SECTION 3C

Inpatient rehabilitation facility services

R E C O M M E N D A T I O N

The Congress should update payment rates for inpatient rehabilitation facility services by 1 percent for fiscal year 2008.

COMMISSIONER VOTES: YES 14 • NO 0 • NOT VOTING 0 • ABSENT 3

SECTION 3C

Inpatient rehabilitation facility services

Section summary

In this section, we present information on providers of intensive rehabilitation services—such as physical, occupational, and speech therapy—in an inpatient setting. Beneficiaries generally must be able to tolerate and benefit from three hours of therapy per day to be eligible for treatment in a rehabilitation hospital or unit, also called an inpatient rehabilitation facility (IRF). Medicare, the principal payer for IRF services, accounts for about 70 percent of discharges. Medicare payments to IRFs were $6.4 billion in 2005.

After the cost-based payment system ended and the per case prospective payment system (PPS) began in 2002, the number of facilities, volume of cases, and payments grew while costs per case declined. In 2004, CMS modified the 75 percent rule, which required that 75 percent of IRF admissions have one or more conditions from a specified list. Enforcement of this modified policy is the main reason the volume of patients admitted to IRFs declined in 2005 and 2006.

In this section

- What is inpatient rehabilitation facility care and where is it provided?
- Are Medicare payments adequate in 2007?
- How should Medicare payments change in 2008?
- Update recommendation

We have a mix of data for examining payment adequacy. Some data are available through 2005, the first full year of the transition to the revised 75 percent rule. Patient assessment data provide a preliminary picture of 2006, the second year of the phase-in of the revised rule.

Supply of facilities—The supply of IRFs increased after implementation of the PPS at 1.6 percent per year from 2002 to 2004, but it remained stable in 2005 (increasing by 4 facilities to a total of 1,231). Rural IRFs, however, have had a different trend: Their number increased rapidly under PPS, consistent with the rural adjustment of about 20 percent included in the PPS payment. From 2002 to 2004, the number of rural IRFs increased by more than 4 percent per year and then grew at almost double that rate from 2004 to 2005. For-profit IRFs also have had a different growth trend. The number of for-profit IRFs grew at a faster pace than the number of nonprofit IRFs after implementation of the PPS, with even faster growth from 2004 to 2005 when for-profit IRFs grew at 3.7 percent per year compared with –1 percent for nonprofit IRFs.

Volume of services and beneficiaries' access to care—The number of IRF cases increased rapidly after introduction of the PPS (by 6 percent from 2002 to 2004), but the number of cases decreased (by 10 percent from 2004 to 2005) as the 75 percent rule started to be phased in. Medicare spending increased at almost 16 percent per year from 2002 to 2004 and decreased by 3 percent from 2004 to 2005. The patients still treated by IRFs in 2005 were more complex than those who shifted to alternative settings. From 2004 to 2005, IRFs experienced a 6 percent increase in case-mix index (CMI). These changes are consistent with the first year of the revised 75 percent rule and IRFs admitting more cases compliant with it. Noncompliant cases have much lower relative weights (0.93) than compliant cases (1.34) (eRehabData® 2006). We have no direct measures of beneficiaries' access to care, but an indirect measure of access, the number of beneficiaries who used IRFs, increased by almost 7 percent annually from 2002 to 2004 and then decreased by 9 percent from 2004 to 2005. If patients who

need intensive rehabilitation are getting it and achieving good outcomes somewhere else, the drop in volume may not be an access issue.

Quality—Between 2004 and 2006, quality indicators for all IRF patients and for those who were discharged home improved slightly. Our quality indicator for IRFs is the number of points gained on a scale of patients' ability to function between admission and discharge. All patients improved from 22.9 points gained in 2004 to 23.4 points in 2006, an improvement of about 2 percent. Patients discharged home improved their scores from 25.9 points gained in 2004 to 26.9 points in 2006, an improvement of almost 4 percent over the same years.

Access to capital— Hospital-based units represent more than 80 percent of IRFs. They access capital through their parent institutions, which have good access as we discuss in Chapter 2A. Freestanding IRFs also appear to have access to capital; a new chain of freestanding IRFs has raised capital from private equity firms.

Payments and costs—With the introduction of the IRF PPS in 2002, payments per case rose rapidly and growth in costs per case remained low in both 2002 and 2003. Implementation of the revised 75 percent rule resulted in the growth in costs per case accelerating between 2004 and 2005 at 10.1 percent as CMI increased and the volume of cases declined. The increase in the CMI and consequent increase in costs are primarily due to a decrease in the volume of less intensive cases in IRFs.

We estimate that the aggregate Medicare margin for 2005 is 13.0 percent. The IRFs at the 25th percentile have a margin of –4 percent and those at the 75th percentile have a margin of 22 percent in 2005. For-profit IRFs have a margin twice that of nonprofits. We estimate that margins in 2007 will be 2.7 percent, largely because of the effect of the 75 percent rule. If we vary our assumptions about growth in per case costs in response to the 75 percent rule, the margin will range between 0.5 percent and 5.5 percent.

