CHAPTER 8

Inpatient rehabilitation facility services

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

8 For fiscal year 2026, the Congress should reduce the 2025 Medicare base payment rate for inpatient rehabilitation facilities by 7 percent.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

CHAPTER 8

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In this chapter

- Are FFS Medicare payments adequate in 2025?
- How should FFS Medicare payments change in 2026?

Chapter summary

Inpatient rehabilitation facilities (IRFs) are hospitals and units of hospitals that provide intensive rehabilitation services to patients after illness, injury, or surgery. Care provided in IRFs is supervised by rehabilitation physicians and includes services such as physical and occupational therapy, rehabilitation nursing, and speech–language pathology. In 2023, the fee-for-service (FFS) Medicare program and its beneficiaries spent $9.6 billion on 404,000 IRF stays in about 1,200 IRFs nationwide. The FFS Medicare program accounted for about 51 percent of IRF stays.

Assessment of payment adequacy

In 2023, IRF payment-adequacy indicators were positive.

Beneficiaries' access to care—Our analysis of IRF supply and volume of services provided and of IRFs' marginal profit under the IRF prospective payment system (PPS) suggests that access remains adequate.

- ***Capacity and supply of providers***—Between 2022 and 2023, the number of IRF beds increased by 3 percent. The aggregate IRF occupancy rate remained relatively stable at 69 percent, indicating that in markets with IRFs, capacity is more than adequate to meet demand.

- ***Volume of services*—**From 2022 to 2023, the total number of FFS Medicare stays in IRFs increased by about 7 percent, and stays per FFS beneficiary increased by about 10 percent. In 2023, the average length of stay was 12.5 days.
- ***FFS Medicare marginal profit*—**The FFS Medicare marginal profit, an indicator of whether IRFs with excess capacity have an incentive to treat more Medicare beneficiaries, was 18 percent for hospital-based IRFs and 40 percent for freestanding IRFs—a very strong indicator of access.

***Quality of care*—**For the two-year period of 2022 through 2023, the median facility risk-adjusted rate of discharge to the community from IRFs was 67.2 percent, essentially stable from the prior period of 2021 through 2022. The median facility risk-adjusted rate of potentially preventable readmission remained relatively stable at 8.8 percent compared with the rate of 8.6 percent over the period from 2021 through 2022 and was higher for freestanding and for-profit providers than for hospital-based and nonprofit facilities.

***Providers' access to capital*—**Between 2022 and 2023, freestanding IRFs' all-payer total margin rose from 8 percent to about 10 percent. For-profit corporations continued to open new IRFs and enter joint ventures with other organizations, suggesting strong access to capital. Hospital-based IRFs access capital through their parent hospitals.

***FFS Medicare payments and providers' costs*—**In 2023, IRFs' average payment per stay increased by less than 1 percent while average cost per stay declined slightly after several years of higher growth. As a result, IRFs' FFS Medicare margin rose to 14.8 percent, up from 13.7 percent in 2022.

How should payment rates change in 2026?

Given our positive payment-adequacy indicators, the recommendation is that, for fiscal year 2026, the 2025 IRF base payment rate should be reduced by 7 percent. This recommendation would continue to provide IRFs with sufficient revenue to maintain FFS Medicare beneficiaries' access to IRF care while bringing IRF PPS payment rates closer to the cost of efficiently delivering high-quality care. ■

Background

After illness, injury, or surgery, some patients need intensive inpatient rehabilitative care, including services such as physical and occupational therapy, rehabilitation nursing, and speech–language pathology. These services can be provided in inpatient rehabilitation facilities (IRFs).[1] IRFs must be focused primarily on treating conditions that typically require intensive rehabilitation, among other requirements. IRFs can be fully licensed freestanding hospitals or specialized units within hospitals. To qualify for a covered IRF stay, a beneficiary must, among other criteria, be able to tolerate and benefit from intensive therapy and must have a condition that requires frequent, face-to-face supervision by a rehabilitation physician. Fee-for-service (FFS) Medicare payments for inpatient IRF services are based on a per stay prospective payment system (PPS).[2] In 2023, about 1,200 IRFs furnished 404,000 Medicare-covered stays. FFS Medicare spending on IRF services was $9.6 billion ($9.5 billion in program spending and $0.1 billion in beneficiary cost-sharing liability). FFS Medicare beneficiaries accounted for about 51 percent of IRF stays.[3]

