CHAPTER 9

Inpatient rehabilitation facility services

RECOMMENDATION

9 For fiscal year 2024, the Congress should reduce the 2023 Medicare base payment rate for inpatient rehabilitation facilities by 3 percent.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

CHAPTER 9

Inpatient rehabilitation facility services

Chapter summary

Inpatient rehabilitation facilities (IRFs) provide intensive rehabilitation services to patients after illness, injury, or surgery. Rehabilitation programs are supervised by rehabilitation physicians and include services such as physical and occupational therapy, rehabilitation nursing, speech–language pathology, and prosthetic and orthotic services. In 2021, Medicare spent $8.5 billion on 379,000 fee-for-service (FFS) IRF stays in about 1,180 IRFs nationwide. On average, the FFS Medicare program accounted for about 52 percent of IRF discharges.

Assessment of payment adequacy

In 2021, most IRF payment adequacy indicators remained positive or improved, despite the continued impact of the coronavirus pandemic on IRFs' daily operations; however, indicators continued to vary substantially across IRFs.

Beneficiaries' access to care**—**Despite the impact of the coronavirus pandemic, our analysis of IRF supply and volume of services provided and IRFs' marginal profit under the IRF prospective payment system (PPS) suggest that access remains adequate.

In this chapter

- Are Medicare payments adequate in 2023?
- How should Medicare payments change in 2024?

- ***Capacity and supply of providers***—Between 2020 and 2021, the number of IRFs and IRF beds slightly increased. The aggregate IRF occupancy rate was 68 percent, indicating that capacity is more than adequate to meet demand.
- ***Volume of services***—From 2020 to 2021, Medicare cases per 10,000 FFS beneficiaries increased by about 4 percent.
- ***Marginal profit***—The marginal profit, an indicator of whether IRFs with excess capacity have an incentive to treat more Medicare beneficiaries, was 22 percent for hospital-based IRFs and 41 percent for freestanding IRFs—a very strong indicator of access.

Quality of care—In 2021, the mean facility risk-adjusted rate of successful discharge to the community from IRFs was 67.6 percent and the mean facility risk-adjusted rate of hospitalizations was 7.2 percent. The coronavirus pandemic and related policies confound our measurement and assessment of trends in our quality measures.

Providers' access to capital—Between 2020 and 2021, freestanding IRFs' all-payer total margin grew from 10.2 percent to 14.0 percent, and the largest IRF chain (which accounted for almost a third of all Medicare FFS IRF discharges) continued to open new IRFs and enter joint ventures with other organizations, suggesting strong access to capital. Hospital-based IRFs continued to have strong access to capital through their parent hospitals.

Medicare payments and providers' costs—IRFs' Medicare margin increased to 17.0 percent in 2021, driven by slow cost growth. The Medicare margin for relatively efficient IRFs was even higher, at about 20 percent, as these IRFs were generally able to leverage greater economies of scale. We anticipate that the 2023 margin will decrease to 11 percent, driven in part by the expiration of public health emergency–related increases in Medicare payments to IRFs.

How should payment rates change in 2024?

Given our positive payment adequacy indicators, the Commission recommends that, for fiscal year 2024, the 2023 IRF base payment rate be reduced by 3 percent. This recommendation would continue to provide IRFs with sufficient revenues to maintain beneficiaries' access to IRF care while bringing IRF PPS payment rates closer to the cost of delivering high-quality care efficiently. ■

Background

After illness, injury, or surgery, some patients need intensive inpatient rehabilitative care, including speech-language pathology, physical, and occupational therapy. Such services can be provided in inpatient rehabilitation facilities (IRFs).[1] IRFs must be focused primarily on treating conditions that typically require intensive rehabilitation, among other requirements. IRFs can be freestanding facilities or specialized units within acute care hospitals (ACHs). To qualify for a covered IRF stay, a beneficiary must, among other criteria, be able to tolerate and benefit from intensive therapy and must have a condition that requires frequent, face-to-face supervision by a rehabilitation physician. To reimburse IRFs for their facility's costs of providing inpatient services, fee-for-service (FFS) Medicare sets per discharge payment rates under the IRF prospective payment system (PPS).[2] In 2021, Medicare spent $8.5 billion on 379,000 IRF stays paid under the IRF PPS in about 1,180 IRFs nationwide. On average, the FFS Medicare program accounted for about 52 percent of IRF discharges.

Under the IRF PPS, each Medicare patient is assigned to a rehabilitation impairment category (RIC) based on the principal diagnosis or impairment and further classified to a case-mix group (CMG) within the RIC based on the patient's age and level of motor and cognitive function.[3] And within each CMG, patients are further classified into one of four tiers based on the presence of certain comorbidities that have been found to increase the cost of care. The IRF PPS also has outlier payments for patients who are extraordinarily costly.[4]

Medicare facility requirements for IRFs

To qualify as an IRF for Medicare payment, a facility must meet the Medicare conditions of participation for ACHs.[5] It must also:

- have a preadmission screening process to determine that each prospective patient is likely to benefit significantly from an intensive inpatient rehabilitation program;
- ensure that the patient receives close medical supervision and provide—through qualified personnel—rehabilitation nursing, physical therapy, occupational therapy, and, as needed, speech–language pathology and psychological (including neuropsychological) services, social services, and orthotic and prosthetic services;
- have a medical director of rehabilitation with training or experience in rehabilitation who provides services in the facility on a full-time basis for freestanding IRFs or at least 20 hours per week for hospital-based IRF units;
- use a coordinated interdisciplinary team led by a rehabilitation physician that includes a rehabilitation nurse, a social worker or case manager, and a licensed therapist from each therapy discipline involved in the patient's treatment;
- have a treatment plan for each patient, which is established, reviewed, and revised as needed by a physician in consultation with other professional personnel who provide services to the patient; and
- meet the compliance threshold, which requires that no less than 60 percent of patients admitted to an IRF have as a primary diagnosis or comorbidity at least 1 of 13 conditions specified by CMS.[6] The intent of the compliance threshold is to distinguish IRFs from ACHs. If an IRF does not meet the compliance threshold, Medicare pays for all its cases based on the inpatient hospital PPS rather than the IRF PPS.

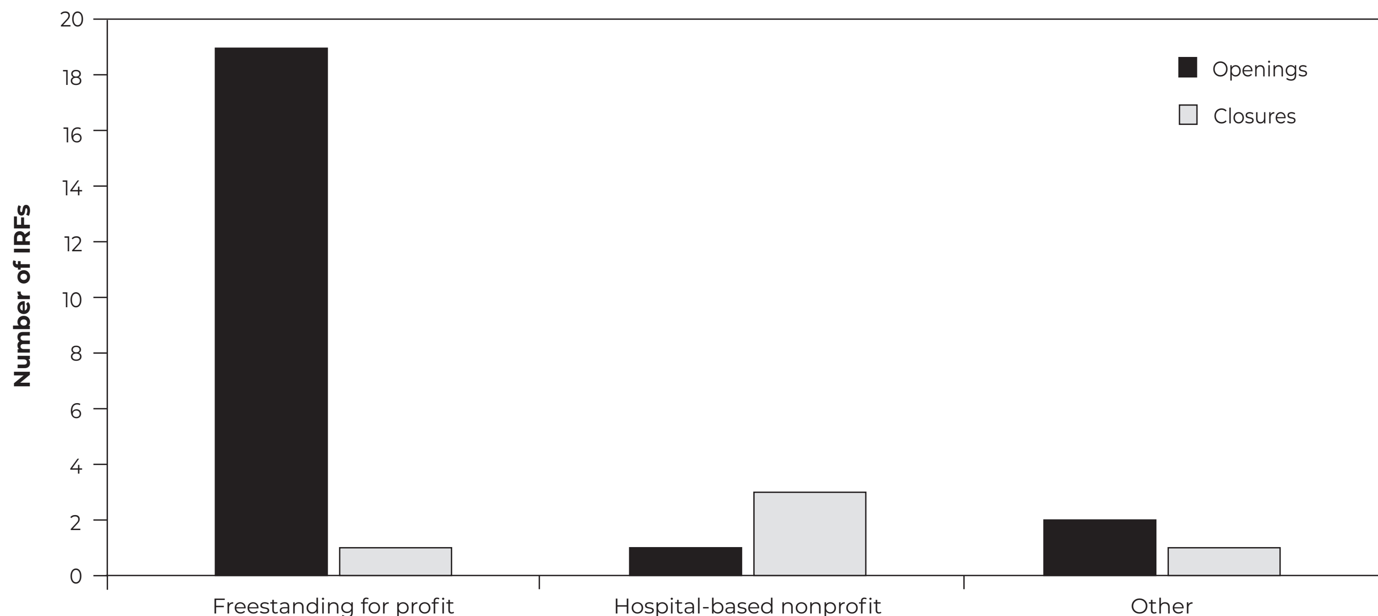
Medicare coverage criteria for beneficiaries

Medicare applies additional criteria that govern whether IRF services are covered for an individual Medicare beneficiary. For an IRF claim to be considered reasonable and necessary, the patient must be reasonably expected to meet the following requirements at admission:[7]

- The patient requires active and ongoing therapy in at least two modalities, one of which must be physical or occupational therapy.
- The patient can actively participate in and benefit from intensive therapy that most typically consists of three hours of therapy a day at least five days a week.