Our recommendation strikes a balance between two considerations. On the one hand, the 75 percent rule is dramatic in its effect on volume and in the consequences if IRFs do not meet it. On the other hand, in the past IRFs benefited from poor enforcement of the rule and the industry has not yet restructured costs to reflect the changes in volume. If IRFs are able to control their costs to compensate for the drop in volume, their 2007 margins could be as high as 5.5 percent, which would allow them to accommodate growth in cost with a 1 percent update. Therefore, we recommend that the Congress update payment rates for IRFs for 2008 by 1 percent. ■

Recommendation 3C

The Congress should update payment rates for inpatient rehabilitation facility services by 1 percent for fiscal year 2008.

COMMISSIONER VOTES:
YES 14 • NO 0 • NOT VOTING 0 • ABSENT 3

What is inpatient rehabilitation facility care and where is it provided?

After an illness, injury, or surgery, some patients receive intensive rehabilitation services—such as physical, occupational, or speech therapy—in an inpatient setting. Relatively few Medicare beneficiaries use intensive rehabilitation therapy because they generally must be able to tolerate and benefit from three hours of therapy per day to be eligible for treatment in an inpatient rehabilitation facility (IRF). IRFs may be freestanding hospitals or specialized, hospital-based units.

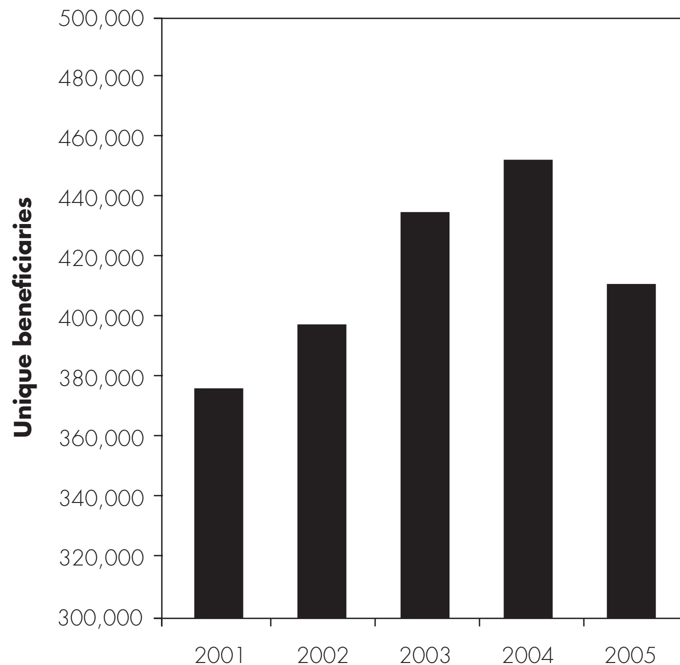
Medicare, the principal payer for IRF services, accounts for about 70 percent of discharges. About 410,000 beneficiaries received care in IRFs in 2005 (Figure 3C-1), with Medicare paying $6.4 billion (Table 3C-1, p. 206).

The most common rehabilitation conditions for Medicare beneficiaries for 2004 to 2006 are shown in Table 3C-2, p. 206. The revised 75 percent rule (discussed in the text box, p. 208) already has affected the distribution of IRF diagnoses as well as the volume of cases. The most frequent rehabilitation diagnosis changed from major joint replacement in 2004 to stroke in 2006. In 2004, stroke patients made up almost 17 percent of IRF cases; by 2006, they made up about 20 percent, although the absolute number of stroke patients declined. In contrast, in 2004 major joint replacement patients made up almost 25 percent of IRF cases; by 2006, these patients made up about 18 percent. In 1996, major joint replacements made up about one-fourth of IRF cases (MedPAC 1998).

To qualify as an IRF for Medicare payment, facilities must meet the Medicare conditions of participation for acute care hospitals. They also must meet the following conditions:

- have a preadmission screening process to determine that each prospective patient is likely to benefit significantly from an intensive inpatient rehabilitation program;
- use a coordinated multidisciplinary team approach that includes rehabilitation nurses, physical and occupational therapists, and speech-language pathologists;
- have a full-time director of rehabilitation, with training or experience in rehabilitating patients; and
- have no fewer than 75 percent of all patients admitted for each year with 1 or more of 13 conditions, such as stroke or burns (see the text box, pp. 208–209, that describes the phase-in schedule).

FIGURE 3C–1 **Beneficiaries using IRFs under PPS**



Note: IRF (inpatient rehabilitation facility), PPS (prospective payment system).

Source: MedPAC analysis of MedPAR data from CMS.

Fiscal intermediary behavior and local coverage determinations also affect IRFs. We plan to examine these issues in the future.