Medicare facility requirements for IRFs

To qualify as an IRF for Medicare payment, a facility must meet the Medicare conditions of participation for acute care hospitals (ACHs). It must also:

- have a preadmission screening process to determine that each prospective patient is likely to benefit significantly from an intensive inpatient rehabilitation program;
- ensure that the patient receives close medical supervision and provide—through qualified personnel—rehabilitation nursing; physical therapy, occupational therapy, and, as needed, speech–language pathology; psychological (including neuropsychological) services; social services; and orthotic and prosthetic services;
- have a medical director of rehabilitation with training or experience in rehabilitation who provides services in the facility on a full-time basis for freestanding IRFs or at least 20 hours per week for hospital-based IRF units;
- use a coordinated interdisciplinary team led by a rehabilitation physician that includes a rehabilitation nurse, a social worker or case manager, and a licensed therapist from each therapy discipline involved in the patient's treatment;
- have a plan of care for each patient, which is established, reviewed, and revised as needed by a physician in consultation with other professional personnel who provide services to the patient; and
- meet the compliance threshold, which requires that no less than 60 percent of patients admitted to an IRF have as a primary diagnosis or comorbidity at least 1 of 13 conditions specified by CMS.[4] The intent of the compliance threshold is to distinguish IRFs from ACHs. If an IRF does not meet the compliance threshold, Medicare pays for all its patients' stays based on the inpatient hospital PPS rather than the IRF PPS.

During the coronavirus public health emergency (PHE), some of the requirements were waived.[5] When the PHE ended on May 11, 2023, requirements were reinstated.

Medicare coverage criteria for beneficiaries

Medicare applies additional criteria to specify whether IRF services are covered for an individual Medicare beneficiary. For an IRF claim to be considered reasonable and necessary, the patient must be reasonably expected to meet the following requirements at admission:[6]

- The patient requires active and ongoing therapy in at least two modalities, one of which must be physical or occupational therapy. The patient can actively participate in and benefit from intensive therapy that most typically consists of three hours of therapy a day at least five days a week.
- The patient is sufficiently stable at the time of admission to actively participate in the intensive rehabilitation program.
- The patient requires supervision by a rehabilitation physician. This requirement is satisfied by face-to-face physician visits with a patient at least three days a week. Beginning with the second week of the IRF stay, a nonphysician practitioner who is determined by the IRF to have specialized

training and experience in inpatient rehabilitation may conduct one of the three required face-to-face visits with the patient per week, provided that such duties are within the nonphysician practitioner's scope of practice under applicable state law.

- The patient requires an intensive and coordinated interdisciplinary team approach to the delivery of rehabilitative care.

Are FFS Medicare payments adequate in 2025?

To examine the adequacy of FFS Medicare payments, we analyze beneficiaries' access to care (including the capacity and supply of IRFs and changes over time in the volume of services provided), quality of care, providers' access to capital, and the relationship between Medicare payments and providers' costs.

In general, our indicators of IRF payment adequacy are positive.

IRF supply and service volume suggest sufficient access

Nevertheless, our analysis of IRF supply and volume of services suggests that, in markets with IRFs, capacity remains adequate to meet demand. Moreover, FFS Medicare marginal profit, an indicator of whether IRFs with excess capacity have an incentive to treat more Medicare beneficiaries, was robust in 2023 for both freestanding and hospital-based IRFs, a very strong indicator of patient access.

Number of IRFs and occupancy rates suggest adequate capacity and supply

In 2023, the supply of IRFs grew, with more openings (49) than closures (24). The majority of new IRFs were freestanding for-profit facilities and opened in markets in which another IRF was already serving beneficiaries; most closures were nonprofit hospital-based facilities in areas with another IRF. After rising by less than 1 percent per year between 2019 to 2022, the number of IRFs increased by 2.1 percent between 2022 and 2023, climbing from 1,181 to 1,206 (Table 8-1). The majority of IRFs (1,051) were located in urban areas, and 155 were located in rural areas (13 percent). About two-thirds of IRFs in urban areas were hospital-based facilities compared with 92 percent among IRFs in rural areas (data not shown).

The growth in the number of IRFs was driven by a 7.4 percent increase in freestanding IRFs in 2023 compared with the prior year (Table 8-1). In contrast, the number of hospital-based IRFs continued to decline, falling by 0.1 percent between 2022 and 2023. Freestanding IRFs tended to be larger facilities compared with hospital-based IRFs: In 2023, 95 percent of freestanding IRFs had 25 or more beds, while most hospital-based IRFs (60 percent) had fewer than 25 beds (data not shown).

