



Advising the Congress on Medicare issues

Assessing payment adequacy: Inpatient rehabilitation facility services

Christine Aguiar and Craig Lisk
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Inpatient rehabilitation facilities

- Provide intensive rehabilitation
- IRFs are hospital-based (80%) or freestanding (20%)
- Medicare FFS is largest payer
 - 60% of IRF cases
 - \$6.32 billion in expenditures (2010)
- IRF PPS established in 2002 (BBA)
- Must meet coverage criteria and compliance threshold

Assessing adequacy of IRF payments

- Access to care
 - Supply of facilities, number of rehabilitation beds, and occupancy rates
 - Volume of services
- Quality of care
- Access to capital
- Payments and costs

IRF capacity and supply are relatively stable in 2010

	2008	2009	2010	Annual change '08-'09	Annual change '09-'10
Number of beds					
All IRFs	35,762	35,767	35,440	0%	-0.9%
Hospital-based	22,670	22,267	21,907	-1.8%	-1.6%
Freestanding	13,092	13,500	13,533	3.1%	0.2%
Occupancy rates					
				% point change	% point change
All IRFs	62.1%	62.9%	62.4%	0.7	-0.5
Hospital-based	59.8%	60.2%	59.4%	0.4	-0.8
Freestanding	66.1%	67.3%	67.2%	1.2	-0.1

Note: Data is preliminary and subject to change

Source: Medicare hospital cost report data from CMS

Volume remains relatively stable in 2010

	2008	2009	2010	Annual change '08-'09	Annual change '09-'10
FFS Spending (\$ billions)	\$5.95	\$6.03	\$6.32	+1.3%	+4.8%
Number of cases	356,000	364,000	359,000	+2.2%	-1.3%
Payment per case	\$16,646	\$16,552	\$17,085	-0.6%	+3.2%

Note: Data is preliminary and subject to change

Source: CMS Office of the Actuary (FFS spending), MedPAC analysis of Medicare MEDPAR from CMS (number of cases and payment per case)

Small improvement in risk-adjusted quality since 2004

	FIM gain	Discharge to community	Discharge to acute hospital	Hospital readmission within 30 days after discharge to community	SNF admission within 30 days after discharge to community
Preliminary risk-adjusted estimates					
2004	25.3	77.8%	8.7%	10.8%	3.1%
2006	26.3	78.1%	7.6%	9.7%	2.9%
2008	27.2	78.4%	7.6%	9.4%	2.9%
2009	27.9	78.9%	7.2%	9.3%	2.9%

Note: Data is preliminary and subject to change. Estimates developed from risk-adjustment models and by holding the 2004 Medicare IRF patient cohort constant through 2009.

Access to capital appears adequate

- Hospital-based units
 - Access capital through their parent institutions
- One major freestanding IRF chain
 - Cost of accessing capital under equity and debt markets increased in 2011; however able to access capital markets because of positive revenue growth

Note: Data is preliminary and subject to change

Medicare margins increased in 2010, but vary by type of facility

	Percent of spending	2008 margins	2009 margins	2010 margins
All	100%	9.5%	8.4%	8.8%
Hospital-based	58.4%	4.1%	0.4%	-0.2%
Freestanding	41.6%	18.2%	20.3%	21.4%
Bed size				
1-10	2.5%	-5.0%	-11.6%	-10.9%
11-21	19.6%	0.7%	-2.6%	-3.2%
22-59	40.9%	8.5%	6.6%	7.0%
60+	36.9%	17.1%	18.3%	18.5%

Note: Data is preliminary and subject to change

Source: MedPAC analysis of Medicare hospital cost reports from CMS

Characteristics of hospital-based IRFs

- 80% of facilities, but 57.8% of Medicare IRF discharges
- Tend to be smaller facilities
 - More than half have less than 21 beds
- Higher costs than freestanding IRFs
 - 30% higher direct costs per case; 11% higher indirect costs per case
- Are able to cover their direct costs
 - 2010 direct cost margin: 34.4%

Note: Data is preliminary and subject to change

Policy changes for modeling 2012 margins

	<u>2010</u>	<u>Estimated 2012</u>
All IRFs' margin:	8.8 %	8.0%

- 2011: Market basket minus 0.25% (PPACA) and outlier adjustment (CMS)
- 2012: Market basket plus outlier adjustment (CMS); minus 0.1% (PPACA), minus 1.0% for productivity (PPACA)

Note: Data is preliminary and subject to change

Summary

- Beneficiary access
 - Supply, capacity, and volume are relatively stable in 2010
- Small improvement in risk-adjusted quality since 2004
- Access to credit appears to be adequate
- 2010 margin is 8.8%
- 2012 projected margin is 8.0%

Note: Data is preliminary and subject to change



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