CHAPTER 9

Inpatient rehabilitation facility services

RECOMMENDATION

9 For fiscal year 2027, the Congress should reduce the 2026 Medicare base payment rate for inpatient rehabilitation facilities by 7 percent.

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

CHAPTER 9

Inpatient rehabilitation facility services

Chapter summary

Inpatient rehabilitation facilities (IRFs) are freestanding hospitals or hospital-based units that provide intensive rehabilitation services to patients after illness, injury, or surgery. Care provided in IRFs is supervised by rehabilitation physicians and includes services such as physical and occupational therapy, rehabilitation nursing, and speech–language pathology. In fiscal year (FY) 2024, the fee-for-service (FFS) Medicare program and its beneficiaries spent $11.0 billion on about 435,000 IRF stays in about 1,170 IRFs nationwide. FFS Medicare beneficiaries accounted for about 51 percent of IRF stays.

Assessment of payment adequacy

The indicators of FFS Medicare payment adequacy for IRFs were generally positive.

***Beneficiaries' access to care*—**Indicators of IRF capacity and supply and FFS Medicare beneficiaries' volume of IRF stays show that access remains adequate.

- ***Capacity and supply of providers*—**Between FY 2023 and FY 2024, IRFs' available capacity and supply of IRFs remained relatively stable. IRFs' occupancy rate remained below capacity (71 percent), indicating

In this chapter

capacity was more than adequate to meet demand. The number of IRFs increased slightly, driven by growth in freestanding and for-profit IRFs.

- ***Volume of services*—**FFS beneficiaries used notably more IRF services in FY 2024. From 2023 to 2024, the total number of FFS Medicare stays in IRFs increased by about 8 percent, and stays per FFS beneficiary increased by about 10 percent. In 2024, the average length of stay was 12.4 days, similar to the level in 2023.

***Quality of care*—**Quality of care was relatively stable. For the two-year period of FY 2023 through FY 2024, the median facility risk-adjusted rate of discharge to the community from IRFs was relatively stable at 67.5 percent. The median facility risk-adjusted rate of potentially preventable readmissions was 9.2 percent, 0.4 percentage points more than in the prior period of FY 2022 through FY 2023.

***Providers' access to capital*—**In FY 2024, freestanding IRFs' all-payer total margin increased 2 percentage points to 12 percent. For-profit corporations continued to open new IRFs and enter into joint ventures with other organizations, suggesting strong access to capital. Hospital-based IRFs access capital through their parent hospitals, and these hospitals' access to capital also improved.

***FFS Medicare payments and providers' costs*—**In FY 2024, IRFs' FFS Medicare margin rose to 17.1 percent, up from 14.8 percent in 2023, as the average payment per stay increased by 3.4 percent while average cost per stay increased by 0.6 percent. IRFs' FFS Medicare margin continued to vary substantially across IRF categories, including a much higher margin for freestanding IRFs (25.0 percent) than for hospital-based IRFs (4.1 percent). For FY 2026, we project that IRFs' FFS Medicare margin will increase to about 18 percent.

How should payment rates change in 2027?

Given the positive payment-adequacy indicators, the Commission recommends that, for FY 2027, the Congress reduce the 2026 IRF base payment rate by 7 percent. This recommendation would continue to provide IRFs with sufficient revenue to maintain FFS Medicare beneficiaries' access to IRF care while bringing IRF prospective payment system payment rates closer to the cost of efficiently delivering high-quality care. ■

As required by law, the Commission annually makes payment-update recommendations for providers paid under Medicare's traditional fee-for-service (FFS) payment systems. Such providers include inpatient rehabilitation facilities (IRFs), which provide intensive rehabilitation care after illness, injury, or surgery, including services such as physical and occupational therapy, rehabilitation nursing, and speech–language pathology.[1]

Background

IRFs must be focused primarily on treating conditions that typically require intensive rehabilitation, among other requirements. IRFs can be fully licensed freestanding hospitals or hospital-based units within general or other hospitals. To qualify for a covered IRF stay, a FFS Medicare 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. FFS Medicare makes payments for inpatient IRF services under the IRF prospective payment system (PPS).[2] In fiscal year (FY) 2024, about 1,170 IRFs furnished about 435,000 FFS Medicare-covered stays. FFS Medicare spending on IRF services was $11.0 billion ($10.8 billion in program spending and $0.2 billion in beneficiary cost-sharing liability). FFS Medicare beneficiaries accounted for about 51 percent of IRF stays.[3]

Medicare facility requirements for IRFs

IRFs must meet the requirements to be a hospital or be a unit within a hospital meeting the hospital requirements, but IRFs have additional requirements for payment. They must:

- 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 services; 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 plan of care 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 required intensive rehabilitation services for treatment of one or more of the 13 conditions, either as a principal diagnosis or comorbidity, specified by CMS.[4] The intent of the compliance threshold is to distinguish IRFs from acute care hospitals (ACHs). If an IRF does not meet the compliance threshold, Medicare pays for all its patients' stays based on the inpatient hospital PPS rather than the IRF PPS.

Medicare coverage criteria for IRF PPS stays

Medicare applies additional criteria to specify whether IRF services are covered for an individual FFS 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:

- 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.
- 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 the IRF stay, 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 FFS Medicare payments adequate in 2026?

Based on the most recent available data, indicators of the adequacy of IRF PPS payments are generally positive. IRFs continued to have available capacity in aggregate, and the number of IRFs was relatively stable. Notably, the number of IRF stays per FFS Medicare beneficiary increased substantially in FY 2024. Our measures of quality of care were relatively stable. IRFs' access to capital improved: Freestanding IRFs' all-payer total margin increased, as did the all-payer margin of hospital-based IRFs' parent hospitals. IRFs' FFS Medicare margin rose more than 2 percentage points to 17.1 percent in FY 2024, and we project that it will increase to about 18 percent in FY 2026.

