Assessing payment adequacy and updating payments: Inpatient rehabilitation facility services

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Inpatient rehabilitation facilities (IRFs)

- Provide intensive rehabilitation
- Medicare spending: $7.4 billion in 2015
  - Facilities = 1,180
  - Cases = 381,000
  - Mean payment per case = $19,100
- Per case payments vary by condition, level of impairment, age, and comorbidity; adjusted for:
  - Rural location, teaching status, low-income share, short stays
  - Outlier payments for extraordinarily costly patients

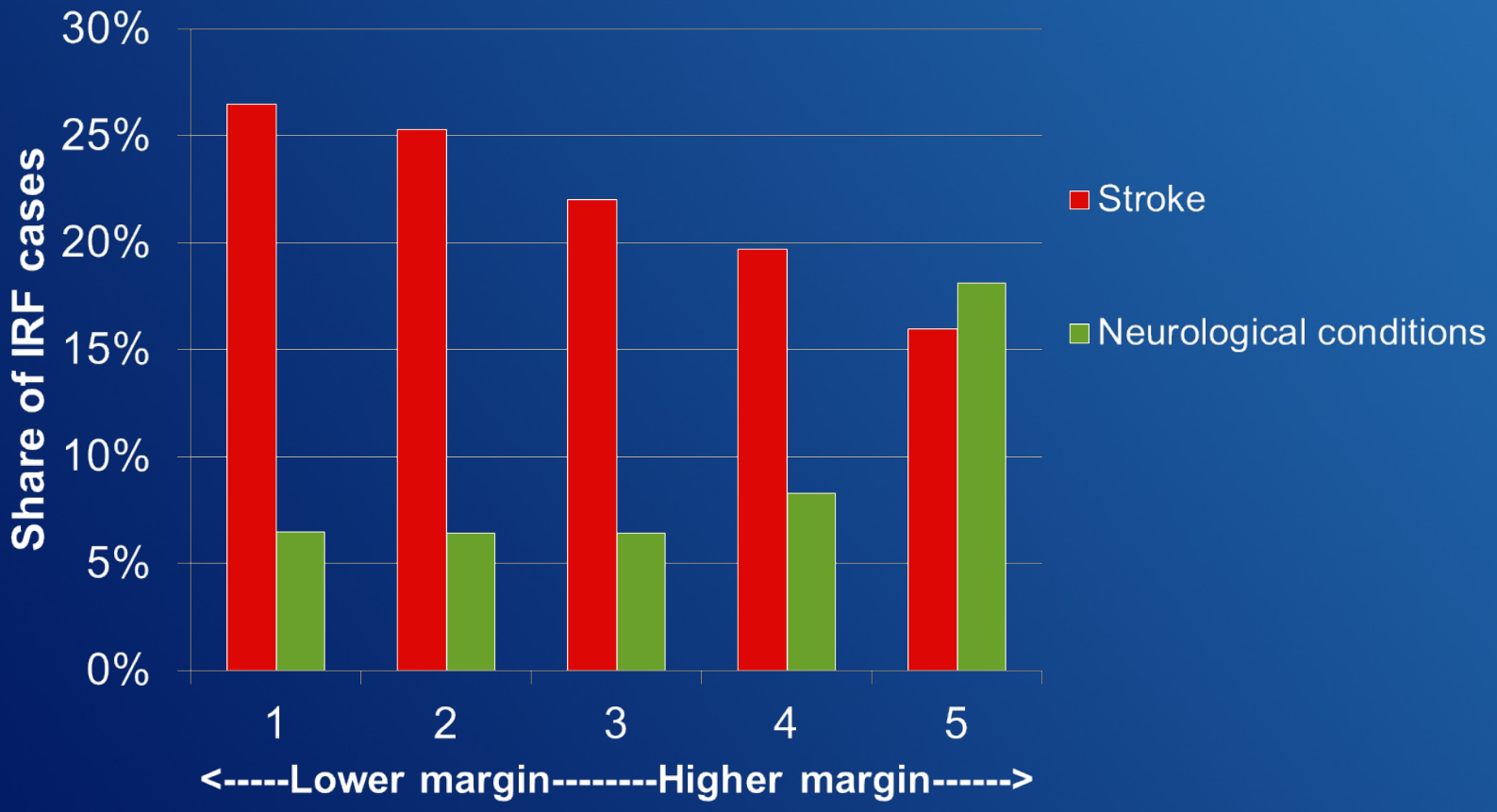
IRF criteria

- IRFs must
  - Meet the conditions of participation for acute-care hospitals
  - Have a medical director of rehabilitation
  - Meet the compliance threshold (60 percent rule)
    - Volume and patient mix sensitive to policy changes
- Patients must
  - Tolerate and benefit from 3 hours of therapy per day
  - Require at least two types of therapy