Nationwide, the number of IRF beds grew by about 3 percent, with an increase in beds in freestanding for-profit IRFs and a slight decrease in beds in the hospital-based nonprofit IRFs. In 2023, the aggregate IRF occupancy rate remained relatively stable at 69 percent compared with 68 percent in the prior year. From 2022 to 2023, the aggregate occupancy rate increased slightly among freestanding IRFs (from 71 percent to 73 percent) and remained stable at about 65 percent among hospital-based IRFs. In general, larger IRFs had higher occupancy rates than smaller IRFs. These rates suggest that, in markets with IRFs, capacity is adequate to meet demand for IRF services.

In 2022, less than 30 percent of hospital service areas (HSAs) had one or more IRFs.[7] (By comparison, 97 percent of HSAs contained at least one skilled nursing facility (SNF).) Of markets with IRFs, most had only hospital-based IRFs (67 percent) or only freestanding IRFs (18 percent), and about 15 percent had both types. (In interviews conducted last year with a small set of ACH discharge planners and executives regarding discharges to an IRF or SNF, interviewees did not distinguish between IRF services received in hospital-based or freestanding IRFs (L & M Policy Research 2023)). Seventy percent of Medicare beneficiaries (including those in FFS and Medicare Advantage) lived in HSAs with IRFs; only about 30 percent of FFS Medicare beneficiaries lived in an HSA without an IRF. Some beneficiaries who lived in these HSAs traveled to other areas to receive IRF care or received rehabilitative care from other post-acute care (PAC) providers.

IRFs are intended to provide a more intense level of therapy under direct medical supervision, but other

TABLE 8–1

The number of for-profit and freestanding IRFs grew in 2023

Type of IRF	Share of Medicare FFS stays 2023	Number of IRFs					Average annual percent change 2019–2022	Percent change 2022–2023
		2019	2020	2021	2022	2023		
All IRFs	100%	1,152	1,159	1,181	1,181	1,206	0.8%	2.1%
Urban	94	1,000	1,004	1,021	1,021	1,051	0.7	2.9
Rural	6	152	155	160	160	155	1.7	–3.1
Freestanding	61	299	310	329	345	371	4.9	7.4
Hospital based	39	853	849	852	836	835	–0.7	–0.1
Nonprofit	30	634	623	620	602	598	–1.7	–0.7
For profit	66	393	414	436	457	503	5.2	10.1
Government	5	116	113	115	111	105	–1.5	–5.4

Note: IRF (inpatient rehabilitation facility), FFS (fee-for-service). Components may not sum to totals due to missing data.

Source: MedPAC analysis of Provider of Services data and Medicare Provider Analysis and Review data from CMS.

providers also furnish post-acute care services in communities with and without IRFs. SNFs provide post-acute care in an institutional setting, and home health agencies, hospital outpatient departments, comprehensive outpatient rehabilitation facilities, and independent therapy providers furnish such care at a beneficiary's home or on an outpatient basis. Given the number and distribution of these other providers, it is unlikely that IRFs are the only provider of post-acute care services available to Medicare beneficiaries in any given area.

Few evidence-based guidelines exist to help direct beneficiaries to the post-acute care setting with the best outcomes. For example, one study of patients treated for debility in IRFs concluded that more research was needed to identify the most appropriate setting (Kortebein et al. 2008). However, stroke guidelines established by the American Heart Association/American Stroke Association outline best practices in rehabilitation care for stroke patients (e.g., prevention of falls and skin breakdown and pain management) and recommend placement in IRFs over SNFs for patients who qualify for IRF services (Winstein et al. 2016).

In 2023, IRF stays per beneficiary exceeded prepandemic levels

The number of IRF stays for FFS Medicare beneficiaries increased substantially in 2023 after falling at the start of coronavirus pandemic in 2020 (Table 8-2, p. 254). From 2022 to 2023, the number of stays rose by 7.3 percent, and the number of stays per 10,000 FFS beneficiaries rose by 10.4 percent. Stays per FFS Medicare beneficiary in 2023 were well above prepandemic levels (120 stays per 10,000 FFS beneficiaries in 2023 compared with 107 in 2019). Growth in the number of stays per FFS beneficiary was higher among freestanding IRFs (12 percent higher than the prior year) than for hospital-based IRFs (7 percent) (data not shown). The average length of stay decreased in 2022 and 2023, after increasing during the coronavirus pandemic, falling to just below prepandemic levels (Table 8-2, p. 254).