FIGURE 9–1

In 2021, more IRFs opened than closed, and the majority of new IRFs were freestanding and for profit



Note: IRF (inpatient rehabilitation facility). “Other” includes government, hospital-based for-profit, and freestanding nonprofit facilities.

Source: MedPAC analysis of Provider of Services data.

- The patient is sufficiently stable at the time of admission to actively participate in the intensive rehabilitation program.
- The patient requires supervision by a rehabilitation physician. This requirement is satisfied by face-to-face physician visits with a patient at least three days a week. Beginning with the second week of admission to the IRF, a nonphysician practitioner who is determined by the IRF to have specialized training and experience in inpatient rehabilitation may conduct one of the three required face-to-face visits with the patient per week, provided that such duties are within the nonphysician practitioner’s scope of practice under applicable state law.
- The patient requires an intensive and coordinated interdisciplinary team approach to the delivery of rehabilitative care.

Are Medicare payments adequate in 2023?

To assess whether payments for fiscal year 2023 are adequate to cover the costs providers incur and how much providers’ costs are expected to change in the coming year (2024), we examine several indicators of payment adequacy. Specifically, we assess beneficiaries’ access to care by examining the capacity and supply of IRFs and changes over time in the volume of services provided, quality of care, providers’ access to capital, and the relationship between Medicare payments and providers’ costs.

In general, our indicators of IRF payment adequacy are positive.

TABLE 9–1

The number of IRFs continued to grow in 2021

Type of IRF	Share of Medicare FFS discharges 2021	Number of IRFs					Average annual change	
		2017	2018	2019	2020	2021	2017–2019	2020–2021
All IRFs	100%	1,178	1,170	1,152	1,159	1,181	–1.1%	1.9%
Urban	90	1,019	1,014	1,000	1,004	1,021	–0.9	1.7
Rural	6	159	156	152	155	160	–2.2	3.2
Freestanding	55	279	290	299	310	329	3.5	6.1
Hospital based	41	899	880	853	849	852	–2.6	0.4
Nonprofit	33	655	642	634	623	620	–1.6	–0.5
For profit	60	392	400	393	414	436	0.1	5.3
Government	6	125	121	116	113	115	–3.7	1.8

Note: IRF (inpatient rehabilitation facility), FFS (fee-for-service). Components may not sum to totals due to missing data.

Source: MedPAC analysis of Provider of Services data and Medicare Provider Analysis and Review data from CMS.

Beneficiaries' access to care: IRF supply and service volume suggest sufficient access

We have no direct indicators of beneficiaries' access to IRF care. Although there are IRF admission criteria, it is not clear when IRF care is required for a given patient. Other potentially lower-cost post-acute care (PAC) providers such as a skilled nursing facility (SNF) can provide similar care. The absence of IRFs in some areas of the country implies that beneficiaries in these areas receive similar services in other settings. Nevertheless, our analysis of IRF supply and volume of services suggests that capacity remains adequate to meet demand. Moreover, the marginal profit, an indicator of whether IRFs with excess capacity have an incentive to treat more Medicare beneficiaries, was robust in 2021 for both freestanding and hospital-based IRFs, a very strong indicator of patient access.

Number of IRFs and occupancy rates suggest adequate capacity and supply

In 2021, there were 22 IRF openings and 5 closures (Figure 9-1). The majority of IRFs that opened were freestanding and for profit, and most closures were hospital-based nonprofits.

In 2021, the number of IRFs continued to increase (Table 9-1). After gradually declining from 2017 to 2019, the number of IRFs rose between 2019 and 2020 from 1,152 to 1,159 in 2020. This trend continued in 2021, with the number of IRFs increasing by 1.9 percent to 1,181 facilities. The majority of IRFs are located in urban areas; only about 14 percent of all IRFs are located in rural areas. In 2021, the number of both urban and rural IRFs grew, by 1.7 percent and 3.2 percent, respectively. From 2017 to 2019, freestanding and for-profit IRFs continued an upward trajectory, growing by 3.5 percent and 0.1 percent, respectively. In contrast, hospital-based and nonprofit IRFs have been on a steady decline for many years. Between 2017 and 2019, the number of hospital-based IRFs fell by 2.6 percent and the number of nonprofit IRFs fell by 1.6 percent. Yet, between 2020 and 2021, there were slight increases in multiple categories of IRFs, including the number of hospital-based IRFs.

Though the number of freestanding IRFs has risen from year to year, the share of hospital-based IRFs is still greater than freestanding IRFs. In 2021, over 70 percent of IRFs were hospital based; the rest were freestanding facilities. However, because hospital-based units have,

TABLE 9–2

Stroke, other neurological conditions, and debility remain the most common conditions in IRFs

Condition	Share of IRF Medicare FFS cases				Meets compliance threshold[a]
	2017	2019	2020	2021	
Stroke	20.5%	19.8%	19.1%	18.1%	yes
Other neurological conditions	14.9	14.4	14.0	14.9	yes
Debility	10.7	12.3	13.5	14.0	no
Brain injury	10.7	11.0	11.2	11.3	yes
Fracture of the lower extremity	10.4	10.0	11.3	11.2	yes
Other orthopedic conditions	7.9	8.1	7.4	7.3	no
Cardiac conditions	5.8	6.1	5.8	5.9	no
Spinal cord injury	4.9	4.9	4.7	4.6	yes
Major joint replacement of lower extremity	4.3	3.7	2.9	3.0	[b]
All other conditions	9.8	10.0	10.2	9.6	[c]

Note: IRF (inpatient rehabilitation facility), FFS (fee-for-service). "Other neurological conditions" includes multiple sclerosis, Parkinson's disease, polyneuropathy, and neuromuscular disorders. "Fracture of the lower extremity" includes hip, pelvis, and femur fractures. Patients with debility have generalized deconditioning not attributable to other conditions. "Other orthopedic conditions" excludes fractures of the hip, pelvis, and femur, and hip and knee replacements. "All other conditions" includes conditions such as amputations, arthritis, and pain syndrome. "Brain injury" and "spinal cord injury" include both traumatic and nontraumatic injuries. All FFS Medicare IRF cases with valid patient assessment information were included in this analysis. Yearly figures presented in the table are rounded.

[a]The compliance threshold requires that at least 60 percent of an IRF's patients have 1 of 13 specified diagnoses or have a comorbidity that could cause significant decline in functional ability such that the patient requires intensive rehabilitation. Some FFS cases with conditions that do not meet the compliance threshold could thus be counted toward the threshold if they had certain comorbidities. In response to the coronavirus public health emergency, CMS waived the compliance threshold beginning in March 2020.

[b]Cases admitted for rehabilitation after major joint replacement of the lower extremity count toward the compliance threshold if joint replacement was bilateral, if the patient had a body mass index of 50 or greater, or if the patient was age 85 or older.

[c]Conditions in the "all other" category that meet the compliance threshold include congenital deformity, lower limb amputations, major multiple traumas, burns, and certain arthritis cases.

Source: MedPAC analysis of Inpatient Rehabilitation Facility–Patient Assessment Instrument data from CMS.

on average, fewer beds and a lower share of Medicare discharges, they accounted for only 41 percent of Medicare discharges. In contrast, freestanding facilities made up about 28 percent of the IRF supply but accounted for about 55 percent of Medicare discharges. Similarly, for-profit IRFs made up about 37 percent of the total number of IRFs but accounted for about 60 percent of Medicare discharges. For-profit IRFs are disproportionately freestanding.

In 2021, the aggregate IRF occupancy rate slightly increased to 68 percent (67 percent in 2020). From 2020 to 2021, the aggregate occupancy rate rose from 69 percent to 71 percent among freestanding IRFs, while the aggregate occupancy rate for hospital-based IRFs remained stable at 65 percent. These rates suggest that capacity is more than adequate to meet demand for IRF services. Although IRFs provide a more intense level of therapy, IRFs are not the sole providers of rehabilitation services in communities. SNFs also provide rehabilitation services in an institutional setting, and home health agencies, comprehensive outpatient rehabilitation facilities, and independent therapy providers furnish care at home or on an outpatient basis. Given the number and distribution of these other rehabilitation therapy providers, it is unlikely that areas exist where IRFs are the only provider of rehabilitation therapy services available to Medicare beneficiaries.

TABLE 9–3

Mix of FFS Medicare IRF cases differed by provider type, selected conditions, 2021

	Freestanding		Hospital based	
Condition	**For profit**	**Nonprofit**	**For profit**	**Nonprofit**
Stroke	15%	24%	16%	23%
Other neurological conditions	21	8	10	9
Fracture of the lower extremity	10	8	15	13
Debility	14	14	16	14
Brain injury	11	12	13	11
Other orthopedic conditions	8	6	7	6

Note: FFS (fee-for-service), IRF (inpatient rehabilitation facility). "Other neurological conditions" includes multiple sclerosis, Parkinson's disease, polyneuropathy, and neuromuscular disorders. "Fracture of the lower extremity" includes hip, pelvis, and femur fractures. Patients with debility have generalized deconditioning not attributable to other conditions. "Other orthopedic conditions" excludes fractures of the hip, pelvis, and femur, and hip and knee replacements. "Brain injury" includes both traumatic and non-traumatic injuries. All FFS Medicare IRF cases with valid patient assessment information were included in this analysis.