Beneficiaries' access to care: Beneficiaries maintained good access to IRF inpatient services in 2024

Relatively stable IRF capacity and supply and the growth in FFS Medicare beneficiaries' volume of services suggest that capacity in FY 2024 remained adequate to meet demand.

Occupancy rate and number of IRFs suggest adequate capacity and supply

IRFs' capacity increased in FY 2024, and IRFs maintained adequate available capacity. Nationwide, the number of IRF beds grew by about 3.5 percent in 2024. This increase was driven by an increase in beds in freestanding for-profit IRFs. Beds in hospital-based nonprofit IRFs were stable.[5] Prior interviews with a small set of ACH discharge planners and executives regarding discharges to IRFs or skilled nursing facilities (SNFs), interviewees did not distinguish between IRF services received in hospital-based or freestanding IRFs (L & M Policy Research 2023). Over this same period, the number of all-payer IRF stays grew slightly faster, resulting in IRFs' occupancy rate increasing slightly to 71 percent (compared with 69 percent in the prior year). The occupancy rate among freestanding IRFs rose from 73 percent to 74 percent, and among hospital-based IRFs, the aggregate occupancy rate rose from 65 percent to 67 percent. In general, larger IRFs had higher occupancy rates than smaller IRFs. These occupancy rates continue to indicate that capacity is adequate to meet demand for IRF services.

The supply of IRFs was relatively stable, increasing by less than 1 percent in FY 2024, to 1,169 (Table 9-1), consistent with the average annual change from 2019 through 2023. The vast majority of IRFs (88 percent) were located in urban areas, and the majority of IRFs (66 percent) were hospital based. Over 60 percent of IRFs in urban areas were hospital-based facilities compared with 90 percent of IRFs in rural areas (data not shown). Freestanding IRFs tended to be larger facilities compared with hospital-based IRFs: In FY 2024, 95 percent of freestanding IRFs had 25 or more beds, while most hospital-based IRFs (67 percent) had fewer than 25 beds (data not shown).

The growth in the number of IRFs in FY 2024 was driven by a 4.3 percent increase in both freestanding and for-profit IRFs (Table 9-1). In contrast, the number of hospital-based and nonprofit IRFs continued to decline, falling by 0.9 percent and 2.8 percent, respectively. The majority of new IRFs were freestanding for-profit facilities and opened in markets in which another IRF was already serving beneficiaries (data not shown). Half of the closures were nonprofit hospital-based facilities in areas with another IRF.

In a prior analysis the Commission found that, in 2022, less than 30 percent of hospital service areas (HSAs) had one or more IRFs (Medicare Payment Advisory Commission 2024).[6] (By comparison, 97 percent of HSAs contained at least one SNF.) Of markets with IRFs, most had only hospital-based IRFs (67 percent) or only freestanding IRFs (18 percent), and about 15 percent had both types. Seventy percent of Medicare beneficiaries (including those in FFS and Medicare Advantage) lived in HSAs with IRFs; only about 30 percent of FFS Medicare beneficiaries lived in an HSA

TABLE 9–1

The supply of IRFs was relatively stable in FY 2024, but the number of for-profit and freestanding IRFs continued to grow

Type of IRF	Share of FFS Medicare stays, 2024	Number of IRFs						Average annual percent change 2019–2023	Percent change 2023–2024
		2019	2020	2021	2022	2023	2024		
All	100%	1,119	1,114	1,118	1,132	1,160	1,169	0.9%	0.8%
Type									
Freestanding	64	302	316	330	350	376	392	5.6	4.3
Hospital based	36	817	798	788	782	784	777	–1.0	–0.9
Ownership									
For profit	68	431	439	467	479	529	552	5.3	4.3
Nonprofit	27	575	562	544	542	531	516	–2.0	–2.8
Government	5	113	113	107	102	100	101	–3.0	1.0
Geography									
Urban	94	976	970	973	987	1,016	1,025	1.0	0.9
Rural	6	143	144	145	145	144	144	0.2	0

Note: IRF (inpatient rehabilitation facility), FY (fiscal year), FFS (fee-for-service). "Number of IRFs" refers to the count of IRF provider numbers that provided at least one inpatient service to a FFS Medicare beneficiary in that fiscal year. IRFs in Maryland that are paid under CMS's Maryland All-Payer Model are excluded. "Freestanding" and "hospital-based" designations reflect the IRF's Medicare provider number, with "hospital based" indicating a separately certified unit of another hospital. "Urban" refers to metropolitan counties, which contain an urban cluster of 50,000 or more people; all other counties are classified as "rural." Results differ from those published in prior years because of methodological updates, such as including IRFs that did not submit FFS Medicare claims. Components may not sum to totals due to missing data.

Source: MedPAC analysis of Medicare Provider Analysis and Review, hospital cost-report, Provider of Services, and census geographic data.

without an IRF. Some beneficiaries who lived in these HSAs traveled to other areas to receive IRF care or received rehabilitative care from other post-acute care (PAC) providers.

IRFs are intended to provide a more intense level of therapy under direct medical supervision, but other providers also furnish PAC services in communities with and without IRFs. SNFs provide PAC in an institutional setting, and home health agencies, hospital outpatient departments, comprehensive outpatient rehabilitation facilities, and independent therapy providers furnish such care at a beneficiary's home or on an outpatient basis. Given the number and distribution of these other providers, it is unlikely that IRFs are the only provider of PAC services available to Medicare beneficiaries in any given area.