Patterns of use in IRFs

In 2023, the most common condition treated by IRFs was stroke—accounting for almost one-sixth of stays—followed by "other neurological conditions" and "debility."

TABLE 8–2

IRF stays per FFS Medicare beneficiary increased to above prepandemic levels in 2023

	2019	2020	2021	2022	2023	Average annual percent change 2019–2022	Percent change 2022–2023
Inpatient stays (thousands)	404	374	373	376	404	0.0%	7.3%
Inpatient stays per 10,000 beneficiaries	107	101	104	109	120	2.8	10.4
Average length of stay (days)	12.6	12.9	12.9	12.8	12.5	–0.2	–2.3

Note: IRF (inpatient rehabilitation facility), FFS (fee-for-service). Percentage changes were calculated on unrounded data.

Source: MedPAC analysis of Medicare Provider Analysis and Review and enrollment data from CMS.

The distribution of stay types differs by type of IRF and ownership (Table 8-3). For example, in 2023, only 13 percent of stays in freestanding for-profit IRFs were admitted for rehabilitation following a stroke, compared with 21 percent of stays in hospital-based nonprofit IRFs. By contrast, 20 percent of stays in freestanding for-profit IRFs were admitted with "other neurological conditions," more than twice the share admitted to hospital-based nonprofit IRFs. Stays for "fracture of the lower extremity" made up a larger share of stays in hospital-based for-profit facilities than in all other IRF types. The share of stays with "debility," "brain injury," and "other orthopedic conditions" were similar across IRF types. The distribution of stay types was relatively stable between 2019 and 2023 (data not shown). The Commission has previously reported that some stay types are more profitable than others under the IRF PPS (for more details, see the IRF chapter of our March 2023 report to the Congress).

FFS Medicare marginal profit indicates an incentive to treat more Medicare beneficiaries

Another component of access is whether providers have a financial incentive to expand the number of FFS Medicare beneficiaries they serve. To assess this component, we examine the FFS Medicare marginal profit—the percentage of revenue from FFS Medicare that is left as profit after subtracting the variable costs of providing services to FFS Medicare patients. (Variable costs vary with the number of patients treated. By contrast, fixed costs do not vary (at least in the short run) regardless of the number of patients treated (e.g., rent).) If the FFS Medicare marginal profit is positive, a provider with excess capacity has a financial incentive to care for an additional FFS beneficiary; if the FFS Medicare marginal profit is negative, a provider may have a disincentive to care for an additional FFS beneficiary. (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability.)

When FFS Medicare payments exceed providers' total costs for providing those services, examining the FFS Medicare marginal profit does not yield any additional information about the adequacy of FFS Medicare payment rates. Moreover, it is difficult to use cost reports to precisely estimate IRFs' variable costs. However, when using our estimates from prior work—that about 80 percent of IRFs' costs were variable—in 2023, IRFs' FFS Medicare marginal profit was 31 percent in aggregate, 18 percent among hospital-based IRFs, and 40 percent for freestanding IRFs. If we had instead used the 85 percent upper-bound estimate from our hospital analysis of the share of costs that was variable, IRFs' FFS Medicare marginal profit would still have been substantially positive at 28 percent. Both estimates of marginal profit suggest that IRFs with available beds have a strong financial incentive to admit FFS Medicare

TABLE 8–3

Mix of FFS Medicare IRF stays differed by provider type and selected conditions, 2023

Condition	Freestanding		Hospital based	
	For profit	Nonprofit*	For profit	Nonprofit*
All (share of stays)	57%	5%	9%	29%
Percent of total				
Stroke	13	21	14	21
Other neurological conditions	20	7	10	7
Fracture of the lower extremity	10	10	15	13
Debility	14	14	16	14
Brain injury	12	12	13	12
Other orthopedic conditions	9	7	8	7
All other conditions	22	27	23	25

Note: FFS (fee-for-service), IRF (inpatient rehabilitation facility). "Other neurological conditions" includes neuromuscular disorders, multiple sclerosis, Parkinson's disease, and polyneuropathy included in the neurological impairment group. "Fracture of the lower extremity" includes hip, pelvis, and femur fractures. Patients with debility have generalized deconditioning not attributable to other conditions. "Other orthopedic conditions" excludes fractures of the hip, pelvis, and femur, as well as hip and knee replacements. "Brain injury" includes both traumatic and nontraumatic injuries. Freestanding proprietary IRFs are more likely to have stays in certain subcategories of the "other neurological conditions": neuromuscular conditions (such as myasthenia gravis, motor neuron disease, post-polio syndrome, muscular dystrophy, and other myopathies) and other neurological disorders (such as other extrapyramidal disease, abnormal movement disorders, and hereditary ataxia). Column components may not sum to 100 percent due to rounding.
* "Nonprofit" columns include government IRFs.