Beginning in January 2002, IRFs have been paid prospective per case rates based primarily on patient characteristics, the facility's wage index, and facility characteristics. Before that, IRFs were paid under the Tax Equity and Fiscal Responsibility Act of 1982, on the basis of their average costs per discharge, up to an annually adjusted facility-specific limit. As of 2004, these facilities are paid entirely at prospective payment system (PPS) rates on a per discharge basis (more information on the IRF PPS is available at http://www.medpac.gov/publications/other_reports/Sept06_MedPAC_Payment_Basics_IRF.pdf).

TABLE 3C–1

The trend in volume of IRF cases reversed between 2004 and 2005

	2002	2003	2004	2005	Annual change 2002–2004	Change 2004–2005
Number of cases	439,631	478,723	496,695	449,321	6.4%	–9.5%
Medicare spending (in billions)	$4.9	$6.2	$6.6	$6.4	15.5	–3.0
Payment per case	$11,152	$12,952	$13,275	$14,248	9.1	7.3
Average length of stay (in days)	13.3	12.8	12.7	13.1	–2.4	3.6

Note: IRF (inpatient rehabilitation facility).

Source: MedPAC analysis of MedPAR data from CMS.

Are Medicare payments adequate in 2007?

We examine the following factors in determining the adequacy of Medicare payments to IRFs:

- supply of facilities
- volume of services and beneficiaries' access to care
- quality
- access to capital
- payments and costs

Our indicators of adequacy are mixed. The number of IRFs increased after implementation of the PPS and then remained stable from 2004 to 2005, although the numbers of rural and freestanding IRFs both continued to grow. After the PPS began in 2002, the volume of cases and Medicare spending grew rapidly. From 2004 to 2005, the number of cases and spending dropped as IRFs responded to the revised 75 percent rule. We have no direct indicators of beneficiaries' access to care. Quality indicators for all IRF patients and patients discharged home improved slightly from 2004 to 2006. IRFs appear to have access to capital: Hospital-based units have access through their parent institutions and freestanding IRFs are able to raise capital from private lenders.

The aggregate Medicare margin for 2005 is estimated to be 13.0 percent. Because of changes in payment policies, increases in costs, and responses to the 75 percent rule, the estimated margin for 2007 is 2.7 percent.

Changes in supply of providers

The supply of IRFs increased after implementation of the PPS at 1.6 percent per year from 2002 to 2004 but remained stable during the next year, increasing by 4 facilities to a total of 1,231 (Table 3C-3). Rural IRFs, however, have a different trend: Their number increased rapidly under the PPS, consistent with the rural adjustment of about 20 percent included in the PPS payment. From 2002 to 2004, the number of rural IRFs increased by more than 4 percent per year and then grew at almost double that rate (about 7 percent) from 2004 to 2005. Another factor

TABLE 3C–2

Most common types of cases in inpatient rehabilitation facilities

Type of case	2004	2005	2006
Stroke	16.6%	19.0%	20.3%
Major joint replacement	24.6	21.3	18.4
Hip fracture	13.1	15.0	16.0
Burns	11.8	10.4	10.2
Neurological	5.1	6.0	6.7
Brain injury	4.0	5.1	5.8
Other orthopedic	5.2	5.1	5.0
Spinal cord injury	4.4	4.4	4.6
Cardiac	5.2	4.2	4.0
Other	10.0	9.5	9.0

Note: Figures are the share of cases for that condition for each year. Other includes conditions such as major medical trauma, amputations, and pain syndrome.

Source: MedPAC analysis of Inpatient Rehabilitation Facility–Patient Assessment Instrument data from CMS for 2004, 2005, and January 1 through June 30, 2006.

TABLE 3C–3

Number of IRFs remained stable from 2004 to 2005

	TEFRA		PPS					
Type of IRF	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**Annual change 2002–2004**	**Change 2004–2005**
All IRFs	1,117	1,157	1,188	1,211	1,227	1,231	1.6%	0.3%
Urban	950	971	988	1,001	1,009	1,000	1.1	–0.9
Rural	167	186	200	210	218	231	4.4	6.7
Freestanding	195	214	215	215	217	217	0.5	0.0
Hospital based	922	943	973	996	1,010	1,014	1.9	0.4
Nonprofit	731	733	755	765	772	765	1.1	–0.9
For profit	240	271	277	290	294	305	3.0	3.7
Government	146	153	156	156	161	161	1.6	0.0

Note: IRF (inpatient rehabilitation facility), TEFRA (Tax Equity and Fiscal Responsibility Act of 1982), PPS (prospective payment system).

Source: MedPAC analysis of Provider of Service files from CMS.

contributing to this growth is the ability of critical access hospitals to open IRF units as of October 2004.

For-profit IRFs also have a different growth trend. The number of for-profit IRFs grew at a faster pace than nonprofit IRFs after implementation of the PPS. For-profit IRFs grew at 3 percent per year from 2002 to 2004 and at 3.7 percent per year from 2004 to 2005. During the same periods, nonprofit IRFs grew at 1.1 percent and decreased 0.9 percent per year, respectively.