Source: MedPAC analysis of Inpatient Rehabilitation Facility–Patient Assessment Instrument data from CMS.

Patterns of use in IRFs

In 2021, the most common condition treated by IRFs was stroke—accounting for almost one-fifth of cases—followed by other neurological conditions and debility (Table 9-2).

Debility cases have steadily risen since 2017. Between 2017 and 2021, the share of IRF cases with debility increased from 10.7 percent to 14.0 percent of IRF discharges (Table 9-2). Unlike the other conditions treated in IRFs, debility has a broader definition that encompasses many types of impairment. This condition includes a mix of patients with a state of general weakness or discomfort that may be an outcome of one or more conditions, including coronavirus disease 2019 (COVID-19) (Czeisler et al. 2020, Encompass Health 2021). During the coronavirus public health emergency (PHE), CMS has waived two IRF criteria: the "3-hour rule" and the "60 percent rule." The waiver of the 3-hour rule allows IRFs to admit patients even if they are not able to tolerate three hours of intense therapy a day; the waiver of the 60 percent rule allows IRFs to forgo the requirement that at least 60 percent of patients admitted to an IRF have as a primary diagnosis or comorbidity at least 1 of 13 qualifying conditions (for a description of IRF PHE waivers, see the IRF chapter of our March 2022 report to the Congress). The waiver of these rules allows IRFs to treat a broader mix of patients, including those without a qualifying condition or who were unable to tolerate intensive therapy, possibly leading IRFs to admit a greater number of cases categorized as debility in more recent years.

The distribution of case types differs by type of IRF and ownership (Table 9-3). For example, in 2021, only 15 percent of cases in freestanding for-profit IRFs were admitted for rehabilitation following a stroke, compared with 23 percent of cases in hospital-based nonprofit IRFs. By contrast, 21 percent of cases in freestanding for-profit IRFs were admitted with other neurological conditions, over twice the share admitted to hospital-based nonprofit IRFs. Cases with fracture of the lower extremity made up a higher share of cases in hospital-based for-profit facilities than in all other IRF types. The share of cases with debility, brain injury, or other orthopedic conditions was generally similar across IRF types. The Commission has previously reported that some case types are more profitable than others under the IRF PPS (for more details, see the IRF chapter of our March 2022 report to the Congress); we

TABLE 9–4

In 2021, FFS Medicare beneficiaries' IRF cases held steady while cases per beneficiary increased to near prepandemic levels

	Prepandemic		Coronavirus pandemic		Average annual change	
	2017	2019	2020	2021	2017–2019	2020–2021
Number of FFS cases	396,000	409,000	379,000	379,000	1.6%	0.0%
Cases per 10,000 FFS beneficiaries	102.0	106.0	100.9	104.6	2.0	3.6
ALOS (in days)	12.7	12.6	12.9	12.9	–0.6	–0.2
Number of users	355,000	363,000	335,000	335,000	1.2	–0.1

Note: IRF (inpatient rehabilitation facility), FFS (fee-for-service), ALOS (average length of stay). The number of FFS cases and the number of beneficiaries are rounded.

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

further discuss profitability by IRF case type below (see p. 269).

In 2021, FFS Medicare beneficiaries' IRF stays held steady, but IRF cases per beneficiary neared prepandemic levels

Between 2017 and 2019, the number of FFS cases steadily rose, reaching over 409,000 cases by 2019 (Table 9-4). In 2020, however, the total number of FFS IRF cases fell by 7.4 percent to about 379,000 cases. The number of cases fell in April 2020 and subsequently rebounded by July 2020, reaching about 95 percent of prepandemic levels for the rest of the year. A large portion of IRF volume comes from patients who are transferred from the ACH setting after surgery. The drop in volume in April 2020 is consistent with a temporary suspension of elective surgeries in ACHs from March 2020 through May 2020. The rebound in volume in summer 2020 was likely the result of the pent-up demand for surgical services after many FFS beneficiaries' surgeries had been canceled or delayed.

From 2020 to 2021, the number of FFS cases was stable at about 379,000 cases (Table 9-4). However, controlling for the number of FFS beneficiaries, the number of cases increased 3.6 percent in 2021. The number of FFS IRF users remained steady in 2021 at about 335,000. Average length of stay remained stable at 12.9 days.

Marginal profit provides incentive to treat more Medicare beneficiaries

Another measure of access is whether providers have a financial incentive to expand the number of Medicare beneficiaries they serve. In considering whether to treat a patient, a provider with excess capacity compares the marginal revenue it will receive (i.e., the Medicare payment) with its marginal costs—that is, the costs that vary with volume. If Medicare payments are larger than the marginal costs of treating an additional beneficiary, a provider has a financial incentive to care for Medicare beneficiaries.[8,9] We found that Medicare payments in 2021 exceeded marginal costs by a substantial amount—22 percent for hospital-based IRFs and 41 percent for freestanding IRFs—suggesting that IRFs with available beds have a strong incentive to admit Medicare patients.

Quality of care is difficult to assess

The quality of IRF care in 2020 and 2021 is difficult to assess due to the effects of the coronavirus pandemic on beneficiaries and providers. Each year, we track

TABLE 9–5

Risk-adjusted quality indicators for IRFs

Measure	Provider subgroup	Prepandemic		Coronavirus pandemic	
		2017	2019	2020	2021
All-condition hospitalizations within an IRF stay	**All IRFs**	7.9%	7.8%	7.8%	7.2%
	Nonprofit	7.8	7.7	7.8	7.3
	For profit	7.9	7.9	7.8	7.2
	Hospital based	7.8	7.7	7.8	7.2
	Freestanding	8.0	7.8	8.0	7.2
Successful discharge to community	**All IRFs**	64.8%	65.5%	67.3%	67.6%
	Nonprofit	64.9	65.6	67.6	68.0
	For profit	64.7	65.3	66.8	67.0
	Hospital based	65.2	66.0	67.9	68.1
	Freestanding	63.6	64.2	66.0	66.5

Note: IRF (inpatient rehabilitation facility). "Successful discharge to the community" includes beneficiaries discharged to the community (including those discharged to the same nursing home) who did not have an unplanned hospitalization or die in the 30 days after discharge. The all-condition hospitalization measure captures all unplanned hospital admissions and readmissions and outpatient observation stays that occur during the stay. Both measures are uniformly defined and risk adjusted across the four PAC settings. Providers with least 60 stays in the year (the minimum count to meet a reliability of 0.7) were included in calculating the average facility rate. High rates of successful discharge to the community indicate better quality. High rates of hospitalizations during a stay indicate worse quality.

Source: MedPAC analysis of IRF claims and linked inpatient hospital stays from 2017 through 2021 for fee-for-service beneficiaries.

changes in the quality measures and assess whether they improved, declined, or stayed the same. While we report 2021 results for our quality measures, we have not used those results to inform our conclusions about trends in IRFs' quality of care. The results reflect temporary changes in the delivery of care and data limitations unique to the coronavirus pandemic rather than trends in quality of care provided to beneficiaries. In addition, the Commission's IRF quality metrics rely on risk-adjustment models developed using data from previous years. COVID-19 is a relatively new diagnosis and therefore is not included in the current risk-adjustment models, though many associated conditions are. As a result, our models may not adequately represent the acuity and mix of patients receiving care from IRFs in 2021. Therefore, we report the changes observed in the quality measures but do not draw conclusions about whether quality has improved, worsened, or stayed the same.

We report two quality-of-care measures: average risk-adjusted rates of successful discharge to the community and all-condition hospitalizations during an IRF stay. Discharges to hospice and beneficiaries with the hospice benefit are excluded from the calculation of both measures. Both measures are uniformly defined and are risk adjusted across all PAC settings.[10]

Hospitalizations within an IRF stay

In 2021, the national average rate of risk-adjusted all-condition hospitalizations within FFS Medicare IRF stays was 7.2 percent (Table 9-5). There were not large differences by type of IRF. The hospitalization measure captures all unplanned hospitalizations (admissions and readmissions) and outpatient observation stays that occur during the IRF stay. (Beneficiaries who died during the IRF stay are excluded from the measure.) Rehospitalizations expose beneficiaries to hospital-acquired infections, increase the number of transitions

between settings (which are disruptive to patients), and can result in medical errors (such as medication errors). In addition, they unnecessarily increase Medicare spending. Because IRFs are also hospitals, the rate of rehospitalizations is typically lower than for other PAC settings.