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

patients. Therefore, in future years, the Commission may consider whether to continue to report the marginal profit when Medicare total payments more than cover providers' total costs.

Quality of care: Discharge to the community and potentially preventable readmissions

In our assessment of payment adequacy, the Commission prioritizes quality measures tied to clinical outcomes. We report two outcome measures for IRFs: risk-adjusted potentially preventable hospital readmissions after discharge and risk-adjusted discharge to the community, which are claims-based outcome measures developed by CMS. CMS publicly reports facility-level measures after providers are given an opportunity to review the data. The measures are updated annually and cover a 24-month period. The most recent available data, released in October 2024, cover fiscal year (FY) 2022 through FY 2023. Data from this period indicate that, in aggregate, rates of successful discharge to the community and potentially preventable readmissions were stable compared with the previous 24-month period.

Readmissions and community-discharge measures assess key outcomes of IRF care, but they do not capture all aspects of quality in IRFs. Ideally, we could measure other outcomes and the experience of IRF care for Medicare beneficiaries in a Part A stay. However, lack of data on patient experience and concerns about the validity of function data limit our ability to assess the quality of IRF care.

Successful discharge to the community

The measure of successful discharge to the community is the rate at which patients returned home or to the community from the IRF and remained alive without

any unplanned hospitalizations in the 31 days following discharge (higher rates are better) (Centers for Medicare & Medicaid Services 2023).[8] IRFs can improve their rate of successful discharge to the community by providing rehabilitation strategies to improve functional ability, discharge planning and care coordination, patient and family education, and solutions to barriers a patient may face in the community.

From FY 2022 through FY 2023, the median facility risk-adjusted rate of successful discharge to the community was 67.2 percent, almost exactly the same as the rate for FY 2021 and FY 2022, which was 67.3 percent (latter figure not shown). About one-quarter of facilities had a risk-adjusted rate below 63.8 percent and one-quarter had a rate above 70.3 percent (Figure 8-1). Discharges to community by rural IRFs were slightly lower than for urban IRFs (with a median of 66.1 percent compared with 67.4 percent, respectively) (data not shown).

Potentially preventable readmissions

Readmissions expose beneficiaries to hospital-acquired infections, increase the number of transitions between settings (which is disruptive to patient care), and can result in medical error. In addition, they unnecessarily increase Medicare spending (Centers for Medicare & Medicaid Services 2023). IRFs can reduce the number of potentially preventable hospital readmissions by preventing complications, providing clear discharge instructions to patients and families, and ensuring a safe discharge plan. Potentially preventable readmissions after discharge are calculated as the percentage of patients discharged from an IRF stay who were readmitted to a hospital within 30 days for a medical condition that might have been prevented (lower percentages are better). During the FY 2022 and FY 2023 period, the median facility-level risk-adjusted rate of potentially preventable readmissions was 8.8 percent (relatively similar to 8.6 percent for the FY 2021 and FY 2022 period). In 2023, about one-quarter of facilities had a risk-adjusted rate below 8.4 percent and one-quarter had a rate above 9.3 percent (Figure 8-1). The rate was higher (worse) among freestanding and for-profit providers than for hospital-based and nonprofit providers (Figure 8-1). The rate of potentially preventable readmissions was the same for urban and rural IRFs (data not shown).

Patient-experience data are not collected for IRF patients

Patient experience is an important measure of quality. Research finds that, across the health care system, improving patient experience correlates with better health outcomes and adherence to treatment plans (Boulding et al. 2011, Navarro et al. 2021). The Commission has recommended the general use of patient-experience surveys for beneficiaries who use SNF services (Medicare Payment Advisory Commission 2022, Medicare Payment Advisory Commission 2018).