Many providers and caregivers (such as therapists) use guidelines to make placement recommendations for beneficiaries needing rehabilitative care, but these are often based on Medicare coverage rules rather than on evidence of what practices result in the best outcomes for a given clinical condition. Few evidence-based guidelines exist to help beneficiaries and their clinicians choose the PAC setting that is best suited to their needs. For example, one study of patients treated for debility in IRFs concluded that more research was needed to identify the most appropriate rehabilitation setting for debility patients to achieve functional improvement (Kortebein et al. 2008). One exception is for stroke: Guidelines established by the American Heart Association/American Stroke Association outline

TABLE 9–2 **FFS Medicare beneficiaries' IRF stays per capita increased substantially in FY 2024**

	2019	2020	2021	2022	2023	2024	Average annual percent change 2019–2023	Percent change 2023–2024
IRF inpatient stays (thousands)	404	374	373	376	404	435	0.0%	7.6%
IRF inpatient stays per 10,000 beneficiaries	107	101	104	109	120	132	2.8	9.7
Average length of stay (days)	12.6	12.9	12.9	12.8	12.5	12.4	–0.2	–0.7

Note: FFS (fee-for-service), IRF (inpatient rehabilitation facility), FY (fiscal year). "Inpatient stays per 10,000 beneficiaries" refers to FFS Medicare inpatient stays divided by all FFS Medicare beneficiaries who resided in the U.S. and had Part A. Percentage changes were calculated on unrounded data.

Source: MedPAC analysis of Medicare Provider Analysis and Review and Common Medicare Environment data.

best practices in rehabilitation care for stroke patients (e.g., prevention of falls and skin breakdown and pain management) and recommend placement in IRFs over SNFs for patients who qualify for IRF services (Winstein et al. 2016).

Notable increase in FFS Medicare beneficiaries' IRF stays per capita

The number of FFS IRF stays, both in aggregate and per capita, increased substantially in FY 2024, for the second straight year (Table 9-2). In 2024, the aggregate number of stays rose by 7.6 percent to 435,000 inpatient stays, and the number of stays per 10,000 FFS beneficiaries rose by 9.7 percent to 132. Both were well above prepandemic levels. The average length of stay was 12.4 days, similar to the level in 2023.

Most of the growth in the number of stays per FFS Medicare beneficiaries was from growth in freestanding and for-profit IRFs. In FY 2024, IRF stays per capita increased 14 percent at freestanding IRFs, compared with only 3 percent at hospital-based IRFs. Similarly, IRF stays per capita increased 13 percent at for-profit IRFs, compared with 3 percent at nonprofit IRFs and 4 percent at government IRFs. High growth in the number of stays per FFS beneficiary occurred across many of the most common rehabilitation impairment categories (RICs) of IRF stays, such as over 12 percent growth in other neurological rehabilitation and nontraumatic brain injury. Stroke stays per beneficiary grew by 4 percent compared to the prior year. The Commission continues to examine the drivers of the growing use of IRFs by FFS beneficiaries.

Patterns of use in IRFs

In FY 2024, the three most common conditions among FFS Medicare beneficiaries treated by IRFs nationwide, as reported on the IRF Patient Assessment Instrument (IRF–PAI) at admission, were stroke (15.1 percent of stays), "other neurological conditions" (15.0 percent of stays), and debility (14.7 percent of stays).

The distribution of FFS Medicare stay types differs by type of IRF and ownership (Table 9-3). For example, in FY 2024, only 13 percent of stays in freestanding for-profit IRFs were admitted for rehabilitation following a stroke, compared with 20 percent of stays in hospital-based nonprofit IRFs. By contrast, 20 percent of stays in freestanding for-profit IRFs were admitted with other neurological conditions, more than twice the share admitted to hospital-based nonprofit IRFs. Stays for fracture of the lower extremity made up a slightly

TABLE 9–3

Mix of FFS Medicare IRF stays differed by provider type and ownership, FY 2024

	Freestanding		Hospital based	
Condition	**For profit**	**Nonprofit**	**For profit**	**Nonprofit**
All (share of stays)	55%	9%	9%	27%
Percent of total				
Stroke	13	17	14	20
Other neurological conditions	20	11	11	8
Fracture of the lower extremity	13	12	16	15
Debility	15	15	17	14
Brain injury	12	12	13	12
Other orthopedic conditions	9	8	8	7
All other conditions	19	24	22	24

Note: FFS (fee-for-service), IRF (inpatient rehabilitation facility), FY (fiscal year). "Nonprofit" columns include government-owned IRFs. "Condition" based on impairment group at admission recorded on the IRF Patient Assessment Instrument. "Other neurological conditions" includes neuromuscular disorders, multiple sclerosis, Parkinson's disease, and polyneuropathy included in the neurological impairment group. "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, as well as hip and knee replacements. "Brain injury" includes both traumatic and nontraumatic injuries. Freestanding for-profit IRFs are more likely to have stays in certain subcategories of the "other neurological conditions": neuromuscular conditions (such as myasthenia gravis, motor neuron disease, post-polio syndrome, muscular dystrophy, and other myopathies) and "other neurological disorders" (such as other extrapyramidal disease, abnormal movement disorders, and hereditary ataxia). Column components may not sum to 100 percent due to rounding.

Source: Inpatient Rehabilitation Facility Patient Assessment Instrument data from CMS.

larger share of stays in hospital-based facilities than in freestanding facilities. Other orthopedic conditions were similar across IRF types. The distribution of stay types was relatively stable between 2019 and 2024 (data not shown). The Commission has previously reported that some stay types, especially those for other neurological conditions, are more profitable than others under the IRF PPS (for more details, see the IRF chapter (Chapter 8) of our March 2024 report to the Congress (Medicare Payment Advisory Commission 2024)).