Concerns about IRF PPS

- High-margin IRFs have a different mix of cases
- Patient assessment may not be uniform across IRFs

High-margin IRFs have a different mix of cases



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

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

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High-margin IRFs have a different mix of cases, cont.

In the highest-margin IRFs:

- Stroke cases were more than 2 times more likely to have no paralysis
- Neurological cases were almost 3 times more likely to have neuromuscular disorders (e.g., ALS, muscular dystrophy)

In addition to neuromuscular disorders, neurological cases include multiple sclerosis, Parkinson's disease, and polyneuropathy.

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

Patient assessment may not be uniform across IRFs

- Patients in high-margin IRFs were *less* severely ill during preceding acute care hospital stay:
  - Lower hospital case mix and severity of illness
  - Less likely to spend time in ICU/CCU
  - Less likely to be high-cost outliers in hospital
- but appeared to be *more* impaired during IRF stay
  - Lower motor and cognition scores, which increased payment
- ➢ At any level of severity in the hospital, high-margin IRFs consistently coded higher impairment

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

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

	Motor score	
Type of stroke	**Quintile 1 (Lowest margin)**	**Quintile 5 (Highest margin)**
With paralysis	29.2	24.6
Without paralysis	35.3	29.0

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

Previous MedPAC recommendations

- The Secretary should conduct focused medical record review of inpatient rehabilitation facilities that have unusual patterns of case mix and coding

- The Secretary should expand the inpatient rehabilitation facility outlier pool to redistribute payments more equitably across cases and providers

Payment adequacy framework

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

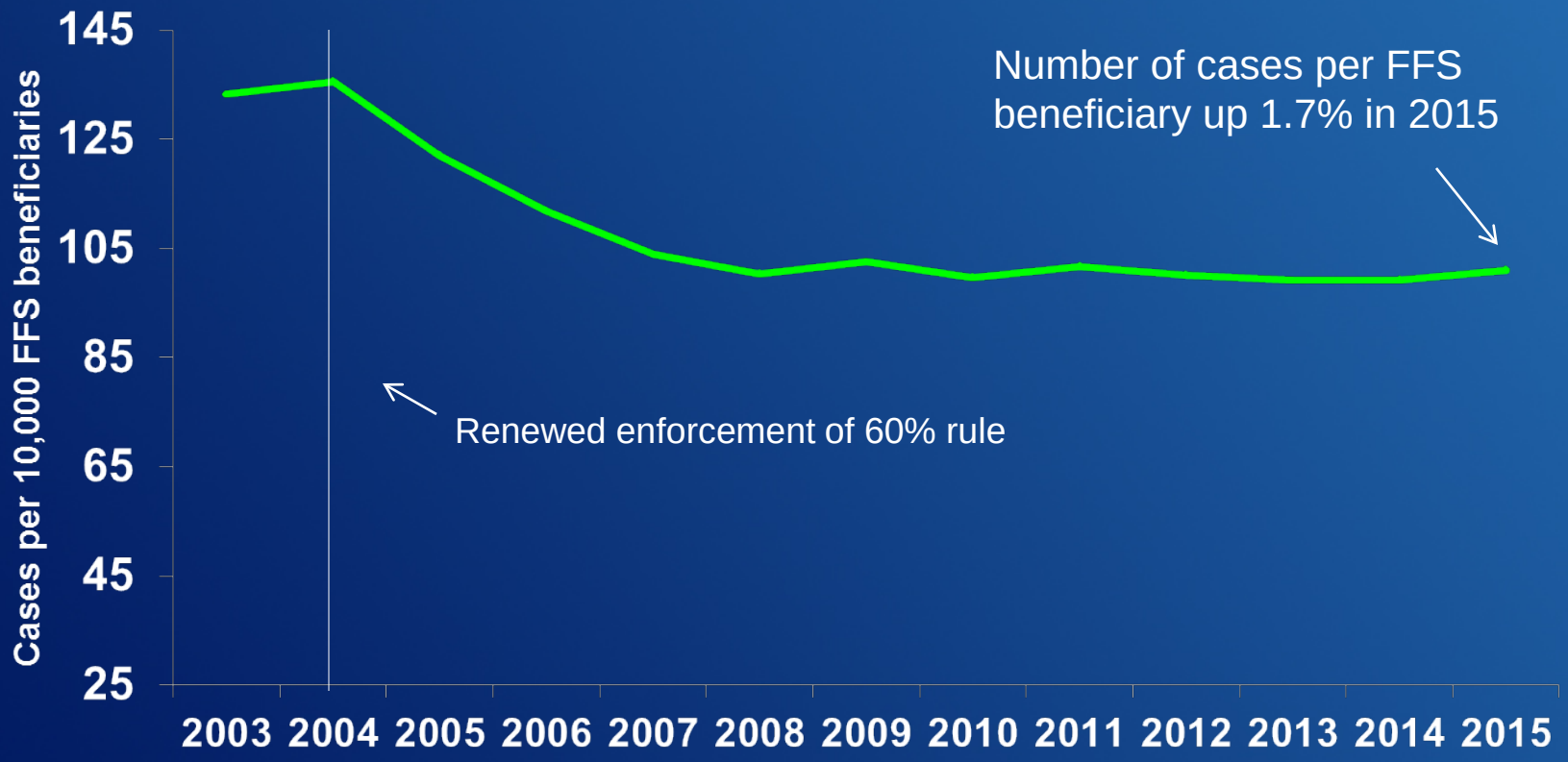
IRF supply remained fairly steady in 2015; share of for-profits continued to increase

