

S E C T I O N

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Post-acute care
Skilled nursing facilities
Home health agencies
Long-term care hospitals
Inpatient rehabilitation facilities

Chart 9-1. Growth in post-acute care providers slowed in 2008

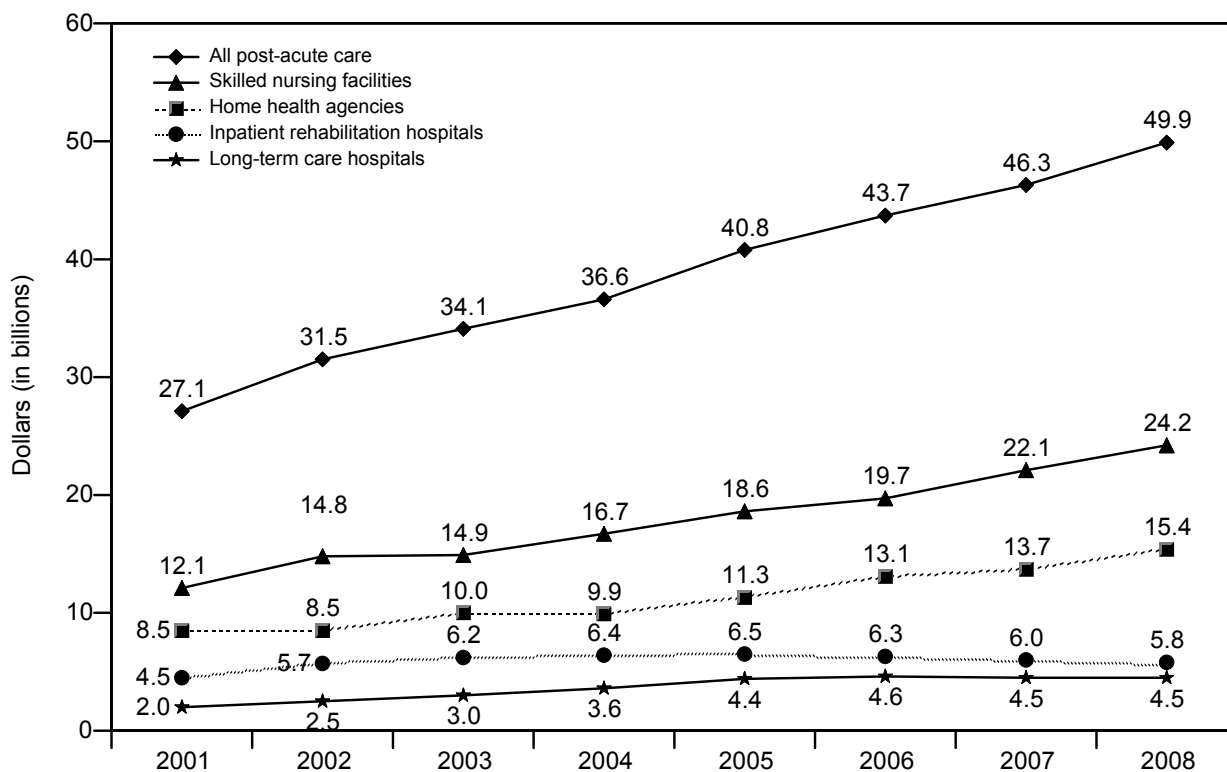
	2000	2001	2002	2003	2004	2005	2006	2007	2008	Average annual percent change 2000–2008	Percent change 2007–2008
Home health agencies	7,525	7,058	7,052	7,335	7,797	8,305	8,949	9,404	9,801	3.4%	4.2%
Inpatient rehabilitation facilities	1,117	1,157	1,188	1,211	1,227	1,231	1,224	1,202	1,202	0.9	0.0
Long-term care hospitals	263	278	297	334	366	392	397	398	409	5.7	2.8
Skilled nursing facilities	14,777	14,713	14,792	14,877	14,937	15,000	15,006	15,048	15,041	0.2	0.0

Note: The skilled nursing facility count does not include swing beds.

Source: MedPAC analysis of data from certification and Survey Provider Enhanced Reporting on CMS's Survey and Certification's Providing Data Quickly system for 2000–2008 and CMS Provider of Service data.

- The number of home health agencies fell in the early part of the decade, but since 2002 has increased significantly.
- The number of inpatient rehabilitation facilities (rehabilitation hospitals and rehabilitation units) was unchanged in 2008, after growing between 2000 and 2005 and then declining modestly from 2005 through 2007.
- The number of long-term care hospitals grew much more slowly since 2005 compared with the early years of the decade.
- The total number of skilled nursing facilities has remained about the same for four years, but the mix of facilities continues to shift from hospital-based to freestanding facilities. Hospital-based facilities make up 7 percent of all facilities, down from almost 12 percent in 2000.

Chart 9-2. Medicare's spending on home health care and skilled nursing facilities fueled growth in post-acute care expenditures



Note: These numbers are program spending only and do not include beneficiary copayments.

Source: Centers for Medicare and Medicaid Services, Office of the Actuary.

- Increases in fee-for-service spending on post-acute care have slowed in part due to expanded enrollment in managed care, whose spending is not included in this spending.
- Despite the slower growth, spending on all post-acute care still grew over 8 percent between 2007 and 2008, fueled by the increases in home health care and skilled nursing facilities expenditures.
- Fee-for-service spending on inpatient rehabilitation hospitals has declined since 2005, reflecting policies intended to ensure that patients who do not need this intensity of services are treated in less intensive settings.
- After years of explosive growth early in the decade, spending on long-term care hospitals remained flat between 2007 and 2008.

Chart 9-3. Ten most common diagnoses among Medicare SNF patients account for more than a third of SNF admissions in 2006

Diagnosis code from hospital stay	Diagnosis	Share of SNF admissions
544	Major joint and limb reattachment of lower extremity	6.9%
127	Heart failure and shock	4.8
089	Simple pneumonia and pleurisy, age >17, with CC	4.5
210	Hip and femur procedures except major joint, age >17, with CC	3.7
014	Intracranial hemorrhage and stroke with infarction	3.3
320	Kidney and urinary tract infection, age > 17, with CC	3.3
416	Septicemia, age >17	2.9
316	Renal failure	2.5
296	Nutritional and miscellaneous metabolic disorders, age > 17, with CC	2.3
079	Respiratory infections and inflammations, age > 17, with CC	2.3
	Total	36.5

Note: SNF (skilled nursing facility), CC (complication or comorbidity). The diagnosis code from hospital stay is the discharge diagnosis related group.

Source: MedPAC analysis of DataPRO files from CMS, 2006.