Discharges from IRF to community

In 2021, the rate of successful discharge to the community was 67.6 percent (Table 9-5, p. 267). There were not large differences by ownership. This measure includes beneficiaries discharged to the community who did not have an unplanned hospitalization and did not die in the succeeding 30 days.[11]

IRFs' access to capital remained strong in 2021

Almost three-quarters of IRFs are hospital-based units that access any necessary capital to maintain, modernize, or expand through their parent hospitals. Overall, as detailed in the hospital chapter of this report (Chapter 3), general acute care hospitals' access to capital strengthened in 2021: The all-payer operating margin among hospitals paid under the inpatient PPSs reached a record high despite a decline in federal relief funds. Additionally, hospitals maintained strong access to bond markets. While the effect of the coronavirus pandemic on hospitals' finances varied substantially across hospitals, we have no evidence that it has had a negative effect on hospitals' long-term access to the capital markets.

In 2021, the all-payer total margins for freestanding IRFs remained strong at 14.0 percent, up from 10.2 percent in 2020.[12] Profitability varied by ownership: For-profit freestanding IRFs had an all-payer total margin of 15.8 percent, compared with about 9.3 percent for nonprofit freestanding IRFs.

In 2021, the IRF industry's largest chain, Encompass Health—which owned almost 45 percent of freestanding IRFs and accounted for about 31 percent of all Medicare IRF discharges—opened 8 IRFs and added 117 beds to existing IRFs. The company opened nine new IRFs in 2022 and has plans to open eight in 2023. Most of the expansion activity is located in Florida, following the recent partial repeal of Florida's certificate-of-need law,[13] effective July 2021 (Encompass Health 2022). In addition, in 2021, Encompass Health acquired or opened 25 home health and hospice locations, including sites in three frontier states where it had not operated previously: Alaska, Montana, and Washington (Encompass Health 2022). More recently, on July 1, 2022, Encompass Health completed its spinoff of Enhabit Home Health and Hospice, which is now a publicly traded company that is separate from its inpatient rehabilitation line of business.

Most other freestanding IRFs are independent or local chains with a limited number of facilities. The extent to which these nonchain IRFs have access to capital is less clear.

Medicare payments and providers' costs: IRFs' Medicare margin remained high in 2021

In 2021, the aggregate Medicare margin remained high, rising above prepandemic levels. IRFs' Medicare margin increased to 17 percent, up from 13 percent in 2020. Including an estimated Medicare share of federal relief funds proportional to FFS Medicare's share of IRFs' revenue in 2019, IRFs' FFS Medicare margin was 17.5 percent.[14]

In 2021, IRFs' payments per case continued to grow faster while growth in costs per case returned to the prepandemic trend

From 2020 to 2021, IRFs' payments per case grew 6.3 percent, which was higher than prepandemic payment growth but slightly lower than growth from 2019 to 2020. The faster growth in payments relative to prior years resulted from several factors:

- ***Higher annual update to payment rates***: In 2021, the annual update to IRF PPS base rates was 2.4 percent. This update was higher than in prior years primarily because the budgetary reductions mandated through 2019 expired.[15]
- ***Increase in Medicare payments during part of the pandemic***: Effective May 1, 2020, through March 31, 2022, the Congress increased Medicare IRF payments by suspending the 2 percent sequestration on the Medicare program's share of all FFS payments. That sequester relief applied to only half of fiscal year 2020 but to the entirety of fiscal year 2021.[16]

- ***Growth in outlier payments:*** Outlier payments to IRFs climbed about 27 percent in 2021, increasing total payments by almost 1 percent.
- ***Growth in case mix:*** After rising 11 percent in 2020, IRFs' overall case-mix index (CMI), which measures the severity of patients' health status, increased by almost 1 percent in 2021.

Meanwhile, in 2021, IRFs' cost growth decreased to slightly below prepandemic levels. Specifically, IRFs' cost per case grew 2.0 percent, compared with 2.3 percent in 2019 and 8.6 percent in 2020.

In 2021, IRFs' Medicare margin increased to 17 percent, but margins across IRFs continued to vary significantly

In 2021, the aggregate IRF Medicare margin increased to 17.0 percent (17.5 percent when including Medicare's share of federal relief funds) from 13.4 percent in 2020 (14.9 percent when including Medicare's share of federal relief funds). The aggregate Medicare margin rose among all subgroups of IRFs we examined, though there continues to be significant variation (Table 9-6, p. 270). For example, the hospital-based IRF Medicare margin was 5.8 percent, compared with 25.8 percent for freestanding IRFs. While there was variation within each group of IRFs, in aggregate, the Medicare margin continued to be higher and positive—with or without federal relief funds—at IRFs that were freestanding, for profit, urban, larger, and had a greater share of FFS Medicare patients. In contrast, the Medicare margin continued to be lower among IRFs that were hospital based, nonprofit, and smaller.

FFS Medicare margins also vary by IRFs' share of low-income patients (Table 9-6, p. 270). Similar to the disproportionate share hospital adjustment for hospitals paid under the inpatient PPSs, IRFs receive low-income percentage (LIP) payments that are intended to offset costs incurred by treating a large or disproportionate number of low-income patients. In 2021, the Medicare margin for IRFs with a large share of low-income patients (constituting more than 25 percent of the facility's discharges) was 9.7 percent. In comparison, the Medicare margin for IRFs with a small share of low-income patients (less than 5 percent of a facility's discharges) was 20.0 percent.

Patient mix contributes to differences in IRF profitability

As previously noted in our March 2021 report to the Congress, multiple factors account for the disparity in margins between hospital-based and freestanding IRFs, including differences in economies of scale and stringency of cost control, but also in service and patient mix. We reported that profitability appeared to vary by IRF rehabilitation impairment categories (RICs). For example, using fiscal year 2017 data, we showed that "other neurological" stays were more profitable than stroke stays (the "other neurological" RIC had an average payment-to-cost ratio (PCR) of 1.20 compared with an average PCR of 1.07 for stroke stays) (Medicare Payment Advisory Commission 2021).

Using more recent data, we found that profitability also differs for stays by CMGs within RICs. Higher-severity CMGs within a RIC were more profitable (i.e., had higher PCRs) compared with lower-severity CMGs. For example, among cases with stroke, the least severe (highest motor score) CMG had payments that were 5 percent lower than costs on average (i.e., a PCR of 0.95), while the most severe (lowest motor score) CMG had payments that exceeded costs by 17 percent on average (i.e., a PCR of 1.17) (Figure 9-2, p. 271). Profitability steadily increased as severity worsened, except for one CMG. We found similar inverse relationships between profitability and functional severity among the CMGs of other IRF conditions.

A general principle of payment systems is that payment weights should reflect differences in the expected relative costs of providing care to patients across CMGs. That is, a case that costs twice as much to treat as another should have twice the payment weight. Having payments aligned with costs is intended to minimize incentives for providers to admit one type of patient over another. A payment system that overpays for more severe cases and underpays for less severe ones might induce providers to differentially select the most severe cases (or code those patients into the most severe category) over less severe (and less profitable) cases.

Differences in profitability by CMG may contribute to variation in provider profitability if some providers tend to admit more profitable cases (or code patients into more profitable CMGs). The CMI, or the average

TABLE 9–6

IRFs' aggregate Medicare margin increased to 17 percent in 2021

	Prepandemic			Coronavirus pandemic	
Type of IRF	**2017**	**2018**	**2019**	**2020**	**2021**
All IRFs	13.9%	14.7%	14.3%	13.4%	17.0%
Hospital based	1.4	2.6	2.2	1.7	5.8
Freestanding	25.7	25.4	24.7	23.4	25.8
Nonprofit	2.0	2.6	1.4	–0.1	5.3
For profit	24.3	24.6	24.3	23.5	25.3
Government	N/A	N/A	N/A	N/A	N/A
Urban	14.2	15.0	14.7	13.7	17.4
Rural	8.7	9.9	8.6	9.5	11.5
Number of beds					
1 to 10	–10.6	–5.9	–4.3	–7.3	–2.4
11 to 24	0.7	2.3	2.1	2.3	5.7
25 to 64	15.7	16.9	16.0	15.1	18.9
65 or more	22.0	21.2	20.9	19.3	22.1
FFS Medicare share					
<50%	7.8	8.7	8.6	7.5	11.5
50% to 75%	18.4	19.2	18.5	17.3	20.5
>75%	12.8	14.0	15.0	17.4	20.4
Low-income patient share					
0% to 5%	18.2	16.9	16.5	15.7	20.0
5% to 10%	16.8	18.2	18.1	16.3	19.1
10% to 15%	14.4	16.7	15.0	14.3	17.3
15% to 20%	14.6	13.6	15.2	15.5	16.7
20% to 25%	2.6	5.8	2.4	7.6	17.2
>25%	7.0	6.3	6.6	4.8	9.7