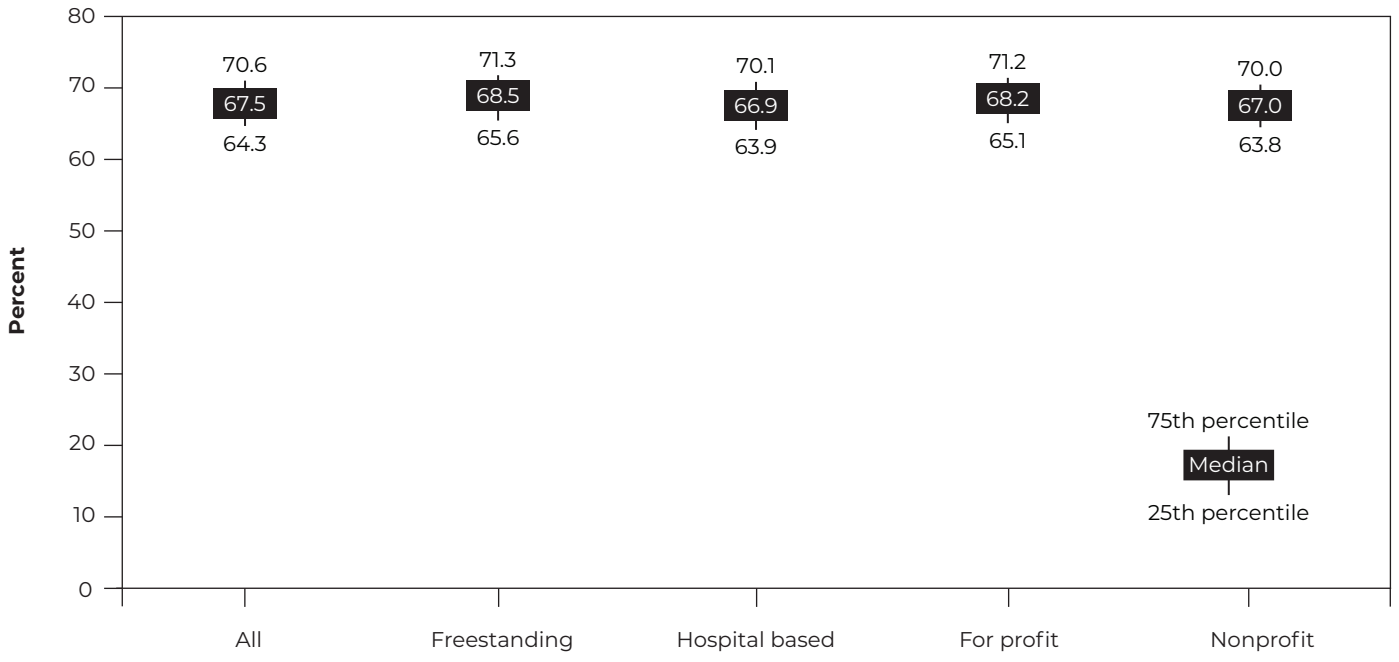
Quality of care: Discharge to the community and potentially preventable readmissions were relatively stable

In our assessment of payment adequacy, the Commission prioritizes quality measures tied to clinical outcomes. We report two outcome measures for FFS Medicare beneficiaries in IRFs: risk-adjusted potentially preventable hospital readmissions after discharge and risk-adjusted discharge to the community, which are claims-based outcome measures developed by CMS. CMS publicly reports facility-level measures after providers are given an opportunity to review the data. The measures are updated annually and cover a 24-month period. The most recent available data, released in October 2025, cover FY 2023 through FY 2024. Data from this period indicate that, in aggregate, rates of successful discharge to the community and potentially preventable readmissions were relatively stable compared with the previous 24-month period.

Readmissions and community-discharge measures assess key outcomes of IRF care, but they do not capture all aspects of quality in IRFs. Ideally, we could measure other outcomes and the experience of IRF care for Medicare beneficiaries in a stay. However, lack of data on patient experience and concerns about the

FIGURE 9–1

Median and interquartile range of IRFs' risk-adjusted FFS Medicare rates of successful discharge to the community in FY 2023–2024



Note: IRF (inpatient rehabilitation facility), FY (fiscal year), FFS (fee-for-service). "Successful discharge to the community" is an IRF's risk-adjusted rate of FFS Medicare patients who were discharged to the community after an IRF stay, did not have an unplanned readmission to an acute care or long-term care hospital in the 31 days following discharge to the community, and remained alive during those 31 days. "Freestanding" and "hospital-based" designations reflect the IRF's Medicare provider number, with "hospital based" indicating a separately certified unit of another hospital. Higher rates of successful discharge to the community are better. The measure is calculated uniformly across post-acute care settings; providers with fewer than 25 stays or missing data were excluded, as were swing beds. Data cover 24 months (FY 2023 and FY 2024 combined).

Source: MedPAC analysis of claims-based outcome measures from CMS's Provider Data Catalog.

validity of function data limit our ability to assess the quality of IRF care.