- The most common diagnosis for a skilled nursing facility (SNF) admission in 2006 was a major joint and limb reattachment procedure of the lower extremity, typically a hip or knee replacement.
- Ten conditions accounted for about 37 percent of all admissions to SNFs in 2006.
- Hospital-based and freestanding facilities, and nonprofit and for-profit facilities had the same top 10 diagnoses, with the same 6 top rank orderings of the conditions. Hospital-based facilities had more than double the share of major joint procedures, making up 14 percent of admissions compared with 6 percent for freestanding facilities.

Chart 9-4. A growing share of Medicare stays and payments go to freestanding SNFs and for-profit SNFs

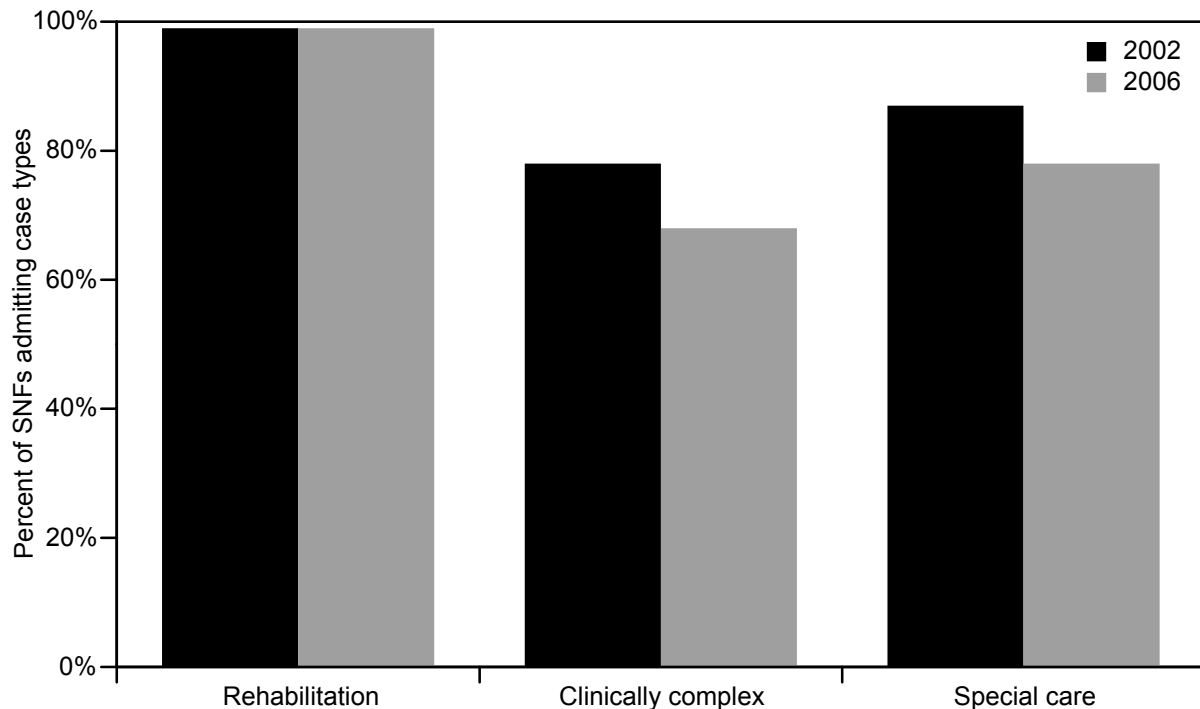
Type of SNF	Facilities		Medicare-covered stays		Medicare payments	
	2005	2007	2005	2007	2005	2007
All SNFs	100%	100%	100%	100%	100%	100%
Freestanding	92	93	87	90	93	95
Hospital based	8	7	13	10	7	5
Urban	67	67	79	79	81	81
Rural	33	33	21	21	19	19
For profit	68	68	66	68	72	74
Nonprofit	28	27	30	28	25	23
Government	5	5	4	4	3	3

Note: SNF (skilled nursing facility). Totals may not sum to 100 due to rounding or missing information about facility characteristics.

Source: MedPAC analysis of the Provider of Services and Medicare Provider Analysis and Review files 2005–2007.

- Freestanding SNFs made up 93 percent of facilities in 2007.
- Freestanding SNFs treated 90 percent of stays (up 3 percentage points from 2005) and accounted for 95 percent of Medicare payments.
- For-profit SNFs' share of Medicare-covered stays and payments each increased 2 percentage points between 2005 and 2007.
- Urban SNFs' share of facilities, share of Medicare-covered stays, and share of payments each remained the same between 2005 and 2007.

Chart 9-5. Fewer SNFs admitted clinically complex and special care cases compared with rehabilitation cases, and the share declined between 2002 and 2007



Note: SNF (skilled nursing facility). Admission category based on admitting case-mix group assignment. The clinically complex category includes patients who are comatose; have burns, septicemia, pneumonia, internal bleeding, or dehydration; or receive dialysis or chemotherapy. The special care category includes patients with multiple sclerosis or cerebral palsy, those who receive respiratory services seven days per week, or those who are aphasic or tube-fed.

Source: MedPAC analysis of 2006 DataPro data from CMS.

- In 2006, fewer SNFs admitted patients grouped into clinically complex and special care RUGs than rehabilitation RUGs. Only 68 percent of SNFs admitted clinically complex patients and 78 percent admitted special care patients compared with 99 percent of SNFs that admitted rehabilitation patients.
- Between 2002 and 2006, the share of SNFs admitting clinically complex and special care patients declined. As a result, medically complex patients were more concentrated in fewer SNFs than rehabilitation patients.