Changes in volume of services and access to care

After rapid increases in the number of cases and in Medicare spending from 2002 to 2004, the number of IRF discharges decreased from 2004 to 2005 (Table 3C-1). IRF cases increased 6.4 percent per year from 2002 to 2004 but decreased by 9.5 percent between 2004 and 2005, the first year of the modified 75 percent rule. Medicare spending increased at almost 16 percent per year from 2002 to 2004 but decreased 3 percent from 2004 to 2005.

From 2002 to 2004, the average length of stay declined, consistent with implementation of a new per discharge PPS that included financial incentives to shorten the length of stay. From 2004 to 2005, the average stay increased 3.6 percent, from 12.7 days to 13.1 days. The increase is consistent with the increased average complexity of patients IRFs treated in 2005.

The patients who continued treatment in IRFs were more complex than those who shifted to alternative settings. From 2004 to 2005, IRFs experienced a 6 percent increase in case-mix index (CMI). These changes in CMI are consistent with the first full year of the modified 75 percent rule, with IRFs admitting more cases compliant with the rule. Noncompliant cases have much lower relative weights (0.93) than compliant cases (1.34) (eRehabData® 2006). IRFs have the incentive to admit more challenging patients who have diagnoses included in the revised 75 percent rule, some of whom might not have been admitted in the past.

We have no direct measures of beneficiaries' access to care. The decrease in IRF discharges is difficult to interpret, because we do not know where beneficiaries who needed intensive rehabilitation received services (e.g., from skilled nursing facilities, long-term care hospitals, home health agencies, or outpatient providers). We also do not know outcomes from that care, especially because these alternative settings—except home health—do not measure functional status at admission and discharge. If patients who need intensive rehabilitation are getting it and achieving good outcomes somewhere else, the drop in volume may not be an access issue.

The number of beneficiaries using IRFs provides an indirect measure of access: This number increased almost 7 percent from 2002 to 2004 but dropped 9 percent

The revised 75 percent rule for inpatient rehabilitation facilities

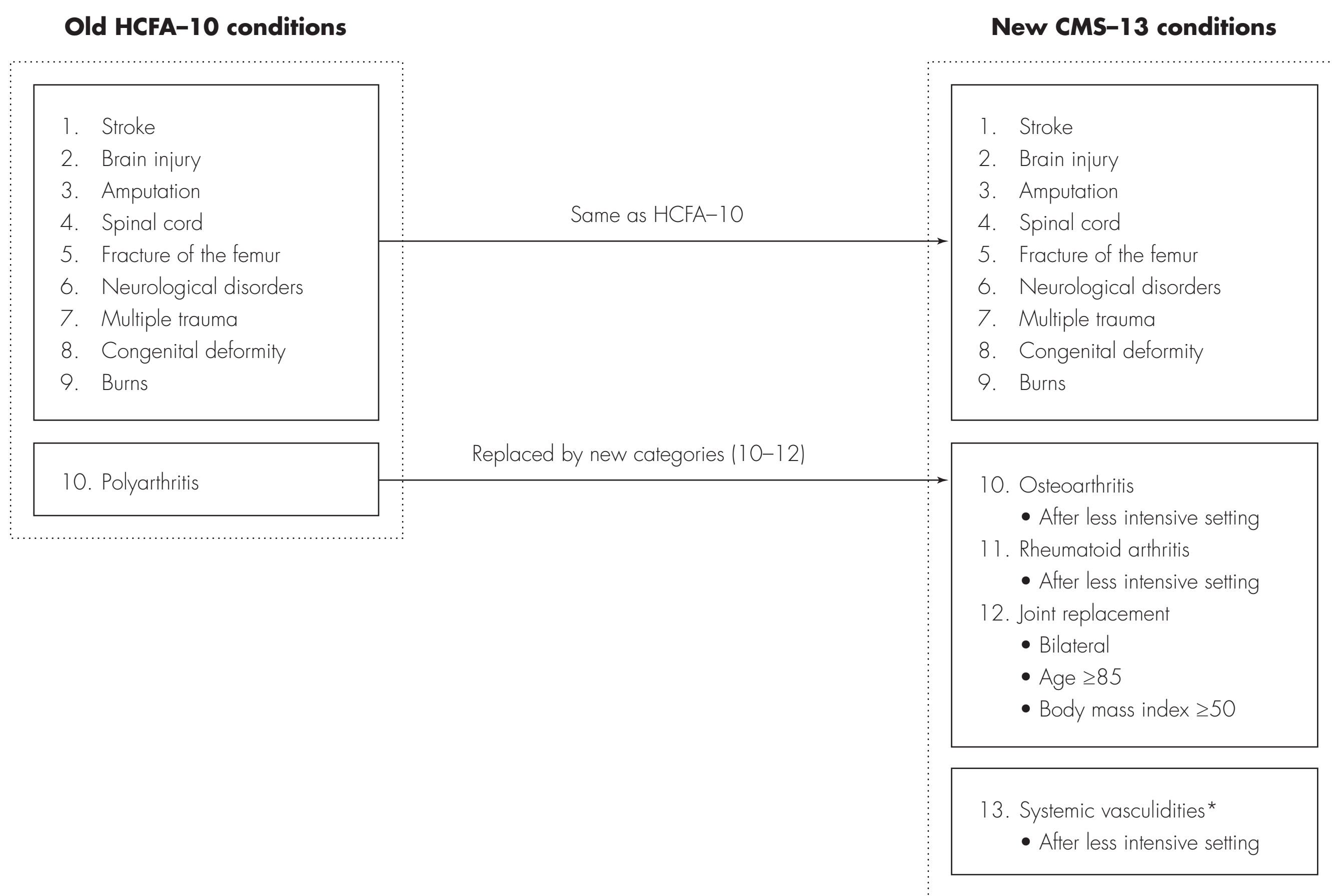
The intent of the so-called "75 percent rule" is to ensure that inpatient rehabilitation facilities (IRFs) provide intensive rehabilitation to unique types of patients. For 20 years, from 1984 to 2004, the same diagnoses were included in the 75 percent rule and were known as the Health Care Financing Administration–10 (Figure 3C-2).[1] In 2002, CMS discovered that fiscal intermediaries were using inconsistent methods to enforce the 75 percent rule. As a result, CMS suspended enforcement of the rule until the agency could examine it and determine whether the regulation should be modified.