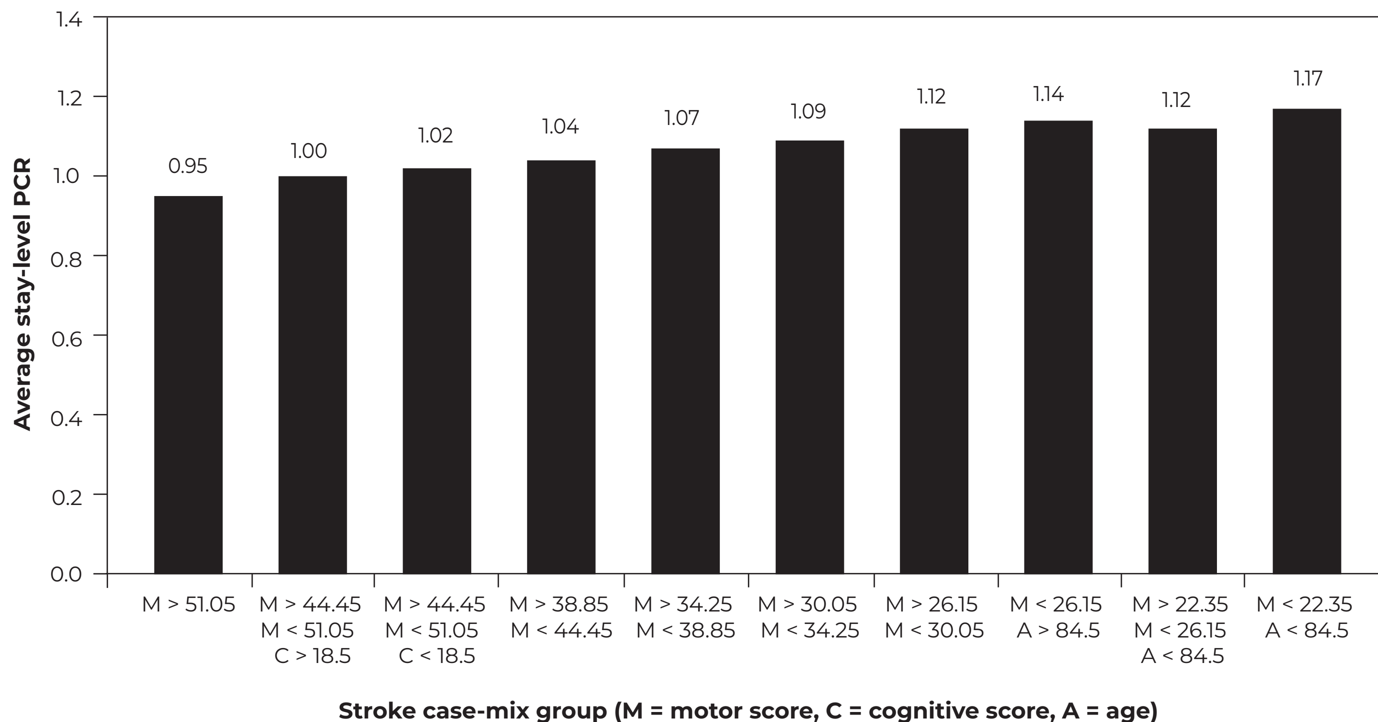
Note: IRF (inpatient rehabilitation facility), FFS (fee-for-service), N/A (not applicable). Government-owned facilities operate in a different financial context from other facilities, so their margins are not necessarily comparable. Their margins are not presented separately here, although they are included in the margins for other groups (e.g., "all IRFs"), where applicable. Percentages may not sum to 100 due to rounding.

Source: MedPAC analysis of cost report data from CMS.

payment weight across a provider's stays, is a measure of the severity of a provider's patient panel: Providers with higher CMIs serve higher-severity patient panels, all else equal. We found that CMIs have increased over time. In 2021, nearly 60 percent of IRFs had a CMI of 1.3 or more, and only 2 percent had a CMI between 1.0 and 1.1 (Figure 9-3, p. 272). In contrast, in 2007, most providers had a CMI between 1.0 and 1.2. A variety of factors has contributed to the increase in CMI, including CMS policy changes related to coverage criteria, the

FIGURE 9–2

Medicare profitability of IRF stroke stays increased with case-mix group severity, FY 2019



Note: IRF (inpatient rehabilitation facility), PCR (payment-to-cost ratio), FY (fiscal year). There are 10 case-mix groups within the IRF stroke rehabilitation impairment group (RIC), which increase in severity from left to right. PCRs are calculated by dividing aggregate payments by aggregate costs for stays assigned to each stroke case-mix group.

Source: Urban Institute's analysis of FY 2019 Medicare fee-for-service claims and cost reports from CMS.

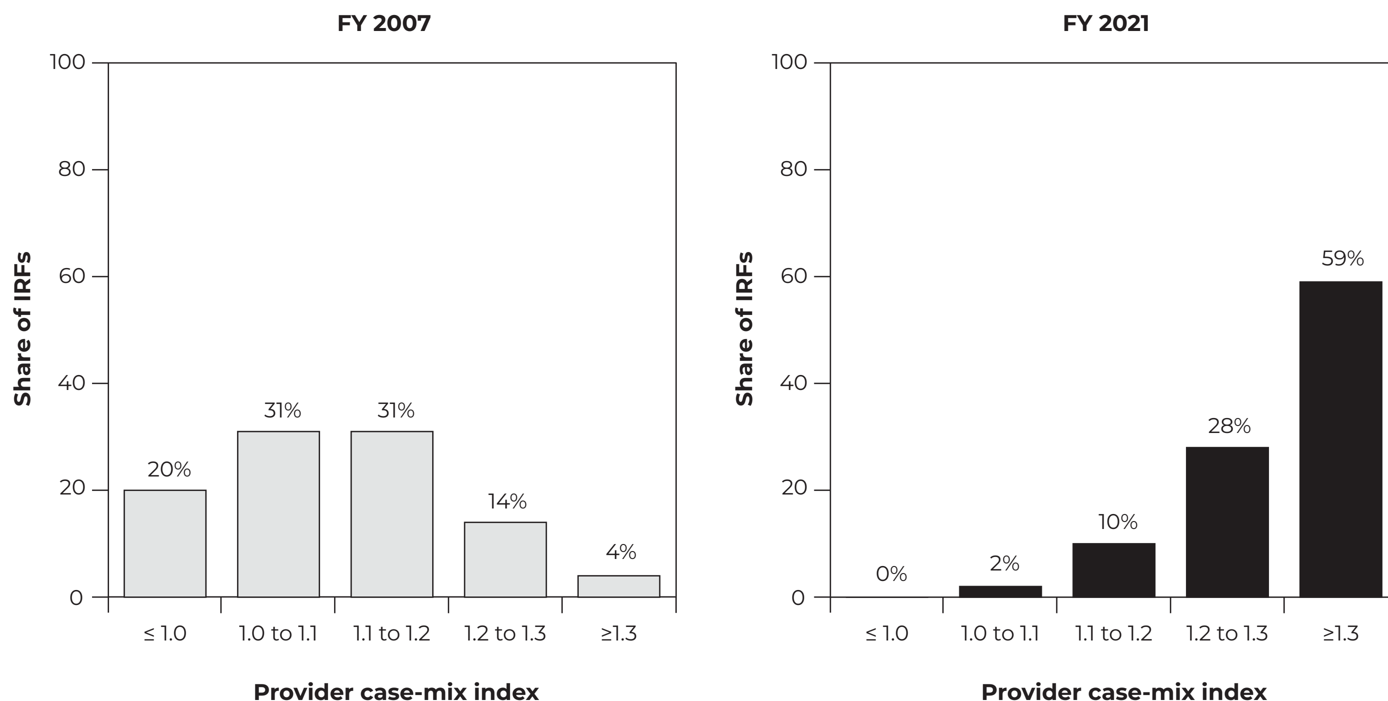
60 percent compliance threshold, and calculation of the functional motor score, as well as demographic and pandemic-related changes to the patient population. Differential coding practices may be another contributor to the upward shift in CMIs, and we will continue to investigate these patterns in future work.[17]

Consistent with our finding of higher PCRs for higher-severity case-mix groups, we found that, in 2021, IRFs with higher CMIs tended to be more profitable, on average (Figure 9-4, p. 273). IRFs with CMIs that were 1.3 or higher had payments that exceeded costs by 27 percent (average PCR of 1.27), while IRFs with CMIs that were 1.0 or less had costs that were higher than payments (average PCR of 0.75). In contrast, no such pattern of higher case mix/higher profitability existed in 2007.

The IRF landscape appears to have changed over time, with widening gaps in profitability. The Commission plans to conduct additional analyses to determine whether these changes are related to the methodology used to calculate the payment weights under the IRF PPS. Further investigation is critical since differences in profitability by CMG could induce providers to select some cases over others, undermining access to care for some patients. Moreover, these patterns further incentivize coding patients as more functionally disabled than they truly are. In 2016, the Commission found evidence of such coding practices among the most profitable providers (Medicare Payment Advisory Commission 2016). We continue to observe similar patterns in more recent data and suggest a

FIGURE 9–3

Substantial growth in the share of high case-mix IRFs in FY 2021 compared to FY 2007



Note: IRF (inpatient rehabilitation facility), FY (fiscal year). The provider case-mix index was obtained from the variable "Estimated Average Weight Per Discharge" for each provider. The percentages may not sum to 100 percent due to rounding.

Source: Inpatient rehabilitation facility prospective payment final rule rate setting files for FY 2009 and FY 2023.

strategy that would mitigate incentives to code certain functional ability responses in order to boost payment (see text box on accuracy of IRF assessments, pp. 274–275).