Chart 9-6. Small increase in SNF days resulted in longer average stays

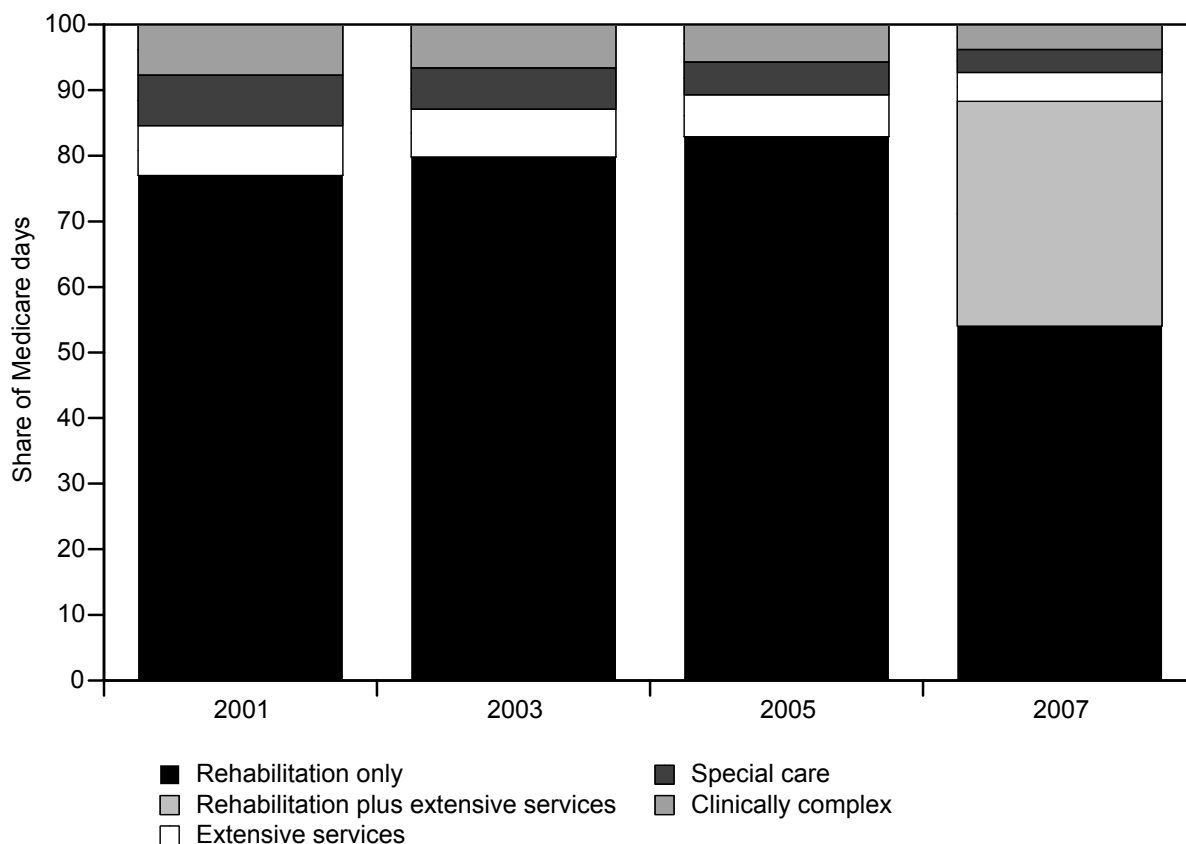
	2005	2006	2007	Change 2006–2007
Volume per 1,000 fee-for-service enrollees				
Covered admissions	70	72	72	0.0%
Covered days	1,817	1,892	1,925	1.7
Covered days per admission	26.0	26.3	26.7	1.5

Note: SNF (skilled nursing facility). Data include 50 states and the District of Columbia. Data for 2007 are preliminary.

Source: Calendar year data from CMS, Office of Research, Development and Information.

- Covered days rose 1.7 percent and admissions remained unchanged, resulting in a small increase in covered days per admission.
- Measures are reported on a per fee-for-service enrollee basis because the counts of days and admissions do not include the utilization of beneficiaries enrolled in Medicare Advantage (MA) plans. Because MA enrollment continued to increase, changes in utilization could reflect a smaller pool of users rather than changes in service use by the beneficiaries captured by the data.

Chart 9-7. Case mix in freestanding SNFs shifted toward rehabilitation plus extensive services RUGs and away from other broad RUG categories

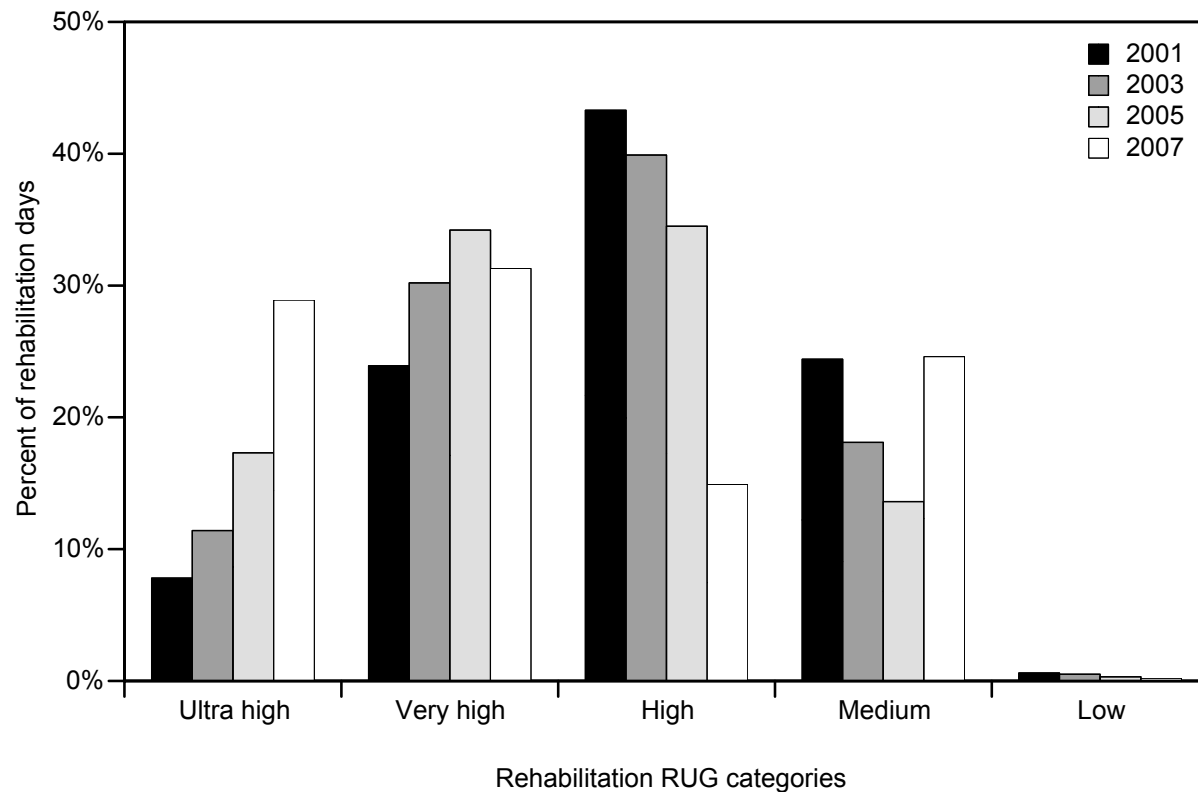


Note: SNF (skilled nursing facility), RUG (resource utilization group). The clinically complex category includes patients who are comatose; have burns, septicemia, pneumonia, internal bleeding, or dehydration; or receive dialysis or chemotherapy. The special care category includes patients with multiple sclerosis or cerebral palsy, those who receive respiratory services seven days per week, or are aphasic or tube fed. The extensive services category includes patients who have received intravenous medications or suctioning in the past 14 days, have required a ventilator or respiratory or tracheostomy care, or have received intravenous feeding within the past 7 days. Days are for freestanding skilled nursing facilities with valid cost reports.

Source: MedPAC analysis of freestanding SNF cost reports.