In 2004, CMS redefined arthritis conditions allowed to be treated in IRFs (CMS 2004), which had the effect of removing the largest single category of IRF admissions (major joint replacements) from the 75 percent rule and substituting three more precise conditions. This change contributed to the reduction in the volume of patients admitted to IRFs between 2004 and 2005 and to the increase in the complexity of patients, as many joint replacement patients are less complex than other IRF patients.

(continued next page)

FIGURE 3C–2

Change in the inpatient rehabilitation facility criteria



Note: HCFA–10 (Health Care Financing Administration–10).
*Systemic vasculidities are relatively rare inflammations of the arteries, frequently autoimmune, that involve a variety of systems, including joints.

The revised 75 percent rule for inpatient rehabilitation facilities (continued)

CMS created a four-year transition period for compliance with the revised 75 percent rule. The Deficit Reduction Act of 2005 added a year to the transition. The policy is:

- 50 percent of the IRF's total patient population must meet the revised regulations in cost reporting years beginning in or after July 2004 through June 2005,
- 60 percent in cost reporting years beginning in or after July 2005 through June 2007, and
- 65 percent in cost reporting years beginning in or after July 2007 through June 2008.[2]
- For cost reporting periods beginning in or after July 2008, the threshold returns to 75 percent.

The Commission commented on CMS's rulemaking for the revised 75 percent rule and recommended that the agency convene an expert panel of clinicians to reach consensus on diagnoses to include in the revised 75 percent rule as well as appropriate clinical criteria for patients with those diagnoses. We also suggested that CMS publicly report the panel's results.

The revised rule is controversial. Even though a 75 percent rule has been in place since 1984, CMS has not consistently enforced it, as noted earlier. CMS concluded that most joint replacement patients did not need the intensive rehabilitation services the IRFs provided and that they could receive rehabilitation services from alternative providers, such as acute hospitals, skilled nursing facilities, long-term care hospitals, outpatient rehabilitation providers, and home health agencies.

The revised 75 percent rule is also controversial because it clarifies that a large category of admissions is not appropriate for IRF care. IRFs that do not comply with the revised rule will be declassified and will receive acute inpatient prospective payment system (PPS) rates for all cases, which generally are much lower than IRF PPS rates.[3] (A more detailed discussion of the revised 75 percent rule is provided in Chapter 4D of MedPAC's March 2006 report.) ■

between 2004 and 2005 (Figure 3C-1, p. 205). Despite this drop, 3 percent more beneficiaries used IRFs in 2005 than in 2002.

At the same time, there are indications that access to intensive rehabilitation care has become more limited for beneficiaries in some market areas and less limited in others. For example, we found 10 cities where the only IRF closed between 2004 and 2006. These cities vary in population from 5,000 to 227,000. At the same time, new IRFs have opened in cities that previously had none. IRFs do not exist in every market area of the nation, so it is difficult to interpret the effect of closings on access for the same reasons we described earlier.