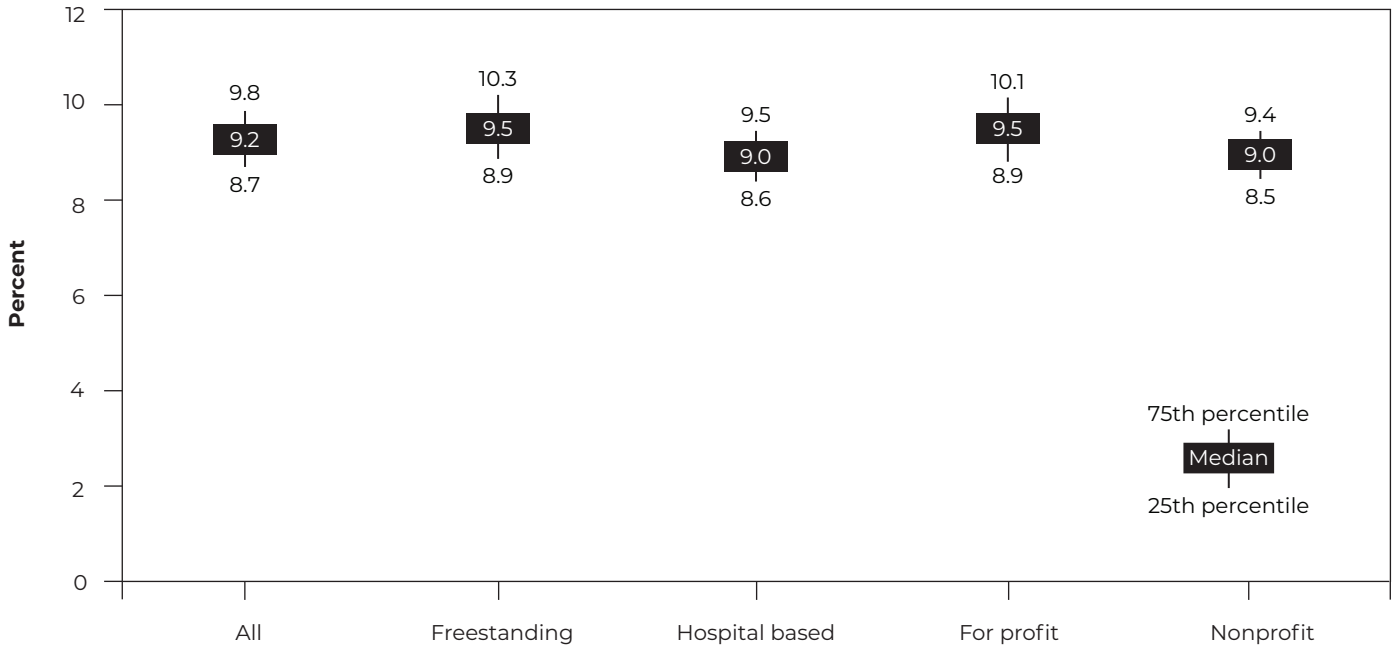
Successful discharge to the community

The measure of successful discharge to the community is the rate at which patients returned home or to the community from the IRF and remained alive without any unplanned hospitalizations in the 31 days following discharge (higher rates are better) (Centers for Medicare & Medicaid Services 2023a, Centers for Medicare & Medicaid Services 2015).[7] IRFs can improve their rate of successful discharge to the community by providing rehabilitation strategies to improve functional ability, discharge planning and care coordination, patient and family education, and solutions to barriers a patient may face in the community.

During the FY 2023 through FY 2024 period, the median facility risk-adjusted rate of successful discharge to the community was 67.5 percent, similar to the rate for FY 2022 and FY 2023, which was 67.2 percent (Figure 9-1; latter figure not shown). About one-quarter of facilities had a risk-adjusted rate below 64.3 percent, and one-quarter had a rate above 70.6 percent.

FIGURE 9–2

Median and interquartile range of IRFs' risk-adjusted FFS Medicare rates of potentially preventable readmissions in FY 2023–2024



Note: IRF (inpatient rehabilitation facility), FY (fiscal year), FFS (fee-for-service). "Potentially preventable readmissions" is an IRF's risk-adjusted rate of FFS Medicare patients who were readmitted to a hospital within 30 days of discharge from the IRF stay for a medical condition that might have been prevented. "Freestanding" and "hospital-based" designations reflect the IRF's Medicare provider number, with "hospital based" indicating a separately certified unit of another hospital. Lower rates of potentially preventable readmissions are better. The measure is calculated uniformly across post-acute care settings; providers with fewer than 25 stays or missing data were excluded, as were swing beds. Data cover 24 months (FY 2023 and FY 2024 combined).

Source: MedPAC analysis of claims-based outcome measures from CMS's Provider Data Catalog.

Potentially preventable readmissions

Readmissions expose beneficiaries to hospital-acquired infections, increase the number of transitions between settings (which is disruptive to patient care), and can result in medical error (Centers for Medicare & Medicaid Services 2016). In addition, they unnecessarily increase Medicare spending (Centers for Medicare & Medicaid Services 2023). IRFs can reduce the number of potentially preventable hospital readmissions by preventing complications, providing clear discharge instructions to patients and families, and ensuring a safe discharge plan. Potentially preventable readmissions after discharge are calculated as the percentage of patients discharged from an IRF stay who were readmitted to a hospital within 30 days for a medical condition that might have been prevented (lower percentages are better).

During the FY 2023 and FY 2024 period, the median facility-level risk-adjusted rate of potentially preventable readmissions was 9.2 percent, similar to the rate for FY 2022 and FY 2023, which was 8.8 percent (Figure 9-2; latter figure not shown). In the FY 2023 to FY 2024 period, about one-quarter of facilities had a risk-adjusted rate below 8.7 percent and one-quarter had a rate above 9.8 percent. The rate was higher (worse) among freestanding and for-

profit providers than for hospital-based and nonprofit providers, with the highest 25 percent of freestanding or for-profit providers having rates above 10 percent. The rate of potentially preventable readmissions was the same for urban and rural IRFs (data not shown).

Patient-experience data are not collected for IRF patients

Patient experience is an important measure of quality. Research finds that, across the health care system, improving patient experience correlates with better health outcomes and adherence to treatment plans (Boulding et al. 2011, Navarro et al. 2021).

CMS has developed a survey of patients' experience of IRF care for public use but is not requiring or collecting results through the Quality Reporting Program (Centers for Medicare & Medicaid Services 2025).[8] The Commission has recommended the general use of patient-experience surveys for PAC beneficiaries (Medicare Payment Advisory Commission 2022, Medicare Payment Advisory Commission 2018). Discussion in Chapter 14 of our March 2022 report to the Congress stated that CMS could explore using the IRF survey as a basis for uniform PAC patient-experience data (Medicare Payment Advisory Commission 2022). To implement the survey, CMS would need to develop patient-experience measures based on the survey responses and develop a process for third-party vendors to collect survey results.

Our set of IRF quality measures is limited by concerns about the validity of function data

Maintaining and improving functional status is a key outcome of PAC. IRFs assess and record information on each beneficiary's level of function at admission to and discharge from the IRF using the IRF-PAI. However, because provider-reported function data are used to assign stays to case-mix groups to adjust payment, the Commission and others have raised concerns about the validity of the provider-reported function data (see discussion in Chapter 6 of this report). In our June 2019 report to the Congress, the Commission discussed strategies to improve the functional-assessment data, the importance of monitoring the data reporting, and alternative measures of function (such as patient-reported surveys) that do not rely on provider-completed assessments (Medicare Payment Advisory Commission 2019). Options to improve the data could include conducting on-site or medical-record audits of providers with aberrant-appearing function data, requiring transferring hospitals to provide function data for patients at the time of transfer, or collecting patient-reported functional outcomes.