- In 2007, rehabilitation RUGs accounted for 88 percent of all Medicare days in freestanding SNFs. Rehabilitation-only RUGs accounted for 54 percent of days, down from 83 percent in 2005.
- The nine rehabilitation plus extensive services RUGs accounted for 34 percent of all freestanding SNFs' RUG days in 2007.
- Some of the growth in total rehabilitation days may be explained by a shift in the site of care from inpatient rehabilitation facilities to SNFs. Between 2004 and 2007, the share of beneficiaries who had a major joint replacement or revision and were discharged from a hospital to a SNF increased 3 percentage points, from 33 percent to 36 percent.

Chart 9-8. Rehabilitation case-mix continues to shift toward higher paying rehabilitation RUGs



Note: SNF (skilled nursing facility), RUG (resource utilization group). Rehabilitation days include days in the rehabilitation case-mix groups and the rehabilitation plus extensive services case-mix groups. Days are for freestanding skilled nursing facilities with valid cost report data.

Source: MedPAC analysis of freestanding SNF cost reports.

- The distribution of rehabilitation days in freestanding SNFs continued to shift toward the highest therapy groups. Between 2006 and 2007, the number of ultra high rehabilitation days increased 30 percent, making up just under one-third of all rehabilitation days. During this period the share of days in the very high, high, and low rehabilitation groups declined.
- The shifts towards higher intensity RUGs could be a function of shifts in site of service from other settings or could reflect the payment incentives to furnish the services necessary to get patients classified into higher paying rehabilitation RUGs.
- After nine new RUGs groups were added in 2006, the payment rates for medium rehabilitation plus extensive services were set higher than the rates for high rehabilitation plus extensive services case-mix groups. Between 2006 and 2007, the volume of all medium days increased almost 5 percent, while the volume of all high days declined 21 percent.

Chart 9-9. Freestanding SNF Medicare margins have exceeded 10 percent for seven years

Type of SNF	2001	2002	2003	2004	2005	2006	2007
All	17.6%	17.4%	10.8%	13.7%	12.9%	13.3%	14.5%
Urban	17.4	16.8	10.0	13.0	12.4	13.0	14.2
Rural	18.4	20.0	14.1	16.5	15.3	14.5	16.0
For profit	19.9	19.9	13.9	16.6	15.6	16.2	17.5
Nonprofit	10.3	9.1	1.5	4.2	4.4	4.0	4.5
Government*	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Note: SNF (skilled nursing facility).

*Government-owned providers operate in a different context from other providers, so their margins are not necessarily comparable.

Source: MedPAC analysis of freestanding SNF cost reports.

- Although aggregate Medicare margins for freestanding SNFs have varied over the past 7 years, they have exceeded 10 percent every year since 2001.
- Aggregate Medicare margins increased from 2006 to 2007 due to costs per day growing more slowly than payments per day. The growth in payments reflected the increased share of days classified into the highest-paying RUGs.
- Examining the distribution of 2007 margins, one-half of freestanding SNFs had margins of 16.1 percent or more, while one-quarter had Medicare margins at or below 5.2 percent. One quarter had margins of at least 24.8 percent.

Chart 9-10. Freestanding SNFs in the top quartile of Medicare margins in 2007 had much lower costs per day

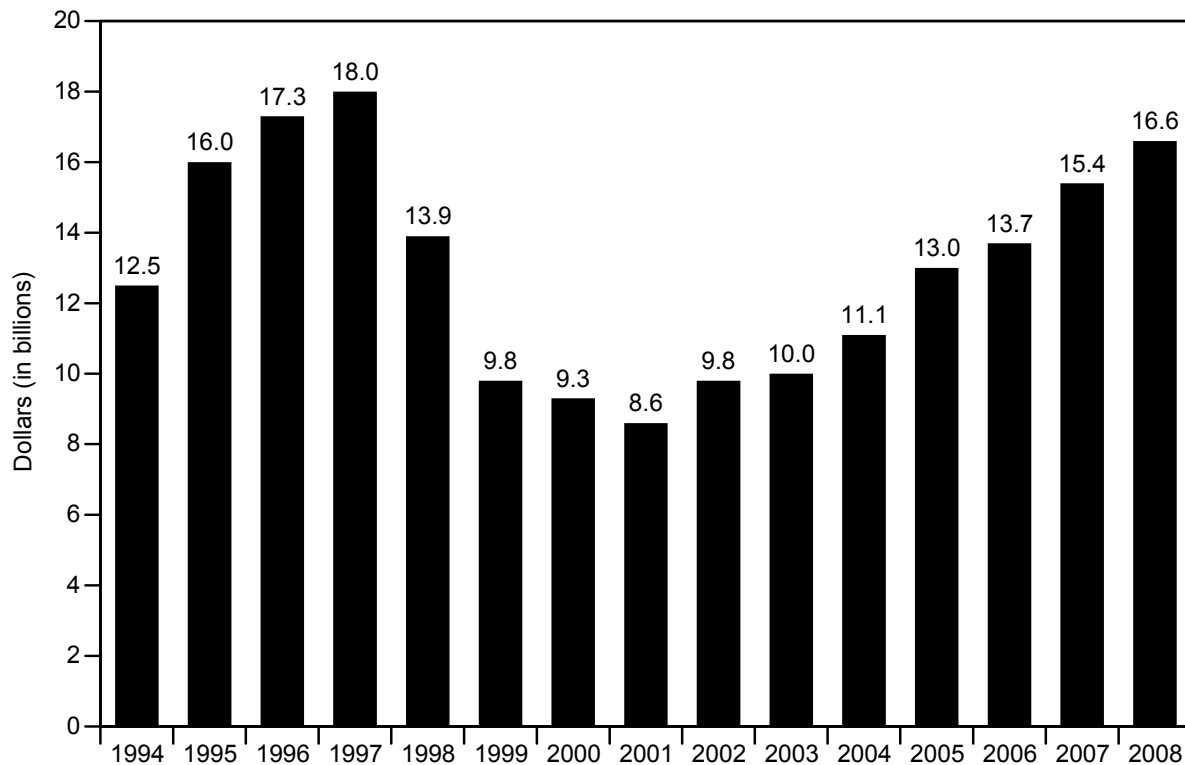
Characteristic	Top margin quartile	Bottom margin quartile
Case-mix adjusted cost per day		
Total	\$212	\$308
Ancillary	\$89	\$123
Average daily census (patients)	86	75
Length of stay (days)	45	38
Medicare payment per day	\$377	\$352
Share of days, by broad RUG category		
Rehabilitation plus extensive services	30%	27%
Clinically complex and special care	4%	6%
Share of SNFs, by type		
Percent for-profit	87%	53%
Percent urban	66%	71%

Note: SNF (skilled nursing facility), RUG (resource utilization group). Values shown are medians for the quartile. Top margin quartile SNFs were in the top 25 percent of the distribution of Medicare margins. Bottom margin quartile SNFs were in the bottom 25 percent of the distribution of Medicare margins. Standardized costs have been adjusted for case mix using the facility's nursing case-mix index.

Source: MedPAC analysis of freestanding cost reports.