			Average annual change in number of facilities	
	Facilities	Cases	2006-2013	2013-2015
All IRFs	1,182	381,000	-0.8%	0.9%
Freestanding	22%	48%	1.6%	3.8%
Hospital-based	78%	52%	-1.3%	0.1%
Nonprofit	58%	42%	-1.6%	0.3%
For-profit	30%	50%	1.1%	4.6%
Government	12%	7%	-1.1%	-5.6%

- Average occupancy rate: 65%

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

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



Results are preliminary and subject to change.

Source: MedPAC analysis of MedPAR data from CMS.

Quality: Improvement since 2011 on most measures

Risk-adjusted measure	2011	2015
Gain in motor function	22.3	23.8
Gain in cognitive function	3.6	3.9
Discharged to community	74.0%	76.0%
Discharged to SNF	6.9%	6.8%
Potentially avoidable rehospitalizations		
During IRF stay	2.9%	2.4%
Within 30 days after discharge from IRF	5.0%	4.2%

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

Access to capital appears adequate

- Hospital-based units
  - Access capital through their parent institutions
  - Hospitals maintain strong access to capital markets
- Freestanding facilities
  - Almost half owned by one company
    - Access to capital appears very good; acquisitions and construction reflect positive financial health
  - Little information available for others

➢ Post-acute care companies continue to pursue vertical integration

IRF Medicare margins, 2015

	% of IRFs	% of cases	Margin
All IRFs	100%	100%	13.9%
Freestanding	22%	48%	26.7%
Hospital-based	78%	52%	2.0%
Nonprofit	57%	42%	3.6%
For-profit	30%	50%	25.0%

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

Source: MedPAC analysis of Medicare cost report data from CMS.

Factors that affect the margins of hospital-based IRFs

- Tend to be smaller with lower occupancy
  - 65% have fewer than 25 beds
- Majority are nonprofit; may be less focused on cost control
  - From 1999-2015, costs up 61% vs. 24% in freestanding
- May provide more therapy and use higher-cost modalities