Freestanding IRFs' access to capital remained strong in 2024

In FY 2024, the all-payer total margin for freestanding IRFs increased to 11.6 percent, up from 10.4 percent in FY 2023.[9] However, the all-payer margin varied substantially by ownership. For-profit freestanding IRFs' all-payer total margin was about 14 percent in 2024, remaining steady over the last few years. In contrast, the all-payer margin for the small number of nonprofit freestanding IRFs continued to be much lower at 4 percent, an increase from 2 percent in 2023.

For-profit corporations continued to have sufficient access to capital to open new IRFs and expand existing IRFs. Almost all of the new IRFs that opened in FY 2024 were for profit. In calendar year (CY) 2024, the IRF industry's largest corporation, Encompass Health, which owned or operated about 42 percent of freestanding IRFs and accounted for about 34 percent of all FFS Medicare IRF stays, opened six new IRFs and one satellite with a combined total of 320 beds and added 107 beds to its existing IRFs (Encompass Health 2025a). Encompass Health's growth continued in 2025 when it added seven new hospitals with a combined total of 290 beds and a 50-bed satellite plus 190 beds to existing facilities. According to its latest investor report, the company has 12 additional IRFs under development (Encompass Health 2025b).

Two-thirds of IRFs are hospital-based units that access any necessary capital through their parent hospitals to maintain, modernize, or expand. Overall, as detailed in the hospital chapter of this report (Chapter 3), ACHs' access to capital generally improved in FY 2024. The all-payer operating margin for hospitals paid under the inpatient prospective payment systems increased to 6.5 percent in 2024, up from 5.2 percent in 2023, despite a decline in coronavirus relief funds. (See the text box in Chapter 2 on the different margin measures that MedPAC uses to assess provider profitability.) In addition, investment income for these hospitals

increased. Hospitals' borrowing costs held stable in 2024, and investors' risk premium on hospitals decreased slightly.

Medicare payments and providers' costs: IRFs' FFS Medicare margin increased in 2024

In FY 2024, IRFs' FFS Medicare payments per stay grew faster than IRFs' costs per stay. As a result, IRFs' FFS Medicare margin increased to 17.1 percent (Table 9-4, p. 286). Margins continued to vary widely across categories of IRFs, with higher margins for IRFs that were freestanding, for profit, urban, larger, or that had a higher FFS Medicare share of days. (See the text box in Chapter 2 on the different margin measures that MedPAC uses to assess provider profitability.)

In 2024, FFS Medicare payments per stay increased more than IRFs' costs per stay

Among IRFs delivering care in cost-reporting periods FY 2023 and FY 2024, FFS Medicare payments per stay increased more than IRFs' costs per stay, with IRF PPS payments per stay rising 3.4 percent in FY 2024, while IRFs' costs per stay rose just 0.6 percent. Growth in cost per stay was higher among freestanding IRFs (2.1 percent) compared to hospital-based IRFs (1.1 percent). At the same time, growth in payments per stay was lower among freestanding IRFs (3.0 percent) compared with hospital-based IRFs (4.7 percent).

IRFs' FFS Medicare margin increased but continued to vary widely

In FY 2024, IRFs' FFS Medicare margin increased to 17.1 percent, up from 14.8 percent in FY 2023 (Table 9-4, p. 286). The FFS Medicare margin varied widely across IRFs, with the facility at the 25th percentile having a margin of −6.3 percent and the facility at the 75th percentile having a margin of 24.9 percent (data not shown).

The FFS Medicare margin increased for nearly all categories of IRFs we examined, though significant variation in margins persisted (Table 9-4, p. 286):

- *Freestanding IRFs continued to have a higher FFS Medicare margin than hospital-based IRFs.* Freestanding IRFs' FFS Medicare margin was 25.0 percent in FY 2024, slightly above the level in FY 2023 and FY 2019. In comparison, hospital-based IRFs' FFS Medicare margin was 4.1 percent, much lower than the margin among freestanding IRFs but a notable increase from 0.6 percent in 2023 and 1.3 percent in 2019. As discussed above, this increase was driven by low growth in costs per stay and higher growth in payments per stay. As discussed below, numerous factors contribute to the lower FFS Medicare margin among hospital-based IRFs than among freestanding IRFs.

- *For-profit IRFs continued to have a higher FFS Medicare margin than nonprofit IRFs.* In FY 2024, the FFS Medicare margin continued to be higher for IRFs that were for profit (24.6 percent) than for IRFs that were nonprofit (2.9 percent). This spread in margin across ownership is similar to the margins of freestanding versus hospital-based facilities, reflecting that for-profit IRFs are more likely to be freestanding while nonprofit IRFs are more likely to be hospital based.

- *Larger IRFs continued to have higher FFS Medicare margins.* The FFS Medicare margin continued to be higher for IRFs with more beds, indicating economies of scale. Notably, in FY 2024, the FFS Medicare margin among IRFs with less than 10 beds was -4.9 percent, negative but higher than in FY 2019. These IRFs tended to be hospital-based with low occupancy rates (about 57 percent compared to the overall average occupancy rate of 71 percent in FY 2024).

- *More FFS Medicare-dependent IRFs continued to have higher FFS Medicare margins.* In FY 2024, the FFS Medicare margin was higher among IRFs for which FFS Medicare beneficiaries constituted over three-quarters of their inpatient days (22.1 percent) than among IRFs for which FFS Medicare beneficiaries constituted less than half of their inpatient days (10.2 percent).