- Freestanding SNFs in the bottom quartile of 2007 Medicare margins had case-mix adjusted costs per day that were 45 percent higher than SNFs in the top quartile and ancillary costs per day that were one-third higher.
- Low-margin SNFs' higher daily costs are partly explained by their lower average daily census (with poorer economies of scale) and shorter stays (over which to spread their fixed costs).
- Low-margin SNFs had lower Medicare payments per day, partly explained by a smaller share of days grouped into the highest-paying rehabilitation plus extensive services RUGs.

Chart 9-11. Spending for home health care, 1994–2008



Note: 2008 is an estimate; all other years are actual expenditures.

Source: CMS, Office of the Actuary, 2009.

- Medicare home health care spending grew at an average annual rate of 20 percent from 1992 to 1997. During that period, the payment system was cost based. Eligibility had been loosened just before this period, and enforcing the program's standards became more difficult.
- Spending began to fall in 1997, concurrent with the introduction of the interim payment system (IPS) based upon costs with limits, tighter eligibility, and increased scrutiny from the Office of Inspector General.
- In October of 2000, the prospective payment system (PPS) replaced the IPS. At the same time, eligibility for the benefit was broadened slightly. Enforcement of the Medicare program's integrity standards continues at the regional home health intermediaries and state survey and certification agencies.
- Home health has risen steadily under PPS. Spending has risen by 9.9 percent a year in 2001–2008.
- Payments in 2006 grew at a lower rate because of a one-year freeze in payments and more beneficiaries opting to receive benefits from Medicare Advantage instead of Medicare fee-for-service. Despite these factors, spending still increased and the share of fee-for-service beneficiaries using home health increased slightly.

Chart 9-12. Trends in the provision of home health care

	2002	2004	2007	Average annual percent change 2002–2007
Number of users (in millions)	2.5	2.8	3.1	4.3%
Percent of beneficiaries who used home health (percent)	7.1%	7.6%	8.9%	4.0
Episodes by type (in millions)				
Less than 10 therapy visits	3.2	3.6	4.3	6.7
10 or more	0.9	1.2	1.6	12.2
Total	4.1	4.8	5.8	8.1
Episodes per home health patient	1.6	1.7	1.9	3.4
Visits per home health patient	31	31	37	3.6
Average payment per episode	\$2,329	\$2,366	\$2,705	3.0

Source: MedPAC analysis of the home health Standard Analytic File.

- Under the prospective payment system (PPS), in effect since 2001, the number of users and the number of episodes has risen significantly. In 2007, about 3 million beneficiaries used the home health benefit.
- The number of home health episodes increased rapidly from 2002 to 2007. The growth in episodes that were therapy intensive—those with 10 or more therapy visits—was about double the growth rate of episodes that were not therapy intensive. The home health PPS in effect prior to 2008 provided a significant payment increase for these episodes.
- The number of episodes per user has increased since 2002, and as a result the growth in episodes has been greater than the growth in users of home health.
- The number of visits per home health patient increased in 2007 to 37. This is due primarily to an increase in the number of home health episodes per patient, which increased to 1.9 episodes per patient in 2007. A slight increase in the number of visits per episode also contributed. Aberrant patterns of utilization in Florida contributed to some of the increase in episodes per beneficiary and visits per beneficiary. CMS is currently investigating operations in south Florida and other areas to determine the extent of fraudulent home health activity.

Chart 9-13. The home health product changed after the prospective payment system started

	1997	2000	2007	Percent change	
				1997–2000	2000–2007
Number of beneficiaries using home health (in millions)	3.6	2.5	3.1	–31	26
Number of visits (in millions)	258	91	114	–65	23
Visit type (percent of total)					
Home health aide	48%	31%	20%	–37	–35
Skilled nursing	41	49	54	20	10
Therapy	10	19	26	101	37
Medical social services	1	1	1	1	*
Visits per home health patient	73	37	37	–49	–2
Percent of fee-for-service beneficiaries who used home health	10.5%	7.4%	8.9%	–30.1	20.0

Note: The prospective payment system began in October 2000.
*Changed by less than a half percent.

Source: Home health Standard Analytic File; Health Care Financing Review, Medicare and Medicaid Statistical Supplement, 2002.

- The types and amount of home health care services that beneficiaries receive have changed. In 1997 home health aide services were the most frequently provided visit type, and beneficiaries who used home health received an average of 73 visits.
- CMS began to phase in the interim payment system in October of 1997 to stem the rise in spending for home health services (see Chart 9-11). By 2000, total visits had dropped by 65 percent, total users had dropped by 31 percent, and average visits per user had dropped to 37. The mix of services changed as well, with skilled nursing and therapy visits now accounting for about two-thirds of all services.
- Medicare shifted to a prospective payment system (PPS) in October of 2000. The PPS makes a single payment for all services provided in a 60-day episode, ending the per visit payment systems in effect for previous years. The number of beneficiaries using home health and total visits has increased under PPS. The growth in users has been more rapid than the growth in visits, and the number of average visits per user in 2007 is the same as in 2000.
- Under the PPS the mix of visits has continued to shift toward therapy (physical therapy, occupational therapy, and speech language pathology) and away from home health aide services. During 2000–2007, the payment system made substantially higher payments for episodes with 10 or more therapy visits.
- Concerns about the growth in therapy led CMS to revise the payments for therapy services in 2008. The new system increases payment for therapy services more gradually than the previous approach, but it still bases payments on the amount of services provided and not patient characteristics.

Chart 9-14. Margins for freestanding home health agencies

	2006	2007	Percent of agencies 2007
All	15.8%	16.6%	100%
Geography			
Urban	15.1	16.4	67
Rural	16.3	14.0	16
Mixed	17.3	18.7	17
Type of control			
For-profit	15.8	18.6	79
Nonprofit	11.8	11.9	14
Government	N/A	N/A	N/A
Volume quintile			
First	10.8	10.3	20
Second	11.4	11.6	20
Third	11.4	12.9	20
Fourth	15.5	16.7	20
Fifth	17.2	17.7	20

Note: N/A (not available). Analysis includes 4,625 agencies for 2006 and 4,629 agencies for 2007.

*The results for government-owned providers are not necessarily comparable to other providers because they operate in a different context.

Source: MedPAC analysis of 2006–2007 Cost Report files.