➢ Marginal profit for hospital-based IRFs = 20.5%

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

Summary

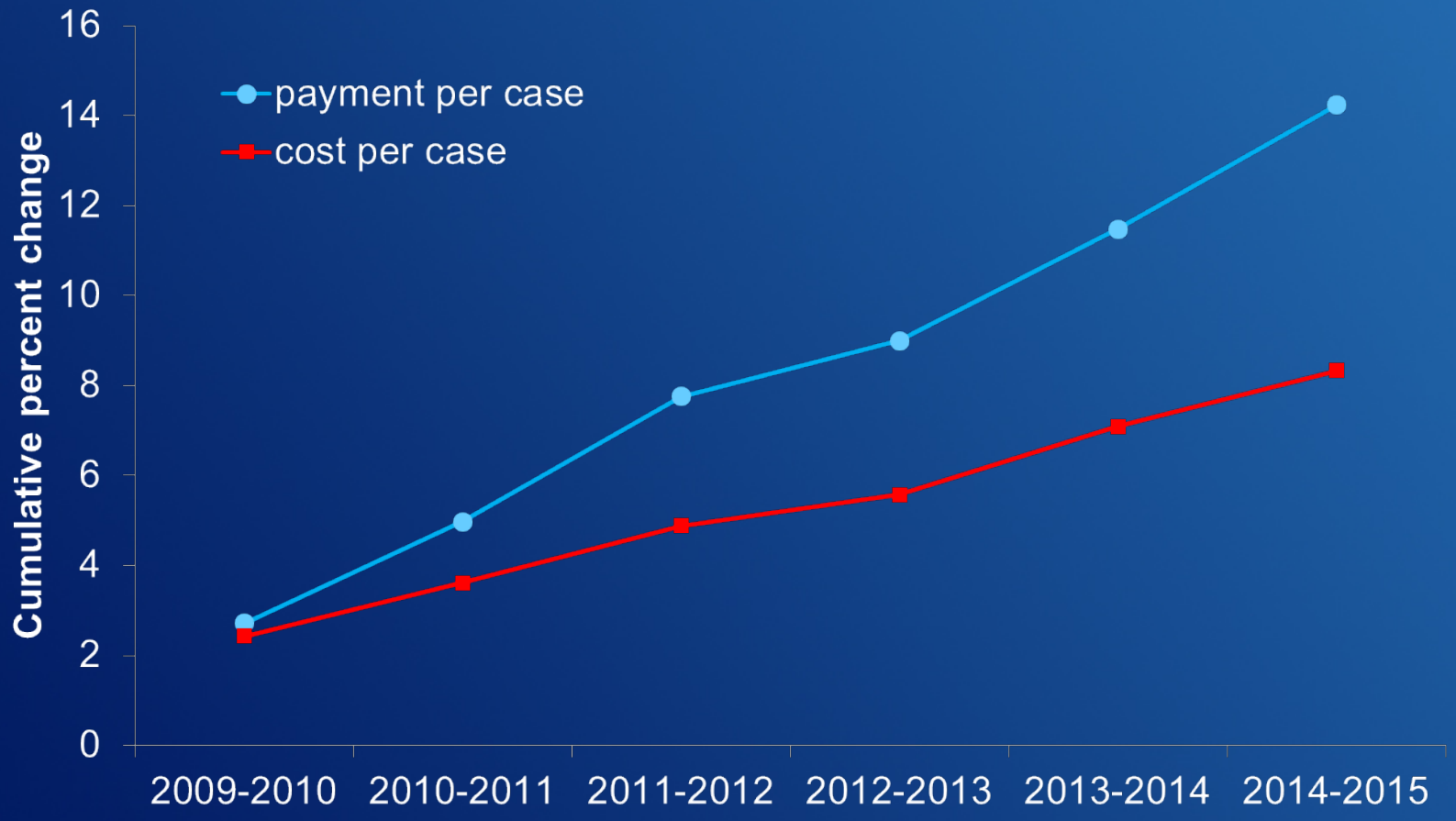
- Access: Capacity appears adequate to meet demand
- Quality: Risk-adjusted outcome measures stable or improved since 2011
- Access to capital: Appears adequate
- 2015 estimated margin: 13.9%
- 2015 estimated marginal profit:
  - Hospital-based = 20.5%
  - Freestanding = 41.5%

Results are preliminary and subject to change.

How should Medicare payments to IRFs change in 2018?

- MedPAC has recommended no payment increase every year since FY2009
- CMS is required to increase payments by adjusted market basket
- Growth in costs per case since 2009 has been low
- Payments to IRFs now substantially exceed the costs of caring for beneficiaries

Payment growth has outpaced cost growth since 2009



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Source: MedPAC analysis of Medicare cost report data from CMS.