Changes in quality of care

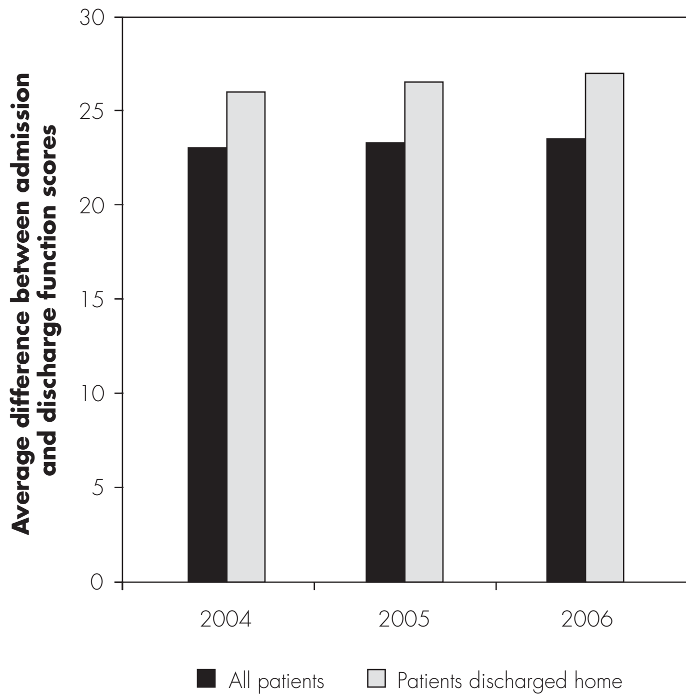
Our indicators of quality of care provided by IRFs show slight improvement from 2004 to 2006. To assess changes, we use a measure commonly tracked by the industry—the difference between discharge and admission scores for the commonly used Functional Independence Measure (FIM™), incorporated in the IRF–Patient Assessment Instrument (IRF–PAI). The 18-item FIM™ measures level of ability in physical and cognitive functioning and burden of care for patients' caregivers (Deutsch et al. 2005). Scores for each item range from 1 (complete dependence) to 7 (independence). To compare quality on a national basis, we use the difference in the total score at discharge versus admission for Medicare patients in two ways (Figure 3C-3, p. 210). We compare differences for:

- all Medicare patients treated in an IRF, and
- Medicare patients discharged home from an IRF.[4]

The actual differences in functioning scores are less important than whether the items remain stable, increase (indicating improvement), or decrease (indicating deterioration). Between 2004 and 2006, the quality indicators for all IRF patients and for those who were discharged home improved slightly. All patients increased their functioning between admission and discharge from 22.9 in 2004 to 23.4 in 2006, an improvement of

FIGURE 3C–3

IRF patients' improvement in function has increased slightly



Note: IRF (inpatient rehabilitation facility). Our quality indicator is the number of points gained on a scale of patients' ability to function between admission and discharge.

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

2 percent. Patients discharged home increased functioning between admission and discharge from 25.9 in 2004 to 26.9 in 2006, an improvement of almost 4 percent over the same years.

We use a summary score for comparing functional improvement. In the future, the Commission and CMS might want to investigate whether using more detail to compare admission and discharge function scores would provide more information about quality of care. For example, comparing scores by case-mix group might be another useful way to examine the quality of IRF care.

CMS has begun a process to develop outcomes measures from the IRF patient assessment instruments and identify other critical factors influencing functional outcomes. A forthcoming report will:

- review the literature,
- consider the appropriateness of existing measures,
- assess the completeness of voluntary IRF–PAI items,
- report results from a pilot test of items in nine IRFs,
- model risk adjustment for measures, and
- recommend next steps.

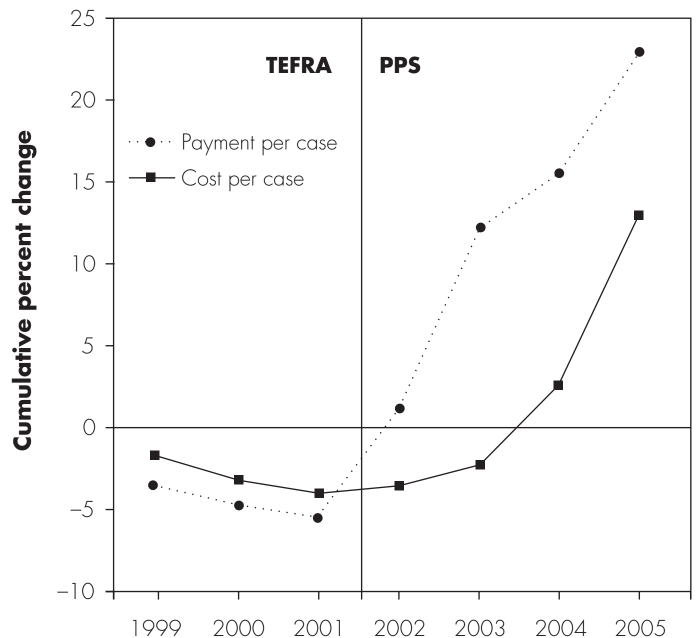
CMS is continuing to collect data, supported by clinical evidence, known to be predictive of outcomes and resource utilization through a demonstration of a common patient assessment instrument to be used after hospital discharge and across post-acute care settings at admission and discharge. The Congress mandated this demonstration in the Deficit Reduction Act of 2005.