- In 2007, about 75 percent of agencies had positive margins (not shown in table). These estimated margins indicate that Medicare's payments are above the costs of providing services to Medicare beneficiaries, for both rural and urban home health agencies (HHAs).
- These margins are for freestanding HHAs, which composed about 85 percent of all HHAs in 2007. HHAs are also based in hospitals and other facilities.
- The 2007 margin is consistent with the historically high margins the home health industry has experienced under the PPS. The weighted average margin in 2002–2007 was 16.5 percent, indicating that most agencies have been paid well in excess of cost under prospective payment.
- HHAs that served both urban and rural patients in 2007 had a weighted average margin of 18.7 percent, those that served mostly urban patients had a weighted average margin of 16.4 percent, and agencies that served rural patients had a weighted average margin of 14 percent.
- For-profit agencies in 2007 had a weighted average margin of 18.6 percent, and nonprofit agencies had a weighted average margin of 11.9 percent.
- Agencies that serve more patients have higher margins. The agencies in the lowest volume quintile in 2007 have a weighted average margin of 10.3, while those in the highest have a weighted average margin of 17.7 percent.

Chart 9-15. The top 15 LTC–DRGs made up almost 60 percent of cases in LTCHs in 2007

LTC–DRG	Description	Discharges	Percentage
565	Respiratory system diagnosis with ventilator support 96+ hours	13,830	10.7%
87	Pulmonary edema and respiratory failure	7,386	5.7
576	Septicemia with mechanical ventilation <96 hours age >17	6,799	5.3
271	Skin ulcers	6,766	5.2
79	Respiratory infections and inflammation age >17 with CC	6,378	4.9
89	Simple pneumonia and pleurisy age >17 with CC	4,655	3.6
88	Chronic obstructive pulmonary disease	4,185	3.2
249	Aftercare, musculoskeletal system and connective tissue	3,915	3.0
466	Aftercare, without history of malignancy	3,836	3.0
263	Skin graft and/or debridement for skin ulcer with CC	3,749	2.9
12	Degenerative nervous system disorders	3,343	2.6
127	Heart failure and shock	3,328	2.6
462	Rehabilitation	3,066	2.4
418	Postoperative and post-traumatic infections	2,575	2.0
316	Renal failure	2,509	1.9
	Top 15 LTC–DRGs	76,320	59.1
	Total	129,202	100.0

Note: LTC–DRG (long-term care diagnosis related group), LTCH (long-term care hospital), CC (complication or comorbidity). LTC–DRGs are the case-mix system for these facilities. Columns may not sum due to rounding.

Source: MedPAC analysis of MedPAR data from CMS.

- Long-term care hospitals (LTCHs) treat beneficiaries with diverse diagnoses. Five of the top 15 diagnoses in LTCHs are related to respiratory conditions.
- The most frequent diagnosis for LTCHs is respiratory system diagnosis with ventilator support. These beneficiaries make up 11 percent of all Medicare LTCH patients.

Chart 9-16. Spending for long-term care hospital services increased rapidly under PPS

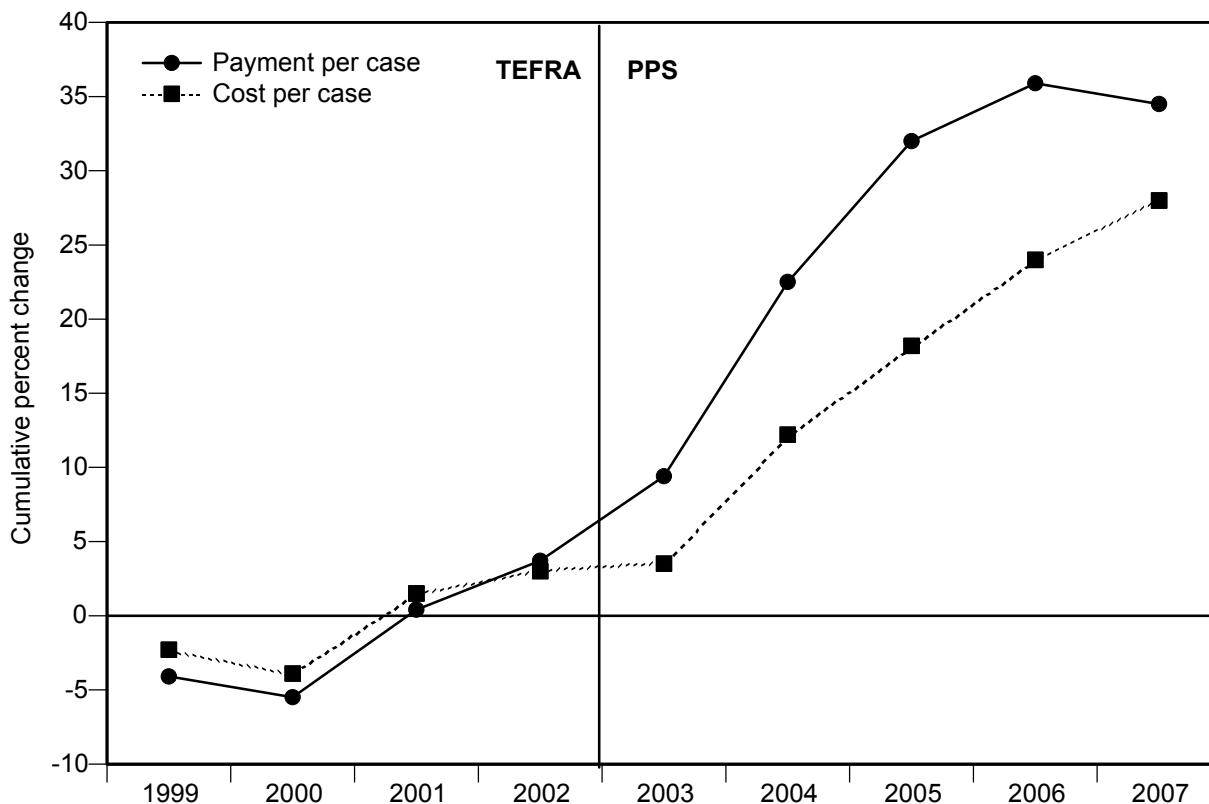
	TEFRA		PPS					Average annual change	
	2001	2002	2003	2004	2005	2006	2007	2003–2005	2005–2007
Cases	85,229	98,896	110,396	121,955	134,003	130,164	129,202	10.2%	–1.8%
Cases per 10,000 FFS beneficiaries	25.1	28.6	31.3	33.9	37.0	36.7	37.3	8.8	0.3
Spending per FFS beneficiary	\$56.0	\$64.3	\$77.5	\$101.8	\$124.6	\$128.0	\$129.6	26.8	2.0
Payment per case	\$22,009	\$22,486	\$24,758	\$30,059	\$33,658	\$34,859	\$34,769	16.6	1.6
Length of stay (in days)	31.3	30.7	28.8	28.5	28.2	27.9	26.9	–1.0	–2.3

Note: FFS (fee for service), TEFRA (Tax Equity and Fiscal Responsibility Act of 1982), PPS (prospective payment system). Numbers may not sum due to rounding. Growth in FFS cases and spending was slowed in 2006 and 2007 by large increases in the number of Medicare Advantage enrollees, whose long-term care hospital use is not included in these totals.

Source: MedPAC analysis of MedPAR data from CMS.

