



Advising the Congress on Medicare issues

Assessing payment adequacy and updating payments: Inpatient rehabilitation facility services

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Inpatient rehabilitation facilities: Summary

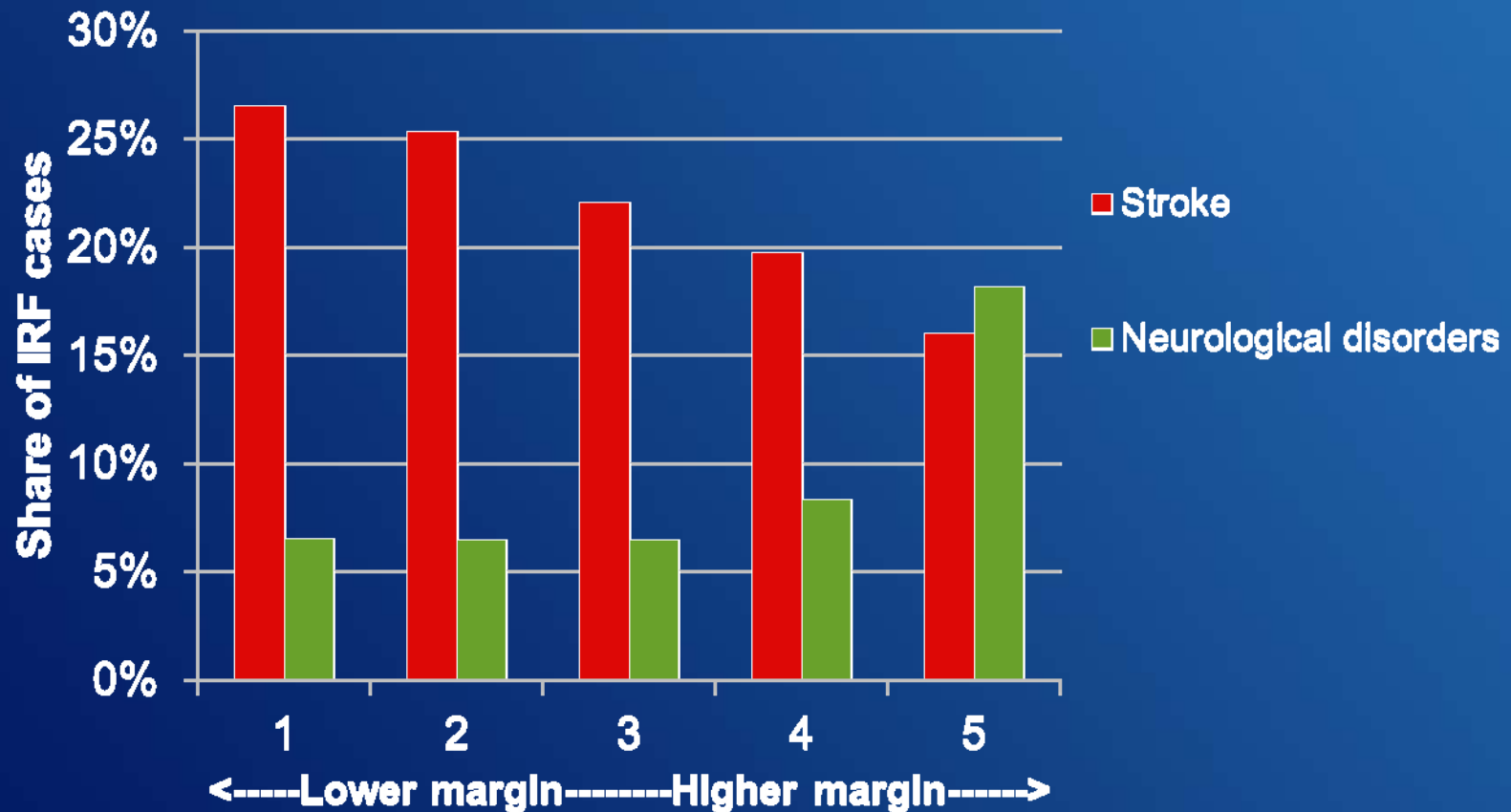
- 1,180 IRFs treated 376,000 FFS cases in 2014
- Medicare FFS spending = \$7.0B
- Access: Supply and volume stable
 - Average occupancy rate = 64%
- Quality measures stable
- Access to capital very good for many facilities
- 2014 margin = 12.5 percent
- 2014 marginal profit = 30.4 percent
- Projected margin for 2016: 13.9 percent

Results are preliminary and subject to change.

