancy rate: 64%

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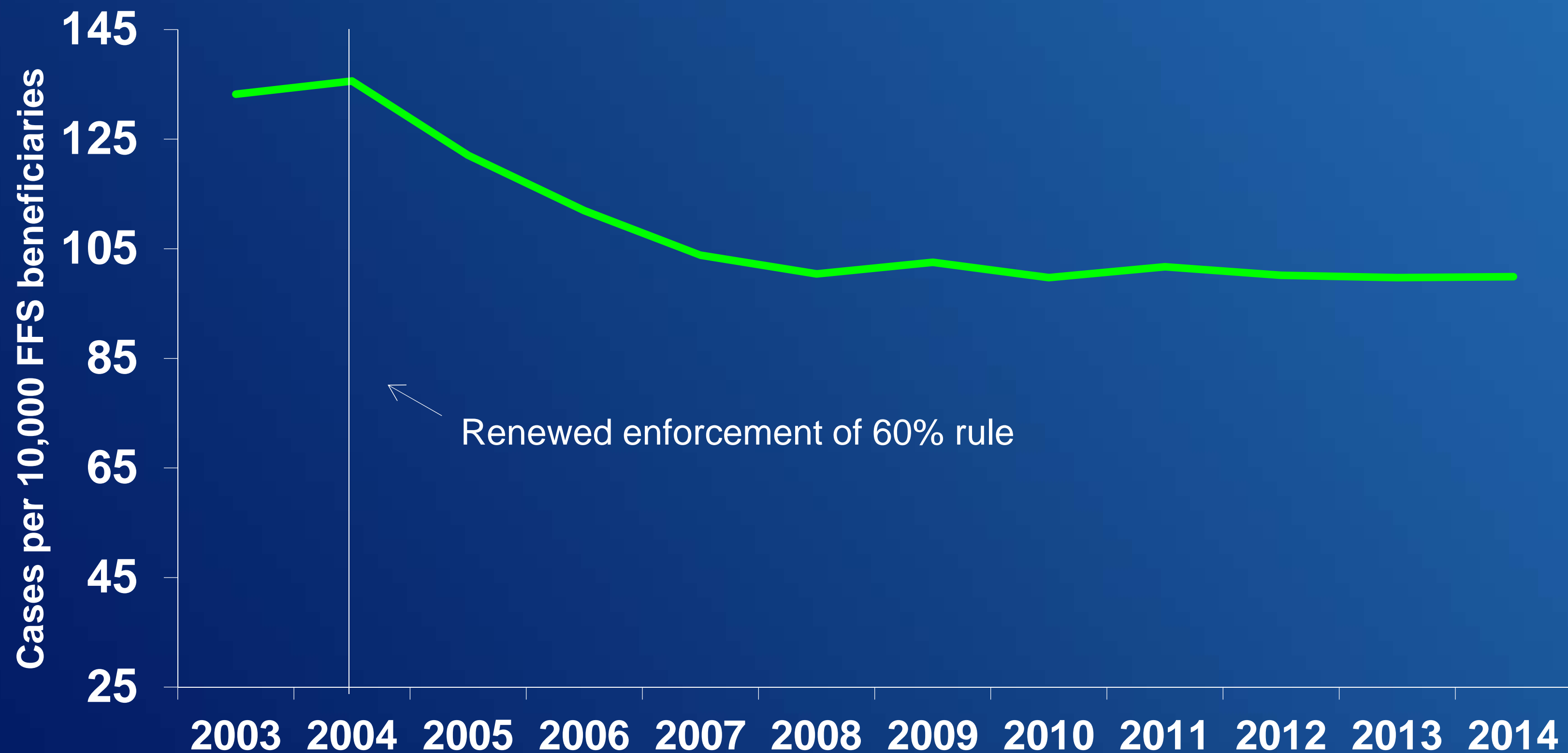
Columns may not sum to 100% due to rounding. Results are preliminary and subject to change.
Source: MedPAC analysis of Provider of Services files and MedPAR and cost report data from CMS.

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



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Results are preliminary and subject to change.

