INPATIENT REHABILITATION FACILITIES PAYMENT SYSTEM

*payment***basics**

Revised: October 2014

After an illness, injury, or surgery care, some patients need intensive inpatient rehabilitation services, such as physical, occupational, or speech therapy. Such services are frequently provided in skilled nursing facilities (SNFs) but are sometimes provided in inpatient rehabilitation facilities (IRFs). Comparatively few Medicare beneficiaries use IRFs in part because nationwide there are fewer IRFs than SNFs but also because, to be eligible for treatment in an IRF, the patient generally must be able to tolerate and benefit from three hours of therapy per day.

IRFs may be freestanding facilities or specialized units within acute care hospitals. To qualify as an IRF, a facility must meet Medicare's conditions of participation for acute care hospitals. In addition, the facility must be primarily focused on treating one of 13 conditions that typically require intensive rehabilitation therapy (see the discussion of the 60 percent rule), and must meet other requirements, such as having a medical director of rehabilitation who provides services in the facility on a full-time basis (or for at least 20 hours per week in hospital-based units). Medicare payments to IRFs totaled an estimated $6.7 billion in 2012. Medicare beneficiaries account for about 60 percent of IRF cases. In 2012, there were about 373,000 fee-for-service Medicare cases, and 1,166 facilities were Medicare certified. Freestanding IRFs accounted for 55 percent of Medicare IRF discharges but just 20 percent of facilities.

Beneficiaries transferred to an IRF from an acute care hospital pay no additional deductible. However, beneficiaries admitted from the community are responsible for a deductible—$1,216 in 2014—as the first admission during a spell of illness. Beneficiaries are responsible for a copayment—$304 per day—for the 61st through 90th days. Coverage of IRF stays is subject to Medicare's limits on inpatient hospital care; thus beneficiaries' IRF stays are covered for 90 days of hospital care per illness, with a 60-day lifetime reserve.[1]

Since January 2002, Medicare has paid IRFs predetermined per discharge rates based primarily on the patient's condition (diagnoses, functional and cognitive statuses, and age) and market area wages. Before 2002, IRFs were paid for furnishing care to Medicare beneficiaries on the basis of their average costs per discharge, as long as they did not exceed a facility-specific limit that was adjusted annually.

Defining the inpatient rehabilitation facility product Medicare buys

Under the IRF prospective payment system (PPS), Medicare patients are assigned to case-mix groups (CMGs) based on the primary reason for intensive rehabilitation care (for example, a stroke or hip fracture), age, and level of functional and cognitive impairments. Within each of these CMGs, patients are further categorized into one of four tiers based on the presence of specific comorbidities that have been found to increase the cost of care. Each CMG tier has a specific weight that reflects the costliness of patients in that CMG tier relative to that of the average Medicare IRF patient. Patients with a length of stay less than 4 days are assigned to a single CMG regardless of diagnosis, age, level of impairment, or presence of comorbidities.[2]

Setting the payment rates

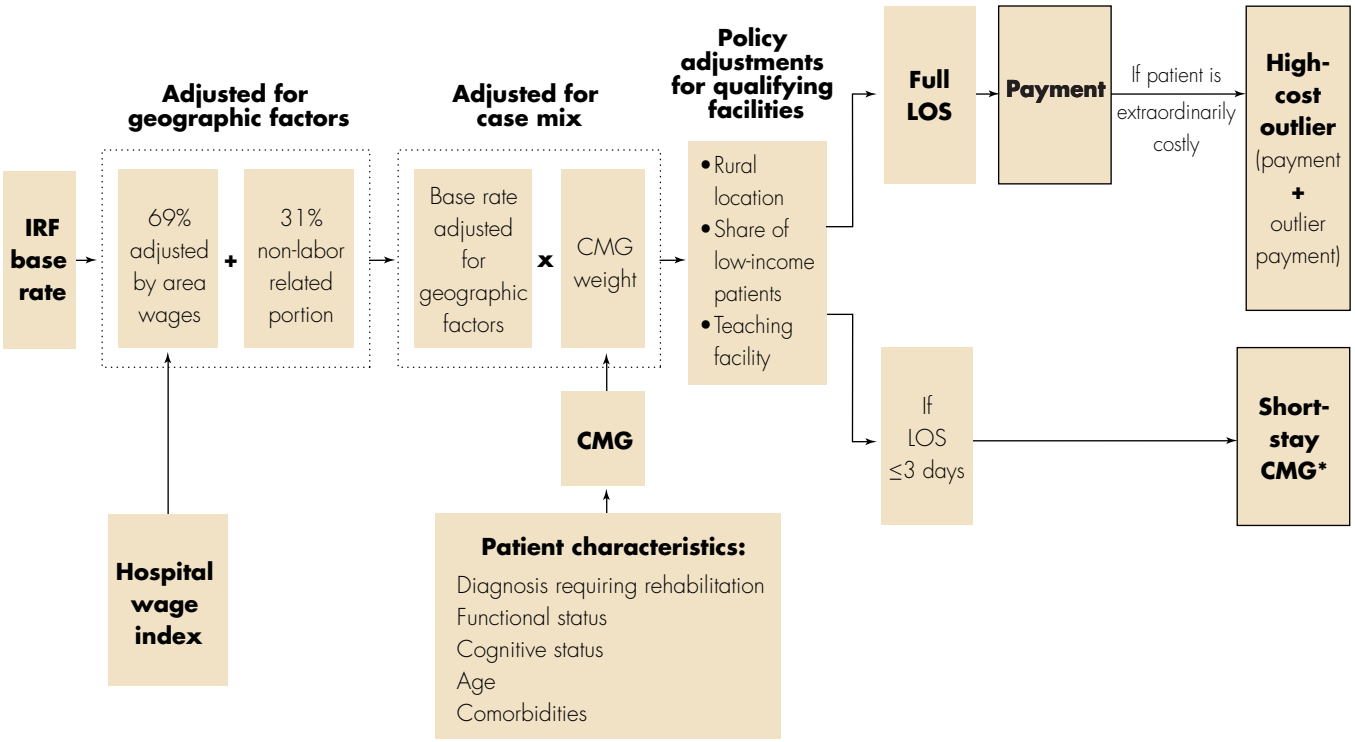
The PPS payment rates cover all operating and capital costs that IRFs are expected to incur in furnishing intensive rehabilitation services. The base rate—$15,198 for fiscal year 2015—is adjusted for area wages by multiplying the labor-related portion of the base payment amount—69 percent—by a version of the hospital wage index