Concerns about IRF PPS

- Aggregate margin is high and projected to increase
 - Should payments be rebased?
- Profitability is highly concentrated
 - High-margin IRFs may be more efficient
 - Patient selection and coding may be a factor

High-margin IRFs have a different mix of cases



“Neurological disorders” include multiple sclerosis, Parkinson's disease, ALS, 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 (quintiles). Results are preliminary and subject to change.

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

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

In the highest-margin IRFs:

- Stroke cases were 2 times more likely as those in other IRFs to have no paralysis
- Neurological cases were 2 times more likely as those in other IRFs to have neuromuscular disorders (e.g., ALS, muscular dystrophy)

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Characteristics of patients in high-margin IRFs

- Appear to be *less* severely ill during preceding ACH stay
 - Lower ACH case mix and severity of illness
 - Less likely to spend time in ICU/CCU
 - Less likely to be high-cost outliers in ACH
 - Appear to be *more* impaired during IRF stay
 - Lower motor & cognition scores, which increases payment
- At any level of ACH severity, high-margin IRFs consistently code higher impairment

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

Type of stroke	Motor score	
	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.

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Quality measures for IRFs with the lowest and highest margins, 2013

Risk-adjusted rates	Quintile 1 (Lowest margin)	Quintile 5 (Highest margin)
Potentially avoidable readmissions During IRF stay	2.4%	2.8%
Within 30 days after discharge from IRF	4.2%	4.9%
Discharge to community	76.3%	75.6%
Discharge to SNF	6.9%	6.0%

IRFs were ranked by their 2013 Medicare margins and then sorted into 5 equal-sized groups (quintiles). Rates were calculated using data from all IRF stays, including those that did not have a preceding acute care hospital stay. Results are preliminary and subject to change.
Source: MedPAC analysis of FY 2013 MedPAR, IRF-PAI, and Medicare cost report data from CMS.

Ensuring the accuracy of IRFs' coding

- Coding practices may contribute to greater profitability in some IRFs
 - Some providers may overstate patients' functional and cognitive impairment, resulting in payments that are too high
- Medicare must ensure that IRFs' coding accurately reflects the rehabilitation needs of patients

Does the IRF PPS adequately capture differences in patient acuity and costs?

- Some providers appear to select certain types of cases
 - Are some conditions more amenable to upcoding?
 - Are some conditions more profitable to treat?
- Research needed to assess:
 - Variation in costs within the IRF case-mix groups
 - Differences in relative profitability across groups
- Reforming the PPS and rebasing IRF payments may be needed

Redistributing payments within the IRF PPS

- In near term, expanding the outlier pool could better align IRF payments with costs
 - Increase outlier payments for the most costly cases
 - Funded by reducing the base payment amount for all IRF cases (budget neutral)

Current IRF outlier policy

- Extra payments for a case if costs exceed cost threshold. Cost threshold = PPS payment + fixed-loss amount
- Outlier payment = 80% percent of costs above the cost threshold
- Fixed-loss amount set each year at a level that CMS estimates will exhaust the outlier pool
- Outlier pool funded by offset to the base payment
- Outlier pool set by CMS at 3% of total IRF payments

Expanded outlier pool would shift payments across cases and providers

Payment increases:

- Brain and spinal cord injuries
- Stroke

- Hospital-based IRFs
- Nonprofit IRFs
- Rural IRFs
- Low-margin IRFs

Payment decreases:

- Neurological disorders
- Hip fracture
- Hip and knee replacement

- Freestanding IRFs
- For-profit IRFs
- High-margin IRFs