Inpatient rehabilitation facilities' access to capital

IRFs appear to have adequate access to capital. Four out of five IRFs are hospital-based units, which access capital through their parent institution. Because acute care hospitals generally have good access to capital, we expect

FIGURE 3C–4

Per case payments for IRFs have risen faster than costs, post-PPS



Note: IRF (inpatient rehabilitation facility), TEFRA (Tax Equity and Fiscal Responsibility Act of 1982), PPS (prospective payment system). Data are from consistent two-year cohorts of IRFs.

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

TABLE 3C–4

IRFs' Medicare margins, by type

Type of IRF	TEFRA 1998	TEFRA 1999	TEFRA 2000	TEFRA 2001	PPS 2002	PPS 2003	PPS 2004	PPS 2005*
All IRFs	2.8%	1.1%	1.3%	1.5%	11.0%	17.8%	16.2%	13.0%
Urban	2.9	1.2	1.3	1.5	11.5	18.6	16.8	13.5
Rural	2.4	0.8	0.9	1.1	4.7	10.0	10.5	8.4
Freestanding	3.3	1.2	1.2	1.5	18.5	23.0	24.3	20.9
Hospital based	2.6	1.1	1.3	1.4	6.1	14.9	12.0	8.5
Nonprofit	2.8	1.2	1.5	1.6	6.5	14.3	12.4	9.6
For profit	3.1	1.0	0.9	1.3	19.1	24.5	24.5	20.0
Government	2.5	0.8	1.3	1.6	2.5	10.8	9.0	5.0

Note: IRF (inpatient rehabilitation facility), TEFRA (Tax Equity and Fiscal Responsibility Act of 1982), PPS (prospective payment system).
*2005 data include imputed margins for one-third of IRFs.

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

that their IRF units do as well. (Hospitals' access to capital is discussed in Chapter 2A.)

Capital appears to be available for stand-alone IRFs as well. For example, a relatively new company obtained $40 million in private equity funding and announced plans to build 36 IRFs throughout the western states over the next five years, starting in cities that have no IRFs (*New Mexico Business Weekly* 2004). This company currently has six IRFs open and plans to open four more by the fall of 2007 (Ernest Health 2006).

Payments and costs

The last component of our update framework examines changes in payments and costs. We also calculate an aggregate Medicare margin for IRFs.

With the introduction of the IRF PPS in 2002, payments per case rose rapidly and growth in cost per case remained low in both 2002 and 2003 (Figure 3C-4). With implementation of the revised 75 percent rule, growth in costs per case accelerated between 2004 and 2005 at 10.1 percent as CMI increased and the volume of cases declined. The increase in CMI and consequent increase in costs are primarily due to a decrease in the volume of less intensive cases in IRFs.

In calculating margins for the IRF sector, we use cost reports for both hospital-based and freestanding facilities, in contrast to the skilled nursing facility, home health, and dialysis sectors. Hospital-based IRFs make up more than 80 percent of facilities and two-thirds of IRF cases. Last year, we examined costs for hospital-based and freestanding IRFs and found that they had very similar total costs per case; we saw no evidence that allocation of overhead resulted in cost differences.

Medicare margins for 1998 through 2005

Because of changes in the cost reporting software, CMS permitted IRFs with cost report periods starting January 2005 to delay submitting their cost reports. Therefore, we are missing about one-third of IRF cost reports for our analysis. To remedy the problem of missing reports, we extrapolated changes in costs and payments from 2004 to 2005 by sorting IRFs into different groups and applying the changes for IRFs in the group that had cost reports to those without reports.

From 2002 (the beginning of the IRF PPS) to 2003, aggregate Medicare margins increased rapidly, from 11 percent to almost 18 percent, and then declined slightly to 16.2 percent in 2004 (Table 3C-4). All groups had rapid increases in margins from 2002 to 2003, although hospital-based IRFs and nonprofit IRFs had the biggest increases.

We estimate that aggregate Medicare margins for 2005 are 13.0 percent, which represents a 3.2 percentage point decrease from 2004. The IRFs at the 25th percentile have a margin of –4 percent and those at the 75th percentile have a margin of 22 percent in 2005. For-profit IRFs have twice the margin of nonprofits. Freestanding IRFs and for-profit IRFs have margins of more than 20 percent in 2004. The margin for hospital-based IRFs declined from 12 percent to 8.5 percent between 2004 and 2005.

Medicare margins for 2007

To project the Medicare margin for 2007, the policy year, we incorporate policy changes that went into effect between the year of our most recent data (2005) and 2007 as well as policies scheduled to be in effect in 2008, which allows us to consider whether current payments will be adequate under all applicable provisions of current law. The policies include:

- for fiscal year 2006, a market basket update of 3.6 percent, a 1.8 percent increase due to change in the outlier policy, and a 1.9 percent decrease in payments to account for coding improvement (as estimated by CMS), for a net increase of 3.4 percent (CMS 2005);
- for fiscal year 2007, a market basket update of 3.3 percent, a decrease in payments to account for coding improvement of 2.6 percent (as estimated by CMS), for a net increase of 0.7 percent (CMS 2006); and
- for 2006 to 2008, the effect of the 75 percent rule.