CMS has developed a survey of patients' experience of IRF care for public use but is not requiring or collecting results through the Quality Reporting Program (Centers for Medicare & Medicaid Services 2023).[9] In order to implement the survey, CMS would need to develop patient-experience measures based on the survey responses and develop a process for third-party vendors to collect survey results.

Concerns about the validity of function data limit our set of IRF quality measures

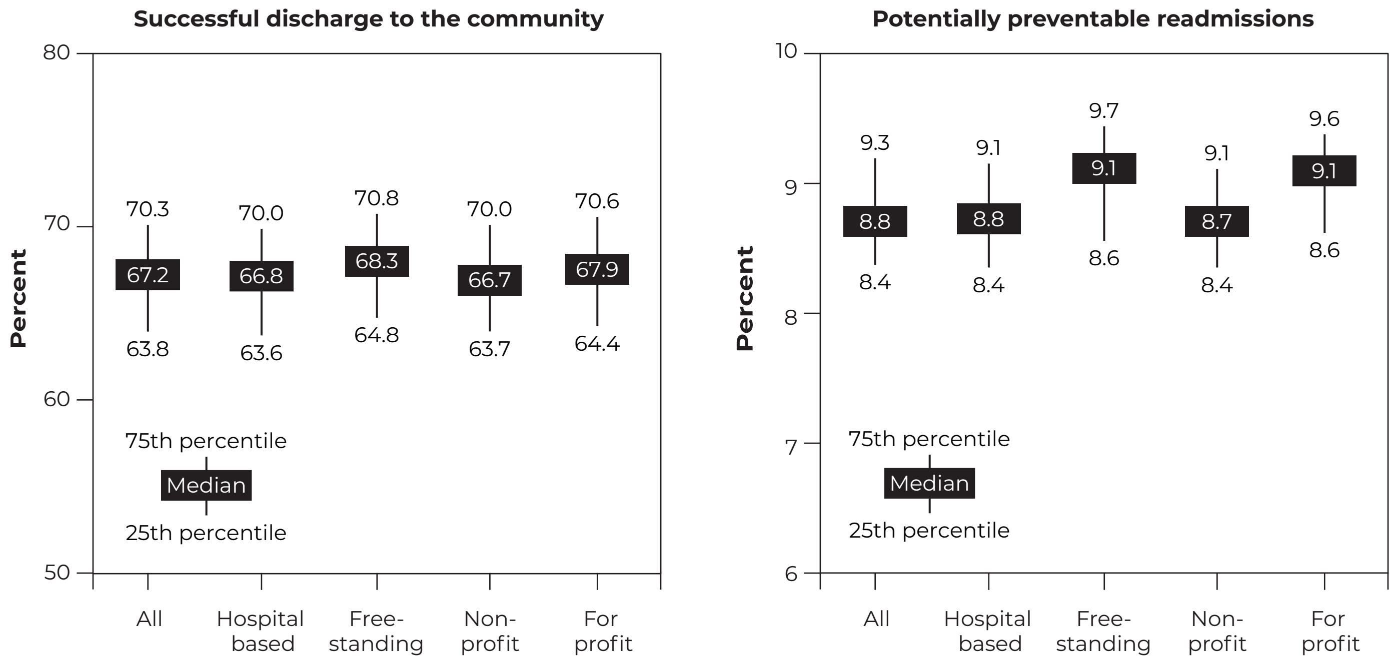
We did not assess measures of provider-reported functional improvement, even though functional outcomes are critically important to patients in need of rehabilitative care. While the Commission contends that maintaining and improving functional status is a key outcome of PAC, over time we have become so concerned about the integrity of this information that we do not report it as a reliable indicator of provider quality. (For a detailed discussion of functional-assessment data, see our June 2019 report to the Congress.) Because functional assessments are used in the case-mix system to establish payments, it is difficult to separate this information from payment incentives. The reporting of assessment data must be improved such that these outcomes can be adequately assessed. In our June 2019 report to the Congress, the Commission discussed strategies to improve the assessment data, the importance of monitoring the data reporting, and alternative measures of function (such as patient-reported surveys) that do not rely on provider-completed assessments (Medicare Payment Advisory Commission 2019).