- In 2007 Medicare spending for long-term care hospitals (LTCHs) was virtually the same as in 2005 (\$4.5 billion). However, because of growth in the number of beneficiaries enrolling in Medicare Advantage plans, Medicare spending per fee-for-service (FFS) beneficiary continued to rise, growing 2 percent per year on average between 2005 and 2007.
- Similarly, between 2005 and 2007 the number of LTCH cases fell 1.8 percent per year, on average. But when we control for the numbers of beneficiaries enrolled in FFS, we find that the number of cases in 2007 was roughly the same as in 2005.

Chart 9-17. LTCHs' payments gap and cost growth narrowed in 2007



Note: LTCH (long-term care hospital), TEFRA (Tax Equity and Fiscal Responsibility Act of 1982), PPS (prospective payment system). Data are from consistent two-year cohorts of LTCHs.

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

- Under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and before the prospective payment system (PPS) was implemented in fiscal year 2003, long-term care hospitals' (LTCHs') Medicare per case costs and payments changed at similar rates. Until 2006, LTCHs' Medicare per case payments under PPS increased much faster than their per case costs. Between 2006 and 2007, the gap between per case payment and cost growth narrowed somewhat.
- These similarities and differences are reflected in LTCHs' Medicare margins, shown in Chart 9-19.

Chart 9-18. LTCHs' Medicare margins by type of facility

Type of LTCH	TEFRA		PPS				
	2001	2002	2003	2004	2005	2006	2007
All	-1.6%	-0.2%	5.2%	9.0%	11.9%	9.7%	4.7%
Urban	-1.5	-0.1	5.3	9.3	12.0	10.0	5.1
Rural	-4.8	-1.6	3.5	1.8	8.2	4.2	-3.6
Freestanding Hospital within hospital	-1.3	0.1	5.4	8.1	11.2	8.9	5.1
	-2.1	-0.5	5.0	9.9	12.5	10.6	4.3
Nonprofit	-1.8	0.1	1.9	6.8	9.1	6.5	1.5
For profit	-1.4	-0.1	6.3	10.0	13.1	11.0	5.8
Government*	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Note: LTCH (long-term care hospital), TEFRA (Tax Equity and Fiscal Responsibility Act of 1982), PPS (prospective payment system), N/A (not available). Rural facilities margins are not presented because the number of rural facilities is very small.
*Government-owned providers operate in a different context from other providers, so their margins are not necessarily comparable.

Source: MedPAC analysis of cost report data from CMS.

- Under the Tax Equity and Fiscal Responsibility Act of 1982 and before the long-term care hospital (LTCH) prospective payment system (PPS) was implemented, these facilities' Medicare margins were generally negative. Under PPS, margins increased rapidly, from 5.2 percent in 2003 to 11.9 percent in 2005. Since 2005, aggregate margins have begun to decline.
- In 2007, the aggregate margin for urban LTCHs was higher than the rural counterpart. The for-profit LTCH aggregate margin was also higher than for other ownership categories.

Chart 9-19. Most common types of inpatient rehabilitation facility cases, 2008

Type of case	Share of cases
Stroke	20.5%
Hip fracture	16.3
Major joint replacement	13.2
Debility	9.1
Neurological	7.9
Brain injury	6.9
Other orthopedic	5.8
Spinal cord injury	4.6
Cardiac	4.3
Other	11.4

Note: Other includes conditions such as amputations, major multiple traumas, and pain syndrome. Numbers may not sum to 100 percent due to rounding.

Source: MedPAC analysis of Inpatient Rehabilitation Facility–Patient Assessment Instrument data from CMS (January 1 through June 30, 2008).

- In 2008, the most frequent diagnosis for Medicare patients in inpatient rehabilitation facilities (IRFs) was stroke, representing just over 20 percent of cases, up from 2004, when stroke represented less than 17 percent of cases.
- Major joint replacement cases represented just over 13 percent of IRF admissions in 2008, down from 24 percent of cases in 2004, when major joint replacement was the most common IRF Medicare case type.

Chart 9-20. The number of IRF cases has declined since 2004, while payments per case increased

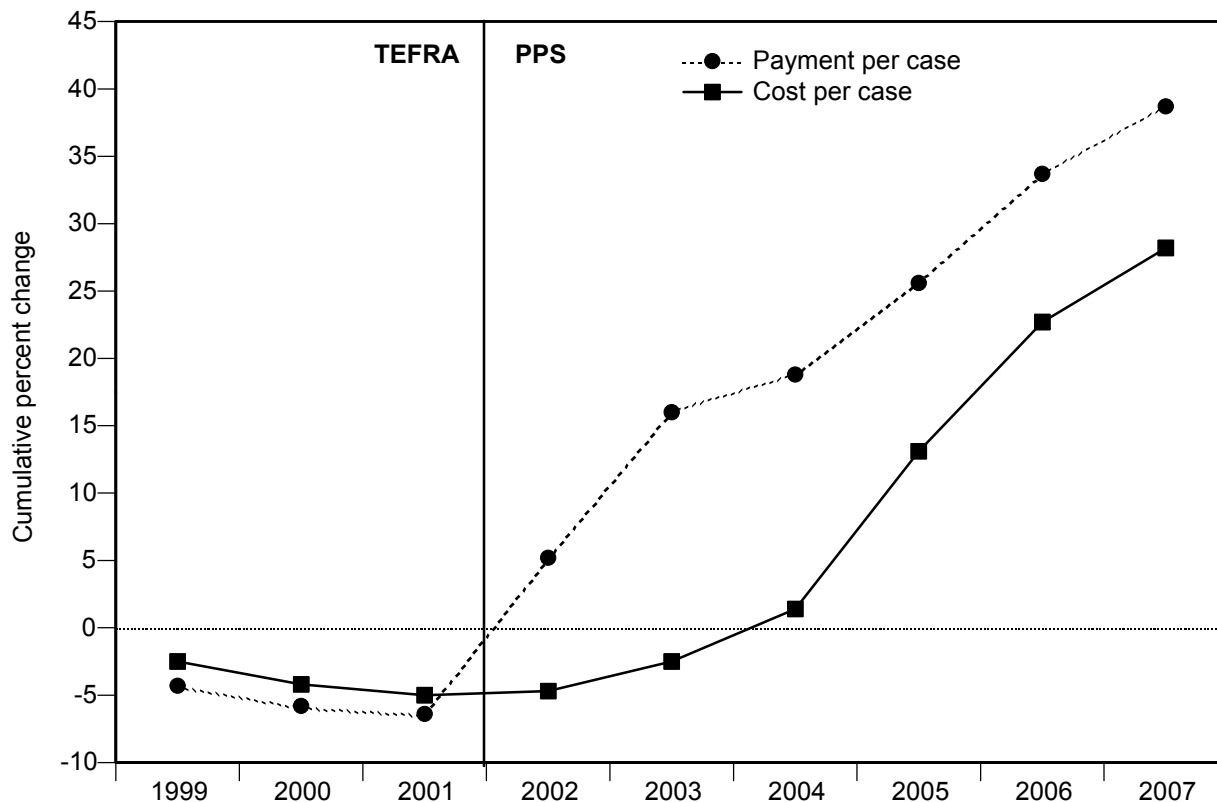
Type of IRF	2002	2004	2006	2007	Average annual change 2002–2004	Average annual change 2004–2007
Number of admissions	439,631	496,695	404,255	370,048	6.3%	-9.3%
FFS patients per 10,000 FFS beneficiaries	114	124	103	98	4.4	-7.5
Payment per case	\$11,152	\$13,275	\$15,354	\$16,143	9.1	6.7
Medicare spending (in billions)	\$5.65	\$6.43	\$6.29	\$5.95	6.7%	-2.6%
Average length of stay (in days)	13.3	12.7	13.0	13.2	-2.3	1.3