Source: MedPAC analysis of MedPAR data from CMS.

Quality measures remained stable

Risk-adjusted measure	2013	2014
Gain in motor function	23.1	23.5
Gain in cognitive function	3.8	3.9
Discharged to community	75.7%	76.1%
Discharged to SNF	6.8%	6.9%
Potentially avoidable rehospitalizations		
During IRF stay	2.5%	2.5%
Within 30 days after discharge from IRF	4.5%	4.5%

Results are preliminary and subject to change.
Source: MedPAC analysis of IRF-PAI data from CMS.

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Access to capital appears adequate

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

IRF Medicare margins, 2014

	% of IRFs	% of cases	Margin
All IRFs	100%	100%	12.5%
Freestanding	21%	48%	25.3%
Hospital-based	79%	52%	1.0%
Nonprofit	58%	43%	2.1%
For-profit	29%	50%	24.3%

- Marginal profit: 30.4%

Government-owned IRFs are not shown but are reflected in the aggregate margin. Results are preliminary and subject to change.

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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
- Majority are nonprofit and may be less focused on cost control
- Tend to be smaller with lower occupancy
  - 66% have fewer than 25 beds

➢ Marginal profit for hospital-based IRFs = 19%

Results are preliminary and subject to change.
Source: MedPAC analysis of Medicare cost report and claims data from CMS.

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Summary

- Access: Capacity appears adequate to meet demand
- Quality: Risk-adjusted outcome measures are stable
- Access to capital: Appears adequate
- 2014 estimated margin: 12.5%
- 2014 estimated marginal profit: 30.4%

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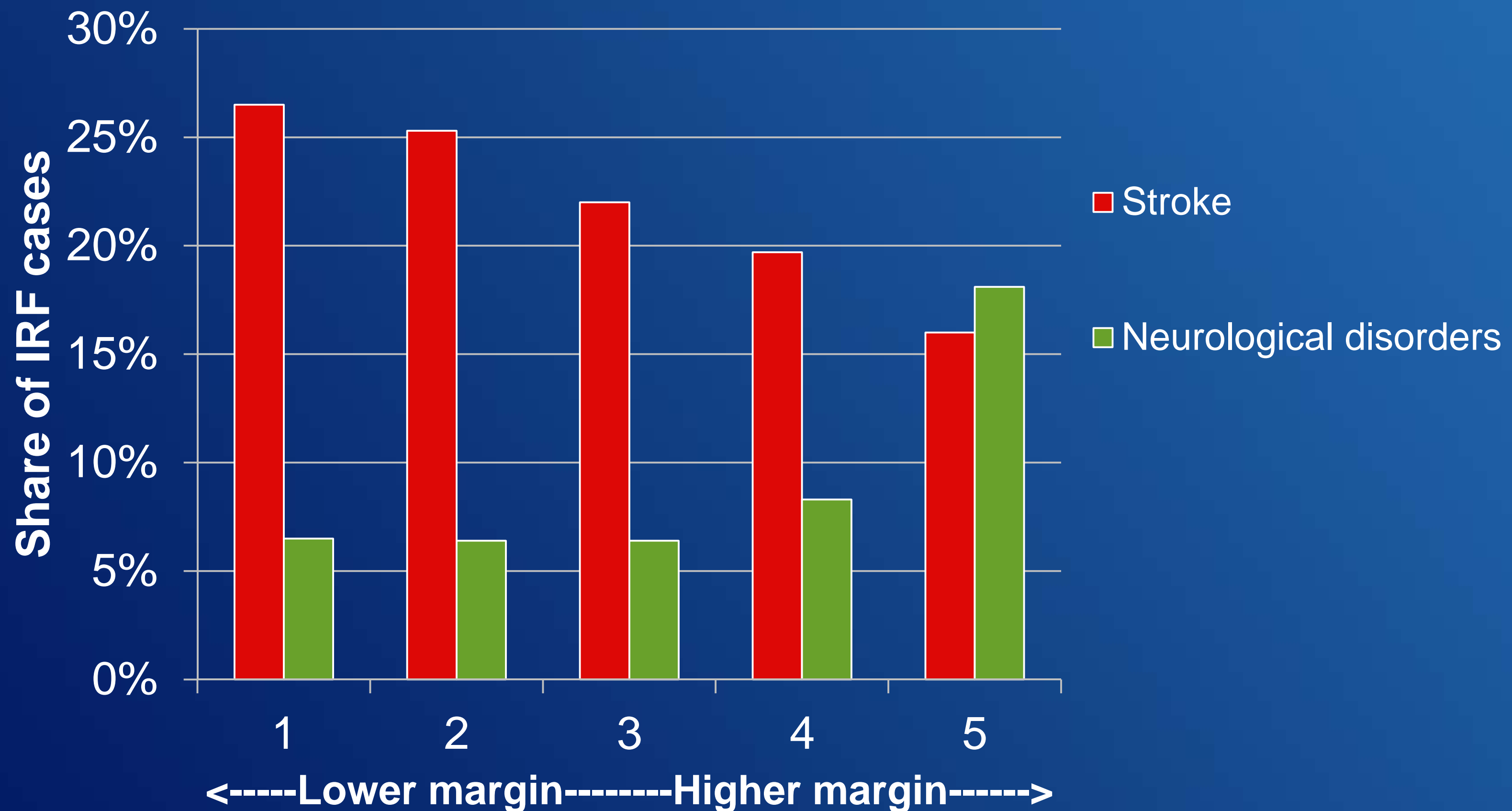
Results are preliminary and subject to change.