IRFs' access to capital remained strong for freestanding IRFs in 2023

More than 60 percent of IRFs are hospital-based units that access any necessary capital through their parent

FIGURE 8–1

Median and interquartile range of IRFs' risk-adjusted rates of discharge to the community and potentially preventable readmissions in FY 2022 and FY 2023



Note: IRF (inpatient rehabilitation facility), FY (fiscal year). The measure of "potentially preventable readmissions" (in the 30 days postdischarge) captures all unplanned, potentially preventable readmissions for beneficiaries who received services in an IRF. "Successful discharge to community" includes beneficiaries discharged to the community who did not have an unplanned rehospitalization and/or die in the 31 days following discharge. Both measures are defined uniformly and risk adjusted across post-acute care settings. Providers with at least 25 stays in the year were included in calculating the average facility rate. High rates of successful discharge to the community indicate better quality. High rates of potentially preventable 30-day postdischarge readmissions indicate worse quality.

Source: Medicare Care Compare data from CMS.

hospitals to maintain, modernize, or expand. Overall, as detailed in the hospital chapter of this report (Chapter 3), ACHs' access to capital generally improved in 2023. The all-payer operating margin for hospitals paid under the inpatient prospective payment systems increased to 5.1 percent in 2023, up from 2.7 percent in 2022, despite a decline in coronavirus relief funds. (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability.) In addition, investment income for these hospitals increased. Hospitals' borrowing costs increased in 2023 and remained elevated 2024, but the increase was less than in the general market.

In 2023, the all-payer total margin for freestanding IRFs increased to about 10 percent, up from 8 percent in 2022.[10] However, the spread in all-payer margins across groups of freestanding IRFs varied by ownership: For-profit freestanding IRFs' all-payer total margin was about 13 percent in 2023, remaining steady over the last few years, while the all-payer margin for the small number of nonprofit freestanding IRFs continued to be much lower at 1 percent, though it did grow substantially from –6 percent in 2022.

In 2023, the IRF industry's largest corporation, Encompass Health, which owned almost 44 percent of freestanding IRFs and accounted for about 32 percent of all FFS Medicare IRF stays, opened eight IRFs with a combined total of 395 beds and added 46 beds to its existing IRFs. Encompass Health's growth continued in 2024 when it added six new hospitals with a combined total of 280 beds and a 40-bed satellite plus 110 beds to existing facilities. According to its latest investor

report, the company has 16 additional IRFs under development.

Most other freestanding IRFs are independent or local chains with a limited number of facilities. The extent to which these nonchain IRFs have access to capital is less clear, though recently two smaller health care corporations that own and operate freestanding IRFs announced plans to build more facilities (ClearSky Health 2024, PAM Health 2024).

Medicare payments and providers' costs: IRFs' FFS Medicare margin remained strong in 2023

In 2023, IRFs' FFS Medicare payments per stay grew faster than IRFs' costs per stay. As a result, the FFS Medicare margin increased in 2023 and remained strong at 14.8 percent. Margins continued to vary widely across types of IRFs, with higher margins in IRFs that were freestanding, for profit, urban, larger, and with a greater share of FFS Medicare days. (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability.)

In 2023, IRFs' payments per stay increased slightly while costs declined

From 2022 to 2023, IRFs' payments per stay grew by 0.9 percent, which was less than in recent years. However, over the same period, IRFs' costs per stay declined by 0.4 percent. Payments and costs per stay varied by type of IRF; notably, among freestanding IRFs, payments per stay increased by 1.5 percent while their costs increased by 0.2 percent. Among hospital-based IRFs, payments per stay increased by 0.5 percent while costs per stay grew by 0.3 percent. Aggregate costs declined because costs per stay are generally lower for freestanding IRFs than for hospital-based IRFs, and growth in the number of stays in freestanding IRFs has been outpacing growth at hospital-based IRFs.

Two factors likely contribute to substantially lower costs per stay among freestanding IRFs than in hospital-based IRFs. First, freestanding IRFs tend to be larger than hospital-based ones. In 2023, almost all freestanding IRFs had more than 25 beds, with about 30 percent having more than 65 beds; by contrast, about 65 percent of hospital-based IRFs had fewer than 25 beds, with about 10 percent having 10 or fewer beds. Because of their size, freestanding IRFs are more likely to achieve economies of scale. Higher occupancy rates in freestanding IRFs (73 percent in 2023 vs. 65 percent for hospital-based IRFs) also contribute to economies of scale.