- *IRFs that treated a smaller share of beneficiaries with low income continued to have higher FFS Medicare margins.* Like the disproportionate-share-hospital adjustment for acute care hospitals paid under the inpatient PPS, IRFs receive low-income-patient (LIP) payments that are intended to offset costs incurred by treating a large or disproportionate share of low-income patients. Nevertheless, in FY 2024, the FFS Medicare margin was substantially

TABLE 9–4

IRFs' FFS Medicare margin increased in FY 2024, and substantial variation across IRFs persisted

IRF category	2019	2020	2021	2022	2023	2024
All	14.1%	13.5%	16.7%	13.7%	14.8%	17.1%
Type						
Freestanding	24.7	23.6	25.7	23.0	24.3	25.0
Hospital based	1.3	1.5	5.2	0.9	0.6	4.1
Ownership						
For profit	24.2	23.6	25.2	22.4	23.5	24.6
Nonprofit	0.7	–0.3	4.6	–0.1	–0.2	2.9
Geography						
Urban	14.5	13.8	17.0	14.1	15.0	17.3
Rural	7.3	8.5	11.7	7.7	10.6	12.5
Number of beds						
1 to 10	–9.6	–6.2	–3.3	–7.0	–6.4	–4.9
11 to 24	1.3	2.0	5.0	0.8	1.1	5.1
25 to 64	15.9	15.6	18.6	15.3	16.4	18.6
65 or more	21.0	18.6	21.9	19.4	20.5	22.0
FFS Medicare share of days						
<50%	4.0	6.3	11.4	7.0	7.0	10.2
50% to 75%	16.2	16.5	20.0	17.6	19.1	20.8
>75%	22.4	20.3	20.5	21.7	21.8	22.1
Low-income patient share						
0% to 5%	18.2	15.7	20.0	16.8	18.4	21.3
5% to 10%	18.3	18.8	20.1	18.1	18.3	22.2
10% to 15%	13.7	12.6	16.9	13.8	14.5	14.3
15% to 20%	15.3	14.9	16.6	12.6	14.7	15.0
20% to 25%	2.3	8.3	14.1	6.6	12.5	12.7
25% or more	5.9	5.0	9.6	10.0	5.5	5.4

Note: IRF (inpatient rehabilitation facility), FFS (fee-for-service), FY (fiscal year). "FFS Medicare margin" is calculated based on revenue and costs for services included under the IRF prospective payment system. Government-owned IRFs operate in a different financial context from other IRFs, so their margin is not necessarily comparable; therefore, data for government-owned IRFs are not reported separately or included in the ownership rows (but are included in other rows). "Freestanding" and "hospital based" designations reflect the IRF's Medicare provider number, with "hospital based" indicating a separately certified unit of another hospital. "Urban" refers to metropolitan counties, which contain an urban cluster of 50,000 or more people; all other counties are classified as "rural." "Low-income patient share" was calculated as the sum of two ratios: the share of all Medicare days devoted to patients on Supplemental Security Income plus the share of Medicaid days out of all inpatient days.

Source: MedPAC analysis of IRF cost-report data.

higher among IRFs with an LIP share of less than 5 percent (21.3 percent) than among IRFs with an LIP share of 25 percent or more (5.4 percent).

Numerous factors contribute to lower margins in hospital-based IRFs

The Commission has long noted the substantial difference between freestanding and hospital-based

IRFs' FFS Medicare margins. Several factors are likely to contribute to this difference:

- *Higher costs per stay in hospital-based IRFs:* In FY 2024, average cost per stay was $25,000 for hospital-based IRFs compared with $18,000 for freestanding IRFs. Although, on average, both routine and ancillary costs per stay were higher among hospital-based IRFs, routine costs per stay were substantially higher among hospital-based IRFs than freestanding IRFs. The amount of hospital-based IRFs routine costs per stay (such as room and board) may depend, to some extent, on how parent hospitals allocate their overall routine costs to their IRF subunits; on the other hand, routine costs at freestanding IRFs would be directly related to IRF services rather than including costs allocated from the parent hospital. In addition, higher costs at hospital-based IRFs can result, in part, from a relative lack of economies of scale because these facilities tend to be smaller (67 percent had fewer than 25 beds compared to 5 percent for freestanding IRFs) and have a lower occupancy rate (67 percent compared to 74 percent for freestanding IRFs).

- *Differences in patient mix not accounted for by the payment system:* As noted previously, there are also marked differences in hospital-based and freestanding IRFs' mix of stays. In FY 2024, compared with freestanding IRFs, hospital-based IRFs admitted a smaller share of patients with a diagnosis in the other neurological conditions category and a larger share of patients with stroke as the primary reason for rehabilitation (Table 9-3, p. 281). The Commission previously reported on profitability differences among different types of stays: Notably, stays for beneficiaries diagnosed with other neurological conditions were among the most profitable, with payments in aggregate exceeding costs by 26 percent in 2019 (Medicare Payment Advisory Commission 2024). By contrast, stays for beneficiaries diagnosed with a stroke were among the least profitable case types in IRFs. As we noted in our March 2024 report, using an alternative method to set payment weights in the IRF PPS would yield more uniform profitability across case-mix groups (Medicare Payment Advisory Commission 2024). This change could also help to reduce providers' incentives to code patients as more functionally impaired (thereby increasing case-mix severity and payment rates). The Commission has previously reported findings that were suggestive of such differential coding between freestanding and hospital-based IRFs (Medicare Payment Advisory Commission 2016). We will continue to monitor the variation in performance.

- *Differential prevalence of outlier stays:* Hospital-based IRFs' higher costs and patient mix may contribute to their increased likelihood of outlier stays, which are stays with extraordinarily high costs. In FY 2024, hospital-based IRFs accounted for about 36 percent of FFS stays but 78 percent of high-cost outlier stays. Although outlier payments diminish the financial loss per outlier stay, by design, outlier payments do not completely cover facilities' costs. Since outlier payments cover only a portion of the excess costs, having more outliers has the potential to lower margins.