Relatively efficient IRFs continued to have higher quality and lower Medicare costs than other IRFs

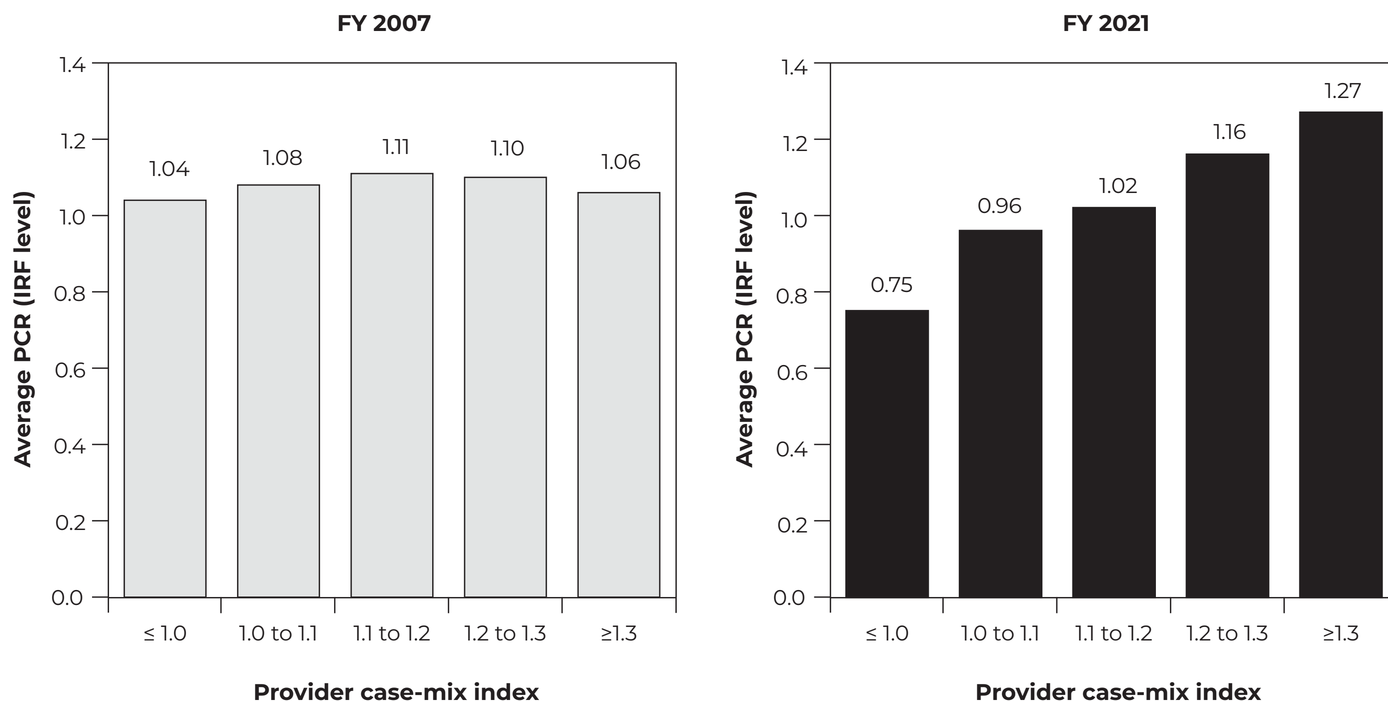
Table 9-7 (p. 276) details the characteristics of relatively efficient providers by quality measures; cost and payment measures; and facility differences in case mix, length of stay, occupancy rates, number of beds, and discharges for stroke and other neurological conditions. (For a more detailed discussion of the Commission's methodology for identifying relatively efficient IRFs, see text box, p. 277.)

Our analysis included the 1,012 IRFs that met data requirements and minimum case counts (60). About 17 percent of these IRFs were identified as relatively efficient providers. Hospital-based nonprofit IRFs represented about 45 percent of the relatively efficient group, while freestanding for-profit IRFs made up about 34 percent of the group.

In 2021, relatively efficient IRFs continued to have higher quality and lower costs than other IRFs. Relatively efficient IRFs had lower (better) rates of hospitalization and higher (better) rates of successful discharge to the community. While payment rates to relatively efficient IRFs and all other IRFs were similar, standardized costs per discharge for the relatively efficient group were about 17 percent lower, leading to a large difference in the median Medicare margin (20.4 percent for relatively efficient IRFs compared with 9.5 percent for other IRFs (Table 9-7, p. 276).

FIGURE 9–4

IRF profitability increased with CMI in 2021 but not in 2007



Note: IRF (inpatient rehabilitation facility), CMI (case-mix index), PCR (payment-to-cost ratio), FY (fiscal year). PCRs were calculated using variables from the annual rate setting files. We divided total estimated payments by number of discharges multiplied by the estimated average cost per discharge for each provider and calculated a weighted average across providers using the number of discharges. The provider case-mix index was obtained from the estimated average weight per discharge for each provider. We aggregated IRFs into CMI groups, as shown in the figure.

Source: Inpatient rehabilitation facility prospective payment final rule rate setting files for FY 2009 and FY 2023 (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRF-Rules-and-Related-Files).

Relatively efficient IRFs were, on average, larger and had higher occupancy rates compared with other IRFs (Table 9-7, p. 276), leading to greater economies of scale. The share of stroke cases was similar between the relatively efficient and other IRFs. On the other hand, the share of other neurological conditions was higher for relatively efficient IRFs compared with other IRFs.

IRFs' Medicare margin in 2023 is projected to be lower than in 2021

Our best estimate is that IRFs' Medicare margin in 2023 will decrease relative to 2021, driven by higher cost growth in 2022 and 2023 than in prepandemic years.

To estimate 2023 payments, costs, and margins with 2021 data, the Commission considers policy changes effective in 2022 and 2023. These changes include:

- an update of 1.9 percent in 2022 based on an IRF market basket increase of 2.6 percent and an offsetting total productivity adjustment of 0.7 percent;
- the suspension of the 2 percent Medicare sequestration through the end of March 2022 and 1 percent relief from April 2022 through the end of June 2022 due to the coronavirus pandemic;
- an update of 3.9 percent in 2023 based on an IRF market basket increase of 4.2 percent and an

Improving the accuracy of the IRF patient assessment information

In 2016, the Commission found that patients admitted by more-profitable inpatient rehabilitation facilities (IRF) were less severely ill in the acute care hospital but were coded as more functionally disabled upon admission to the IRF (thereby boosting payment) compared with patients admitted by less-profitable IRFs (Medicare Payment Advisory Commission 2016). This pattern was observed across various conditions (such as stroke, neuromuscular disorders, debility) and within a condition, such as stroke with and without paralysis.

The inverse relationship between an IRF patient's functional abilities at admission and the profitability of the case may be exacerbated by the methodology for computing the functional motor score in the IRF payment system. The motor score is calculated primarily from 16 functional ability items collected on the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF–PAI) assessment tool when a patient is admitted to an IRF.[18] IRF patients are assessed from "most dependent" (01) to "fully independent" (06) based on their functional ability on various self-care and mobility items:[19]

- Independent (06)
- Setup or clean-up assistance (05)
- Supervision or touching assistance (04)
- Partial/moderate assistance (03)
- Substantial/maximal assistance (02)
- Dependent (01)

The clinician assessing the patient may select an "activity not attempted" (ANA) code if a functional ability item cannot be assessed for any of the following reasons:

- patient refused
- assessment not applicable[20]
- not attempted due to environmental limitations (e.g., lack of equipment, weather constraints)
- not attempted due to medical conditions or safety concerns

If the clinician uses any of the ANA codes, the item is recoded to the most dependent category (01) when computing the motor score, which, all else equal, results in a lower motor score and raises the payment for the stay.[21]

In 2021, 87 percent of IRF stays had an ANA code for at least 1 of the 16 functional items. ANA coding varied by the item, from a low of 3 percent of stays for functional ability items such as eating and toileting hygiene to a high of 82 percent for walking 150 feet (Figure 9-5).[22] "Not attempted due to medical conditions or safety concerns" was the most common ANA code. Not surprisingly, higher-complexity function items (such as walking longer distances and stepping) were more frequently not assessed for these reasons compared with other items. For example, medical conditions or safety concerns accounted for 92 percent of stays for which walking 10 feet was not assessed. Patient refusal was the next most common ANA code and was most frequently used for oral hygiene and shower/bathing. Eighteen percent of stays had at least four items that were not assessed, and 6 percent had at least six items not assessed.

Financial incentives to use "activity not attempted" responses

In many cases, ANA codes are clinically appropriate; it may be harder to assess patients with higher complexity (for medical or safety reasons, for example). However, there is a financial incentive to use ANA codes because they lower the motor score and raise the payment for the stay, all else equal. A 2016 MedPAC study found that patient severity based on the prior acute hospitalization was lower, on average, among high-margin IRFs compared with low-margin IRFs (Medicare Payment Advisory Commission 2016). That is, factors beyond patient severity, such as coding practices, may play a role in IRF profitability.