The policy with the biggest impact on the projected margin over this period is the phase-in of the revised 75 percent rule, which in 2008 will require that 65 percent of cases in IRFs comply with the rule (the text box describes our methods for accounting for the rule's effect on margins). Taking account of these assumptions about the continuing drop in volume of cases and the decreased ability of IRFs to benefit from economies of scale, the aggregate Medicare margin is projected to drop from 13.0 percent in 2005 to 2.7 percent in 2007, largely because of the effect of the enforcement of the modified 75 percent rule. If we vary our cost growth assumptions, the margin ranges between 0.5 percent and 5.5 percent.

How should Medicare payments change in 2008?

For IRFs, the mandated update to payments is the market basket. CMS's latest forecast of the market basket for 2008 is 3.1 percent. The following is our recommendation for an update to IRF payments in 2008.

Update recommendation

IRFs should be able to accommodate cost changes in fiscal year 2008 with an update to payment rates of 1 percent.

RECOMMENDATION 3C

The Congress should update payment rates for inpatient rehabilitation facility services by 1 percent for fiscal year 2008.

RATIONALE 3C

The evidence from the indicators we have examined suggests a mixed picture. There is little growth in this sector; the volume of cases and spending have dropped. At the same time, the number of rural IRFs has increased rapidly, IRFs have access to capital, and private equity firms continue to invest in this industry.

Our recommendation strikes a balance between two considerations. On the one hand, the 75 percent rule is dramatic in both its effect on volume and the consequences if IRFs do not meet it. On the other hand, the IRF industry has benefited in the past from poor enforcement of the rule and IRFs have not restructured costs to reflect the changes in volume. If IRFs are able to control their costs to compensate for the drop in volume, their 2007 margins could be as high as 5.5 percent, which would allow them to accommodate cost growth with a 1 percent update.

IMPLICATIONS 3C

Spending

- This recommendation decreases federal program spending relative to current law by between $50 million and $250 million in one year and by less than $1 billion over five years.

Beneficiary and provider

- This recommendation is not expected to affect providers' ability to provide care to Medicare beneficiaries. ■

Modeling the impact of the revised 75 percent rule

Medicare margins for inpatient rehabilitation facilities (IRFs) are expected to drop as IRFs reduce the number of patients they treat to comply with the revised 75 percent rule. IRFs have a strong incentive to comply because otherwise they will be paid under the acute inpatient prospective payment system (PPS) for all Medicare cases rather than under the IRF PPS. Acute inpatient rates generally are less than IRF PPS rates.

As discussed previously, based on our analysis of cost reports, IRFs reduced the number of Medicare cases they treated by 8.6 percent from 2004 to 2005. (This reduction is consistent with the estimate we used to project margins for 2006.) Cost reports and claims can produce different results; cost report data are based on the provider's fiscal year, and claims are based on the federal fiscal year. As a result of our analysis, we assume that facilities will need to lower patient volume by an additional 20 percent to comply with the 65 percent standard in 2008, even if additional patients with qualifying conditions are admitted. This drop is consistent with the trends we have seen. Although IRFs have strong incentives, they have more difficulty than other sectors in replacing lost patients because replacement patients must comply with both the 75 percent rule and the three-hour rule (patients generally must be able to tolerate and benefit from three hours of therapy per day).

We expect costs per case to rise in 2008 as IRFs spread total costs over fewer patients. Although the cases that comply with the revised 75 percent rule have a much higher case-mix index and thus are costlier than cases not on the list of specified diagnoses, they also generate higher payments. We expect payments to generally match the higher costs that result from the higher case-mix index. However, IRFs will have to spread overhead costs among fewer cases and may not be able to completely adjust their costs for direct patient care to reflect the reduced volume. Having fewer patients may result in IRFs being less able to benefit from economies of scale.

Based on our assumptions that volume of cases will drop an additional 20 percent and that IRFs will be able to eliminate all patient care costs for those cases but will be unable to eliminate all overhead costs for them, the net result is that we estimate the Medicare margin will drop from 13.0 percent in 2005 to 2.7 percent in 2007. If we make different assumptions about volume of cases and costs, the estimated Medicare margin could range from 0.5 percent to 5.5 percent. ■

Endnotes

1 The Health Care Financing Administration administered Medicare and was the predecessor to CMS.

2 Facilities establish their own cost reporting periods that are similar to their fiscal years.

3 Declassified IRFs that are units in critical access hospitals are paid 101 percent of their costs.

4 CMS changed the instructions for assessing functioning at discharge, effective April 1, 2004. Before this date, patients' scores reflected their lowest functioning in the three days before discharge. Afterward, patients' scores reflected functioning at discharge. Our comparisons are for April 1 through December 31, 2004; January 1 through December 31, 2005; and January 1 through June 30, 2006.

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