In FY 2024, the FFS Medicare margin among hospital-based IRFs was about 4 percent, which is substantially higher than the FFS Medicare margin we report for ACHs (–12.1 percent, as reported in Chapter 3). ACHs can discharge eligible patients to their hospital-based IRF subunits, enabling the hospital to open beds to additional acute care patients. Indeed, the FFS margin among ACHs with IRF subunits is slightly higher than the margin among ACHs without IRF subunits.

IRFs' FFS Medicare margin is projected to increase slightly in 2026

We estimate that IRFs' FFS Medicare margin in FY 2026 will be about 18 percent, a slight increase from 17.1 percent in FY 2024. To make this projection, the Commission considered the relationship between FFS Medicare payments and IRFs' costs in 2024 as a starting point and then applied policy changes effective in 2025 and 2026 and estimated changes in costs.

In FY 2025 and FY 2026, IRF payment-rate changes included:

- a regulatory update of 3.0 percent in FY 2025, based on an IRF market basket increase of 3.5 percent and an offsetting total productivity adjustment of 0.5 percentage points; and

- a regulatory update of 2.6 percent in FY 2026, based on an IRF market basket increase of 3.3 percent and an offsetting total productivity adjustment of 0.7 percentage points.

Based on recent cost patterns, we estimate slightly lower increases in IRFs' cost per stay. Specifically, because the industry's costs have continued to normalize after the faster cost growth during the coronavirus pandemic, we used a three-year historical average of cost growth equal to about 2 percent.

Like all projections, ours is subject to uncertainty. The projection is especially sensitive to the uncertainties of estimating costs, whereas the payment updates have been set.

How should FFS Medicare payments change in 2027?

Under current law, Medicare's IRF PPS base payment rate is increased annually based on the projected increase in the IRF market basket, less an amount for productivity improvement. The final update for FY 2027 will not be set until summer 2026; however, using CMS's third-quarter 2025 projections of the market basket and productivity, the update would increase the IRF PPS base payment rate by 2.3 percentage points.

RECOMMENDATION 9

For fiscal year 2027, the Congress should reduce the 2026 Medicare base payment rate for inpatient rehabilitation facilities by 7 percent.

RATIONALE 9

The payment-adequacy indicators for Medicare IRF services were generally positive and show that FFS Medicare payments continue to substantially exceed costs, as they have for many years. IRFs continued to have available capacity in aggregate, and the number of IRFs was relatively stable. Notably, the number of IRF stays per FFS Medicare beneficiary increased substantially in FY 2024. Our measures of quality of care were relatively stable. IRFs' access to capital improved: Freestanding IRFs' all-payer total margin increased, as did the all-payer margin of hospital-based IRFs' parent hospitals. IRFs' FFS Medicare margin rose more than 2 percentage points to 17.1 percent in FY 2024, and we project that it will increase to about 18 percent in FY 2026. The high FFS Medicare margin indicates that the IRF PPS exerts too little pressure on providers to control costs. A 7 percent reduction to 2026 IRF PPS payment rates—the same reduction we recommended last year—would continue to provide IRFs with sufficient revenue to maintain FFS Medicare beneficiaries' access to IRF care while bringing IRF PPS payment rates closer to the cost of efficiently delivering high-quality care.

IMPLICATIONS 9

Spending

- This recommendation would lower spending relative to current law by between $2 billion and $5 billion in one year and by between $10 billion and $25 billion over five years.

Beneficiary and provider

- We do not expect this recommendation to have an adverse effect on Medicare beneficiaries' access to care or out-of-pocket spending. Given the current level of payments, we do not expect the recommendation to affect providers' willingness or ability to care for Medicare beneficiaries, though financial pressure may increase for some providers. ■

Endnotes

1 In markets without IRFs, beneficiaries who need skilled nursing care or therapy services on an inpatient basis can be admitted to skilled nursing facilities, which have less extensive requirements regarding the amount of therapy and the frequency and level of medical supervision that their patients must receive.

2 A more detailed description of FFS Medicare's IRF PPS can be found in our *Payment Basics* series at https://www.medpac.gov/document-type/payment-basic/page/2/.

3 Among freestanding IRFs in FY 2024, about 49 percent of all payments were for FFS Medicare patients. The FFS Medicare share of total IRF payments could not be calculated for hospital-based IRFs due to data limitations on the cost reports.

4 The 13 conditions are stroke; spinal cord injury; congenital deformity; amputation; major multiple trauma; hip fracture; brain injury; certain other neurological conditions (including multiple sclerosis, Parkinson's disease, cerebral palsy, and neuromuscular disorders); burns; three arthritis conditions that have not improved after the patient has participated in an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings but have the potential to improve with more intensive rehabilitation; 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. In fiscal years 2014, 2015, and 2018, CMS updated its lists of codes from the International Classification of Diseases, 10th Revision, Clinical Modification, replacing certain general codes (such as the arthritis codes) with more specific ones for patients who would be likely to require intensive rehabilitation therapy. The updated diagnosis codes are listed in https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-rehabilitation/rules-related-files/cms-1781-f and open Presumptive Compliance-3_FY 2024-ICD-10code update_final_09062023.

5 In FY 2024, there were about 23,000 beds in freestanding IRFs and about 19,000 beds in hospital-based IRFs.

6 HSAs are local health care markets for hospital care. An HSA is a collection of ZIP codes in which Medicare residents receive most of their hospitalizations from hospitals in that area. See https://www.dartmouthatlas.org.

7 For this measure, "community" is defined as home/self-care, with or without home health services, based on Patient Discharge Status Codes 01, 06, 81, and 86 on the FFS Medicare claim.

8 As discussed in Chapter 6 of this report, CMS has solicited comments on IRF patient-experience/patient-satisfaction measures and received mixed support, including concerns about the administrative and financial costs associated with data collection (Centers for Medicare & Medicaid Services 2023b). An industry stakeholder commented that the number of survey responses required for reliable results would be problematic for most IRFs (Encompass Health 2024).

9 Hospital cost reports do not require hospitals to report the components needed to calculate an all-payer margin specifically for their IRFs or other hospital-based units.

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