Alternative recoding when functional ability items cannot be assessed

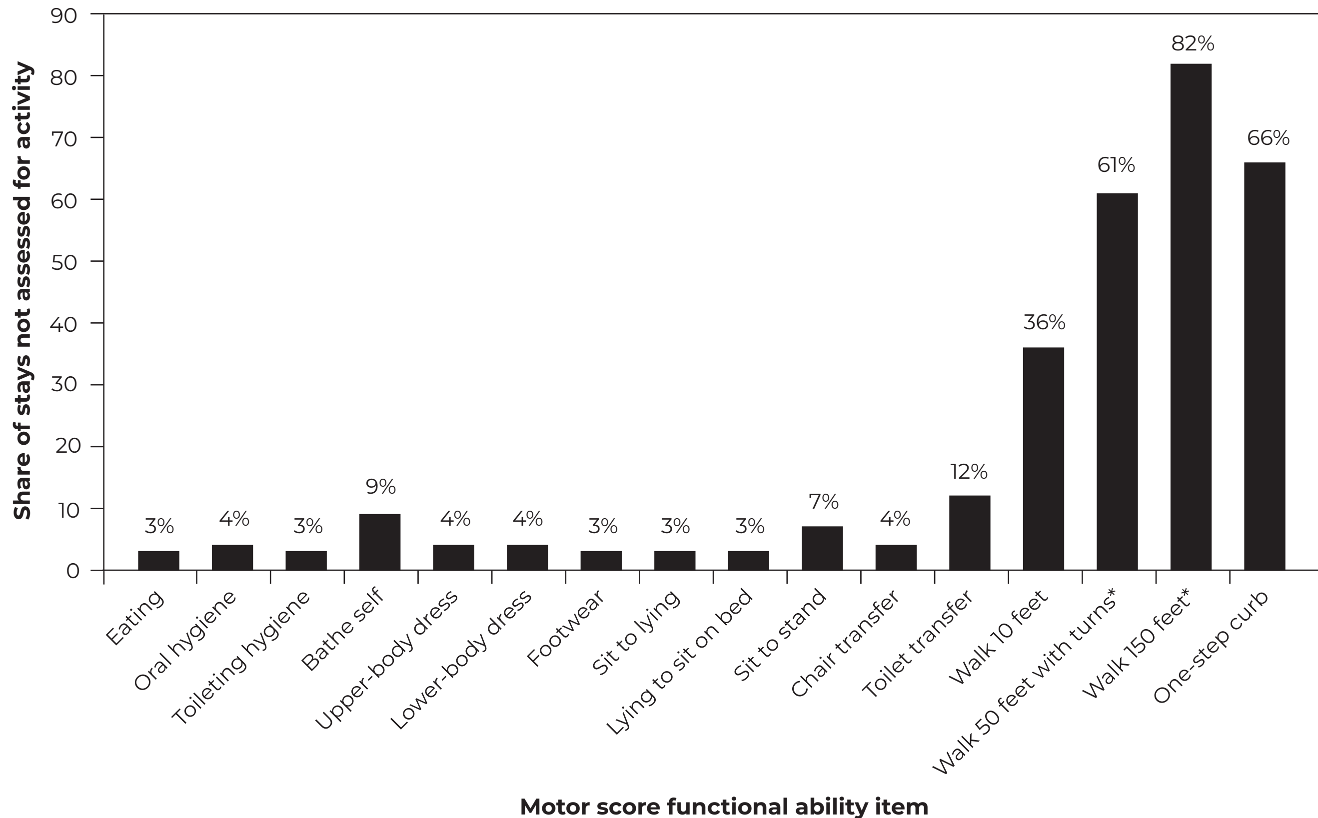
Researchers have found that the "most dependent" (01) response may not be the most appropriate

(continued next page)

Improving the accuracy of the IRF patient assessment information (cont.)

FIGURE 9–5

Medicare IRF patients were frequently not assessed on higher-complexity functional ability items, FY 2021



Note: IRF (inpatient rehabilitation facility), FY (fiscal year). Figure includes assessments for fee-for-service and Medicare Advantage enrollees. *If an individual was not assessed for walking 10 feet, then walking 50 feet with turns and walking 150 feet were automatically skipped in the assessment tool. Skipped responses were included in these percentages.

Source: MedPAC analysis of Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF–PAI) data from CMS.

status for patients who could not be assessed on a functional ability item. In a 2022 report to the Congress regarding a proposed unified post-acute care payment system, the Research Triangle Institute (RTI) used Rasch modeling to examine patients' ability to perform functional ability items that were not coded as ANA and used the resulting relationships to recode ANA items to what the authors considered to be a more appropriate and (most often) higher level of function (RTI International 2022). Of the nine functional ability items that RTI examined, six were recoded one level higher than "most dependent," and one item was recoded two levels higher. In addition, as part of the development of functional outcome quality measures for post-acute care, CMS considered use of an imputation model to impute ANA codes based on the other patient characteristics available on the assessment tool (Acumen LLC 2022). Employing an alternative approach to recode ANA to empirically determined responses rather than automatically recoding them to "most dependent" functional status would promote appropriate use of ANA codes. ■

TABLE 9–7

Relatively efficient IRFs continued to have higher quality and lower Medicare costs than other IRFs in 2021

Performance in 2021	Type of IRF: Relatively efficient IRFs	Type of IRF: Other IRFs	Ratio of relatively efficient to other IRFs
Quality measures:			
All-condition hospitalization rate	6.4%	7.2%	0.89
Successful discharge to community rate	70.3%	67.6%	1.04
Cost and payment measures:			
Payment per discharge	$23,290	$24,371	0.96
Standardized cost per discharge	$14,423	$17,284	0.83
Median Medicare margin	20.4%	9.5%	N/A
Facility characteristics:			
Facility case-mix index	1.38	1.38	1.00
Length of stay (in days)	12.4	12.9	0.96
Occupancy rate	72.8%	66.1%	1.10
Number of beds	30	24	1.25
Share of discharges for:			
Stroke	15.4%	15.3%	1.00
Other neurological conditions	15.9%	13.4%	1.19
Share of facilities:			
Freestanding for profit	33.5%	21.8%	N/A
Hospital-based nonprofit	44.9%	48.8%	N/A

Note: IRF (inpatient rehabilitation facility), N/A (not applicable). All data are medians unless otherwise indicated. The analysis included 1,012 IRFs that met the data requirements and minimum case counts (60). IRFs were identified as "relatively efficient" based on a cost measure (costs per discharge) and two quality measures (rates of hospitalizations during the stay and successful discharge to community) between 2017 and 2019. Relatively efficient IRFs were those in the best third of the distribution for one measure and not in the worst third for any measure in each of the three years. Costs per discharge were standardized for differences in area wages; mix of cases; and prevalence of high-cost outliers, short-stay outliers, and transfer cases. Quality measures were calculated for all facilities with 60 or more fee-for-service stays. Successful discharge to the community includes beneficiaries discharged to the community (excluding those discharged to the same nursing home) who did not have an unplanned hospitalization or die in the 30 days after discharge. The all-condition hospitalization measure captures all unplanned hospital admissions and readmissions and outpatient observation stays that occur during the stay. High rates of hospitalization during the stay indicate worse quality and high rates of successful discharge to community indicate better quality. "Other neurological conditions" includes multiple sclerosis, Parkinson's disease, polyneuropathy, and neuromuscular disorders.

Source: MedPAC analysis of Medicare cost report data, Medicare Provider Analysis and Review data, and Inpatient Rehabilitation Facility–Patient Assessment Instrument data from CMS for 2017 to 2021.

offsetting multifactor productivity adjustment of 0.3 percent; and

- changes to the high-cost outlier amount in 2022 and 2023, which lowered payments by 0.4 percentage point in 2022 and will lower payments by 0.6 percentage point in 2023 (Table 9-8, p. 278).

Historically, cost growth in this sector has been at or below market basket levels, though between 2019

Identifying relatively efficient inpatient rehabilitation facilities

The Commission is required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to consider the costs associated with an efficient provider. To make this assessment, we examined the financial performance of inpatient rehabilitation facilities (IRFs) that had consistently low costs per discharge and high quality using our new cross-sector post-acute care quality measures. We calculated the cost per discharge using cost report and claims data and adjusted for differences in area wages; mix of cases; and prevalence of high-cost outliers, short-stay outliers, and transfer cases. For quality measures, we used risk-adjusted rates of successful discharge to the community and all-condition hospitalizations during a stay. To be included in the group of IRFs that furnished relatively low-cost, high-quality care, an IRF had to be (1) in the best-performing third of the distribution of adjusted cost per discharge or of one of the quality measures for three consecutive years (2017 through 2019)[23] and (2) not in the worst-performing third of the distribution of adjusted cost per discharge or either of the quality measures for three consecutive years. Only IRFs with at least 60 Medicare fee-for-service discharges were included in the analysis.