Concerns about IRF PPS

- Aggregate margin is high and projected to increase
  - Should payments be rebased?
- Wide variation in margins
  - Low-margin IRFs may be less efficient
  - High-margin IRFs: Could patient selection and coding be a factor?

IRF patient mix differs by margin group



"Neurological disorders" include multiple sclerosis, Parkinson's disease, ALS, and polyneuropathy. Only IRF cases with an acute-care hospital stay within 30 days of admission to the IRF were included in the analysis. IRFs were ranked by their 2013 Medicare margins and then sorted into 5 equal-sized groups. Results are preliminary and subject to change.

Source: MedPAC analysis of FY2013 MedPAR, IRF-PAI data, and cost report data from CMS.

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Characteristics of patients in high-margin IRFs

- Appear to be *less* severely ill during preceding ACH stay
  - Lower ACH case mix
  - Less likely to spend time in ICU/CCU
  - Less likely to be high-cost outliers in ACH
- Appear to be *more* impaired during IRF stay
  - Lower motor and cognition scores
  - More likely to be coded with comorbidities that increase payment

➢ At any level of ACH severity, high-margin IRFs consistently code higher impairment

Only IRF cases with an acute-care hospital stay within 30 days of admission to the IRF were included in the analysis. Results are preliminary and subject to change.
Source: MedPAC analysis of FY2013 MedPAR, IRF-PAI data, and cost report data from CMS.

Average IRF motor score at admission by type of stroke, for IRFs with the lowest and highest margins

Type of stroke	Motor score: Quintile 1 (Lowest margin)	Motor score: Quintile 5 (Highest margin)
Left body involvement	28.6	24.4
Right body involvement	29.7	24.9
No paralysis	35.3	29.0

- Stroke cases with no paralysis 2x more common in IRFs with the highest-margins

Lower motor scores indicate greater impairment. Only IRF cases with an acute-care hospital stay within 30 days of admission to the IRF were included in the analysis. IRFs were ranked by their 2013 Medicare margins and then sorted into 5 equal-sized groups (quintiles). Results are preliminary and subject to change.
Source: MedPAC analysis of FY 2013 MedPAR, IRF-PAI, and Medicare cost report data from CMS.

Concerns about IRF PPS: Summary

- Patient selection and coding behavior may contribute to margin disparities
- More work needed:
  - Targeted adjustment to correct for coding?
  - Differences in profitability across case-mix groups? Will inform discussions of payment reform & rebasing
- Possible short-term fixes:
  - Expand outlier pool to redistribute payments to costly cases
  - Increase program oversight