Note: IRF (inpatient rehabilitation facility), fee-for-service (FFS). Numbers of cases and patients reflect Medicare fee-for-service utilization only.

Source: MedPAC analysis of MedPAR data from CMS. Total Medicare spending from CMS Office of the Actuary.

- The number of Medicare fee-for-service (FFS) admissions to inpatient rehabilitation facilities (IRFs) increased rapidly with implementation of the prospective payment system, rising to nearly 500,000 cases in 2004.
- The number of FFS admissions decreased to about 370,000 by 2007, reflecting CMS's renewed enforcement of the 75% rule (now the 60% rule), increased medical review by Medicare's contractors, and reduced FFS enrollment due to greater enrollment in Medicare managed care.
- Controlling for changes in FFS enrollment, the number of Medicare FFS beneficiaries admitted to IRFs increased by more than 4 percent per year from 2002 to 2004, and then declined from 2004 to 2007 by an average of 7.5 percent per year. The number of FFS patients admitted to IRFs declined in 2007, but at a slower rate than in previous years.
- While total Medicare FFS spending on IRFs decreased from 2004 to 2007, Medicare payments per case increased by an average of almost 7 percent per year during this period.

Chart 9-21. Overall IRFs' payments per case have risen faster than costs, post-PPS



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

Source: MedPAC analysis of cost report data from CMS.

- Before implementation of the prospective payment system (PPS) in 2002, Medicare per case costs and payments increased at similar rates, as IRFs received cost-based reimbursement under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).
- Since implementation of the PPS, overall Medicare per case payments have increased faster than costs.
- These trends in Medicare per case payments and costs are reflected in IRFs' Medicare margins, shown in Chart 9-22.

Chart 9-22. Inpatient rehabilitation facilities' Medicare margin by type, 2001–2007

	TEFRA	PPS					
	2001	2002	2003	2004	2005	2006	2007
All IRFs	1.5%	11.0%	17.9%	16.3%	13.1%	12.3%	11.7%
Hospital based	1.5	6.2	14.9	12.1	9.2	9.6	7.9
Freestanding	1.6	18.5	23.0	24.3	20.5	17.4	18.5
Urban	1.5	11.3	18.3	16.6	13.2	12.6	12.1
Rural	1.2	8.2	13.5	14.0	12.4	9.8	8.9
Nonprofit	1.6	6.7	14.5	12.8	10.2	10.6	9.3
For profit	1.3	18.7	24.3	24.1	19.4	16.3	16.9
Government	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Note: IRF (inpatient rehabilitation facility), TEFRA (Tax Equity and Fiscal Responsibility Act of 1982), PPS (prospective payment system), N/A (not available).

Source: MedPAC analysis of cost report data from CMS.

- From 2001 to 2003, the aggregate Medicare margin increased rapidly, from just under 2 percent to almost 18 percent. From 2003 to 2007, margins declined but remained high at nearly 12 percent in 2007.
- Freestanding and for-profit IRFs had a substantially higher aggregate Medicare margin than hospital-based and nonprofit IRFs, continuing a trend that began with implementation of the IRF prospective payment system.

Web links. Post-acute care

Skilled nursing facilities

- Chapter 2D of MedPAC's March 2009 Report to the Congress provides information about the supply, quality, service use, and Medicare margins for skilled nursing facilities. Chapter 7 of MedPAC's June 2008 Report to the Congress provides information about alternative designs for Medicare's prospective payment system that would more accurately pay providers for their SNF services. Medicare payment basics: Skilled nursing facility payment system provides a description of how Medicare pays for skilled nursing facility care.

http://www.medpac.gov/chapters/Mar09_Ch02D.pdf

http://www.medpac.gov/chapters/Jun08_Ch07.pdf

http://www.medpac.gov/documents/MedPAC_Payment_Basics_08_SNF.pdf

- The official Medicare website provides information on SNFs, including the payment system and other related issues.

<http://www.cms.hhs.gov/SNFPFS/>

Home health services

- Chapter 2E of MedPAC's March 2009 Report to the Congress, Chapter 4 of MedPAC's June 2007 Report to the Congress, and Chapter 5 of MedPAC's June 2006 Report to the Congress provide information on home health services. Medicare payment basics: Home health care services payment system provides a description of how Medicare pays for home health care.

http://www.medpac.gov/chapters/Mar09_Ch02e.pdf

http://www.medpac.gov/chapters/Jun07_Ch04.pdf

http://www.medpac.gov/publications/congressional_reports/Jun06_Ch05.pdf

http://www.medpac.gov/documents/MedPAC_Payment_Basics_08_HHA.pdf

- The official Medicare website provides information on the quality of home health care, and additional information on new policies, statistics, and research, as well as information on home health spending and use of services.

<http://www.cms.hhs.gov/HomeHealthPPS/>

Long-term care hospitals

- Chapter 2G of MedPAC's March 2009 Report to the Congress provides information on long-term care hospitals. Medicare payment basics: Long-term care hospital services payment system provides a description of how Medicare pays for long-term care hospital services.

http://www.medpac.gov/chapters/Mar09_Ch02g.pdf

http://www.medpac.gov/documents/MedPAC_Payment_Basics_08_LTCH.pdf

- CMS also provides information on long-term care hospitals, including the long-term care hospital prospective payment system.

<http://www.cms.hhs.gov/LongTermCareHospitalPPS/>

Inpatient rehabilitation facilities

- Chapter 2F of MedPAC's March 2009 Report to the Congress provides information on inpatient rehabilitation facilities. Medicare payment basics: Rehabilitation facilities (inpatient) payment system provides a description of how Medicare pays for inpatient rehabilitation facility services.

http://www.medpac.gov/chapters/Mar09_Ch02F.pdf

http://www.medpac.gov/documents/MedPAC_Payment_Basics_08_IRF.pdf

- CMS provides information on the inpatient rehabilitation facility prospective payment system.

<http://www.cms.hhs.gov/InpatientRehabFacPPS/>