This document does not reflect proposed legislation or regulatory actions.

MEDPAC

425 I Street, NW
Suite 701
Washington, DC 20001
ph: 202-220-3700
fax: 202-220-3759
www.medpac.gov

Figure 1 Inpatient rehabilitation facility prospective payment system



Note: IRF (inpatient rehabilitation facility), CMG (case-mix group), LOS (length of stay).
*IRFs with a wage index of 1.0 are paid $2,354 for short-stay cases.

(Figure 1). The wage-adjusted base rate is then case-mix adjusted by the relative weight for the CMG tier.

Payment rates are adjusted to account for certain facility characteristics. Rural facilities' payment rates are increased by 14.9 percent because they tend to have fewer cases, longer lengths of stay, and higher average costs per case. Payments for IRFs that are teaching institutions are adjusted upward based on the ratio of residents to average daily census. In addition, an IRF's payments are adjusted for the share of low-income patients it treats. This adjustment is based on the facility's combined share of Medicare days furnished to beneficiaries eligible for Supplemental Security Income benefits and the share of all patient days furnished to Medicaid patients not covered by Medicare.[3]

High-cost outliers—The IRF PPS has an outlier policy for cases that are extraordinarily costly. Medicare makes outlier payments when an IRF's estimated total costs for a case exceed the total payment amount for the case plus a fixed loss amount ($8,848 in FY 2015, adjusted by the wage index and the facility characteristics outlined above). Medicare pays 80 percent of the IRFs' costs above the threshold. High-cost outlier payments are funded by reducing the standard base payment amount for all IRFs by an amount estimated to equal 3 percent of total spending for IRFs.

Interrupted stays—IRFs receive one payment for"interrupted-stay" patients. An interrupted stay is when a patient is discharged from an IRF and returns to the same IRF within 3 days.

The 60 percent rule

To receive payment under the IRF PPS, a facility must demonstrate that it is primarily engaged in furnishing intensive rehabilitation services. The 60 percent rule is an important criterion that distinguishes IRFs from acute care hospitals. The rule requires that at least 60 percent of an IRF's patient population have one or more selected conditions that typically require intensive rehabilitation therapy. The 13 qualifying medical conditions used to demonstrate compliance are:

- stroke
- spinal cord injury
- congenital deformity
- amputation
- major multiple trauma
- hip fracture
- brain injury
- neurological disorders (e.g., multiple sclerosis, Parkinson's disease)
- burns
- three arthritis conditions for which appropriate, aggressive, and sustained outpatient therapy has failed, and
- hip or knee replacement if: replacement is bilateral, body mass index is greater than or equal to 50, or patient age is 85 or older.

Facilities that cannot demonstrate compliance with the 60 percent rule are paid as acute care hospitals under the inpatient PPS. The 60 percent rule, established in 2007 by the Medicare, Medicaid, and SCHIP Extension Act (MMSEA), replaces the 75 percent rule that preceded it.

The MMSEA also made permanent a policy allowing secondary medical conditions to meet the 13 medical conditions that qualify toward the threshold. The secondary condition, even in the absence of the admitting condition, must cause a significant enough decline in the patient's functioning that the individual would need intensive rehabilitation services best provided in an IRF.

Payment updates

Both the base rate and relative weights are updated annually. The base rate is updated using the Rehabilitation, Psychiatric, and Long-Term Care (RPL) market basket index, which measures the price increases of goods and services these facilities buy to produce patient care. The Patient Protection and Affordable Care Act of 2010 (PPACA) requires that the annual update to the IRF payment rates be reduced by an adjustment for productivity, beginning in FY 2012. PPACA also requires that the update be further reduced by an additional adjustment through 2019. ■

1 Beneficiaries are liable for a higher copayment for each lifetime reserve day—$608 per day in 2014.

2 The few patients who die in IRFs are assigned to one of four CMGs depending on the primary reason for IRF care and the patient's length of stay.

3 Unlike acute care hospitals, IRFs do not have to reach a threshold of the share of low-income patients before payments are adjusted.