The method we used to assess performance attempts to limit drawing incorrect conclusions about performance based on poor data. Using three years (rather than just one year) of data to categorize IRFs as efficient avoids categorizing providers based on random variation or on one "unusual" year. After determining whether an IRF was relatively efficient based on having relatively low costs and good quality care for three years in a row, we calculated performance on several quality and cost measures in 2021. By first assigning an IRF to a group (relatively efficient or other) and then examining the group's performance in the next year, we avoid having a facility's poor data affect both its own categorization and the assessment of the group's performance. Thus, an IRF's erroneous data in 2017, 2018, or 2019 could result in its inaccurate assignment to a group, but because the group's performance is assessed with data from 2021, these "bad" data would not directly affect the assessment of the group's performance. ■

and 2020, cost growth exceeded the market basket, increasing by 8.6 percent. Many factors related to the coronavirus pandemic drove cost growth in 2020, including faster growth in case mix, spreading fixed costs over fewer IRF cases, labor cost increases, increase in supplies, and longer average length of stay. In 2021, cost growth returned to a level below the market basket, at about 2.0 percent. While the cost growth in the IRF sector is generally low and the rate of cost growth is lower than prepandemic levels in 2021 (2.3 percent in 2019), some effects of the coronavirus pandemic, such as higher costs of labor, could persist through 2023. For that reason, the Commission's margin projection for 2023 conservatively assumes that costs in 2022 and 2023 will increase an average of 4.8 percent a year. Considering these assumptions, we project an aggregate Medicare margin of 11 percent for IRFs in 2023. However, if cost growth remains low, the aggregate margin will be higher.

How should Medicare payments change in 2024?

Our payment adequacy indicators suggest that Medicare payments to IRFs were generally adequate in 2021.

For fiscal years 2009 through 2017, the Commission recommended a 0 percent update to the IRF payment rate. For fiscal years 2018 through 2022, however, as the

TABLE 9–8

IRF prospective payment system updates

	2021	2022	2023
Market basket	2.4%	2.6%	4.2%
Productivity	0.0	–0.7	–0.3
High-cost outlier adjustment	0.4	–0.4	–0.6
Total	**2.8**	**1.5**	**3.3**

Note: IRF (inpatient rehabilitation facility).

Source: Centers for Medicare & Medicaid Services final rules for IRFs, 2020–2022.

payment adequacy indicators remained positive and the aggregate Medicare margin neared historic highs, the Commission recommended that the Congress reduce IRF payment rates by 5 percent. Because our recommendations were not enacted and because, in the absence of legislative action, CMS is required by statute to apply an adjusted market basket increase, payments have continued to rise. IRFs' aggregate Medicare margin has remained above 13 percent since 2015.

The final updates for 2024 will not be set until summer 2023, but CMS's third-quarter 2022 forecasts would result in the IRF base rate increasing by 3.1 percent, absent congressional action. Reducing the payment rate for IRFs would better align Medicare payments with the costs of efficiently providing high-quality IRF care.

RECOMMENDATION 9

For fiscal year 2024, the Congress should reduce the 2023 Medicare base payment rate for inpatient rehabilitation facilities by 3 percent.

RATIONALE 9

IRFs' high Medicare margin of 17 percent in 2021 and our projected margin of 11 percent for 2023 indicate that Medicare payments continue to substantially exceed the costs of caring for beneficiaries.

For every fiscal year since 2009, the Commission has recommended that the update to the IRF payment rate be eliminated or that the payment rate be reduced. However, CMS has been required by statute to apply an adjusted market basket increase each year. Reducing the payment rate for IRFs by 3 percent would better align Medicare payments with the costs of efficiently providing high-quality IRF care.

IMPLICATIONS 9

Spending

- Relative to current law, this recommendation would decrease Medicare spending.

Beneficiary and provider

- We do not expect this recommendation to have an adverse effect on either Medicare beneficiaries' access to care or out-of-pocket spending. This recommendation could increase financial pressure on some providers. We expect that relatively efficient providers will continue to be willing and able to care for Medicare beneficiaries. ■

Endnotes

1 More frequently, Medicare beneficiaries receive inpatient rehabilitation services in skilled nursing facilities (SNFs), in part because there are many more SNFs than IRFs nationwide.

2 More information about the prospective payment system for IRFs is available at https://www.medpac.gov/wp-content/uploads/2021/11/MedPAC_Payment_Basics_22_IRF_FINAL_SEC.pdf.

3 In fiscal year 2020, the IRF PPS case-mix groups were revised. Cognition was not included in the new CMGs; only motor score and age were included.

4 More information about the prospective payment system for IRFs is available at https://www.medpac.gov/wp-content/uploads/2021/11/MedPAC_Payment_Basics_22_IRF_FINAL_SEC.pdf.

5 During the public health emergency (PHE), some exceptions have been made to Medicare's facility requirements for IRFs to help health care providers in affected communities manage patient flow. For example, during the PHE, an IRF that agrees to admit a patient to help a nearby hospital free up an acute care bed may exclude that patient from its compliance threshold calculation as long as the patient's medical record properly indicates that the patient was admitted solely to respond to the pandemic (Centers for Medicare & Medicaid Services 2020). The compliance threshold (commonly referred to as the "60 percent rule") requires that no less than 60 percent of patients admitted to an IRF have as a primary diagnosis or comorbidity at least 1 of 13 conditions specified by CMS.

6 The 13 conditions are stroke; spinal cord injury; congenital deformity; amputation of a lower limb; major multiple trauma; hip fracture; brain injury; certain other neurological conditions (multiple sclerosis, Parkinson's disease, cerebral palsy, and neuromuscular disorders); burns; three arthritis conditions for which appropriate, aggressive, and sustained outpatient therapy has failed; and hip or knee replacement when it is bilateral, the patient's body mass index is greater than or equal to 50, or the patient is age 85 or older.

7 During the PHE, some exceptions have been made to IRF Medicare coverage criteria for beneficiaries to help health care providers contain the spread of coronavirus disease 2019 (COVID-19). For example, the Secretary waived Section 412.622(a)(3)(ii), commonly referred to as the "3-hour rule," the criterion that patients treated in IRFs generally receive at least 15 hours of therapy per week. IRFs are expected to provide typical IRF levels of care for beneficiaries admitted during the PHE who require and can benefit from such care (Centers for Medicare & Medicaid Services 2020).

8 In contrast, if payments do not cover the marginal costs, the provider could have a disincentive to care for Medicare beneficiaries.

9 If we approximate marginal cost as total Medicare cost minus fixed building and equipment cost, then:

Marginal profit = (payments for Medicare services – (total Medicare costs – fixed building and equipment costs)) / Medicare payments.

10 The risk adjustment for the measure of successful discharge to the community includes the age and sex of the beneficiary, end-stage renal disease (ESRD) and disability status for entitlement, principal diagnosis, comorbidities, the length of the preceding hospital stay (if there was one), and a count of the hospitalizations during the preceding year. Risk adjusters for the hospitalization measure include primary diagnosis, comorbidities and severity of illness, special conditions (severe wounds, difficulty swallowing, and bowel incontinence), age and sex, disability and ESRD status, hospitalization in the previous month, days in the intensive care unit during a preceding hospitalization (if there was one), a count of the hospitalizations during the preceding year, and the provision of ventilator care during the PAC stay. Providers with at least 60 stays in the year, the minimum count to meet a reliability of 0.7, were included in calculating the average facility rate.

11 In prior reports, we have erroneously characterized a discharge to community as inclusive of stays that end in a return to the nursing facility from which a beneficiary was admitted. Rather, Medicare-covered IRF stays that end in a discharge to a nursing home are not considered a discharge to the community.

12 Hospital cost reports do not require hospitals to report an all-payer margin specifically for their IRF or other hospital-based units.

13 Effective July 1, 2021, certain specialty hospitals, including inpatient rehabilitation facilities, are exempt from the certificate-of-need (CON) review in Florida. A CON requires the state to determine whether there is enough demand for the services before construction of a new health care facility begins.

14 We estimated the aggregate margin with reported relief funds included based on FFS Medicare's share of 2019 all-payer operating revenue.

15 The Affordable Care Act of 2010 required a budgetary reduction to IRF PPS payments in each year from 2010 to 2019.

16 From April 1, 2022, through June 30, 2022, there was a 1 percent payment adjustment. The full 2 percent adjustment was reinstated July 1, 2022.

17 In FY 2020, CMS transitioned from using Functional Independence Measure™ (FIM™) items on the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF–PAI) to Section GG functional ability items to calculate CMGs. CMS re-estimated payment weights for the new CMGs, which may have affected the CMI in FY 2021 shown in Figure 9-3 (p. 272). However, we observed shifts toward higher CMIs before FY 2020.

18 Two other IRF–PAI items, related to bladder and bowel continence, are also part of the motor score.

19 IRF–PAI version 4.0, effective October 1, 2022.

20 "Not applicable" should be selected if the activity was "not attempted and the patient did not perform this activity prior to the current illness, exacerbation, or injury" (IRF–PAI version 4.0, effective October 1, 2022).

21 The motor score is calculated by summing across the 16 functional ability and 2 bladder and bowel continence items, with equal weight given to each of the 18 items. The functional ability item responses range from 01 to 06, and the bladder and bowel continence items range from 01 to 04; thus, the motor score ranges from 18 to 104.

22 If the individual was not assessed for walking 10 feet, then items for walking 50 feet with turns and walking 150 feet were automatically skipped in the assessment tool (and recoded to 01 (dependent)).

23 This year, in our efficient provider analysis, we used three consecutive prepandemic years (2017 to 2019) to determine efficient IRF providers.

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