Margins vary widely

In 2023, the IRF FFS Medicare margin was 14.8 percent, up from 13.7 percent in 2022. The FFS Medicare margin increased for nearly all subgroups of IRFs we examined, though significant variation in margins persisted (Table 8-4). For example, hospital-based IRFs' FFS Medicare margin was 1.0 percent, compared with 24.2 percent for freestanding IRFs. Overall, the FFS Medicare margin was higher for IRFs that were freestanding, for profit, urban, and larger (25 or more beds). In contrast, the FFS Medicare margin continued to be lower among IRFs that were hospital based, nonprofit, and small (fewer than 25 beds). IRFs in the smallest bed-size category (1 to 10 beds) were primarily hospital-based IRFs, and IRFs in the largest bed-size category (65 or more beds) were primarily freestanding IRFs. Notably, the FFS Medicare margin was higher for IRFs with a high share of FFS Medicare days.

FFS Medicare margins also vary by IRFs' share of low-income patients (Table 8-4). Like the disproportionate-share-hospital adjustment for acute care hospitals paid under the inpatient PPS, IRFs receive low-income-patient (LIP) payments that are intended to offset costs incurred by treating a large or disproportionate share of low-income patients.[11] Nevertheless, the FFS Medicare margin in IRFs that serve a higher share of beneficiaries with low incomes is generally lower than the margin of other IRFs: In 2023, the FFS Medicare margin for IRFs with a large share of low-income patients (those with an LIP share of 25 percent or more) was 5.4 percent, compared with 19.1 percent for IRFs with a small LIP share (less than 5 percent). The LIP share in 2023 differed slightly between freestanding providers (about 14 percent) and hospital-based providers (about 16 percent) (data not shown).

Numerous factors contribute to lower margins in hospital-based IRFs

The Commission has long noted the substantial difference between hospital-based and freestanding IRFs' FFS Medicare margins. Several factors likely contribute to this difference:

TABLE 8–4

IRFs' FFS Medicare margin rose in 2023

Type of IRF	2019	2020	2021	2022	2023
All IRFs	14.1%	13.3%	16.9%	13.7%	14.8%
Hospital based	1.7	1.4	5.7	0.8	1.0
Freestanding	24.6	23.4	25.9	23.3	24.2
Nonprofit	1.1	–0.3	5.3	–0.5	–0.2
For profit	24.2	23.4	25.3	22.7	23.5
Government	N/A	N/A	N/A	N/A	N/A
Urban	14.5	13.6	17.3	14.1	15.0
Rural	7.6	9.0	11.7	7.7	11.2
Number of beds					
1 to 10	–9.1	–7.3	–2.7	–6.5	–5.3
11 to 24	1.6	2.2	5.7	1.1	1.0
25 to 64	15.8	14.8	18.6	15.0	16.6
65 or more	20.9	19.3	22.2	19.8	20.4
Share of FFS Medicare days					
<50%	9.2	8.0	11.8	6.6	7.2
50% to 75%	18.0	17.0	20.3	18.1	19.3
>75%	17.9	21.1	24.6	21.6	20.5
Low-income patient share					
0% to 5%	15.9	15.5	19.6	17.4	19.1
5% to 10%	18.0	16.9	19.4	16.4	17.8
10% to 15%	15.4	14.4	17.7	13.6	13.9
15% to 20%	13.9	14.1	15.4	14.3	15.3
20% to 25%	2.5	5.8	17.6	6.2	12.1
>25%	6.5	5.3	9.6	9.9	5.4

Note: IRF (inpatient rehabilitation facility), FFS (fee-for-service), N/A (not applicable). Government-owned facilities operate in a different financial context from other facilities, so their margins are not necessarily comparable. Their margins are not presented separately here, although they are included in the margins for other groups (e.g., "all IRFs"), where applicable.

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

- *Higher costs per stay in hospital-based IRFs:* In 2023, on average, standardized cost per stay was $21,000 for hospital-based IRFs compared with $15,000 for freestanding IRFs. Although on average both routine and ancillary costs per stay were higher among hospital-based IRFs, routine costs per stay were substantially higher among hospital-based IRFs than freestanding IRFs. The amount of IRFs' routine costs per stay (such as room and board) may depend, to some extent, on how the parent hospital allocates its overall routine costs to its IRF subunit; presumably, a larger share of

routine costs at freestanding IRFs would be directly related to IRF services. In addition, higher costs at hospital-based IRFs can stem, in part, from a relative lack of economies of scale because facilities tend to be smaller and have lower occupancy rates (65 percent vs. 73 percent for freestanding IRFs, as discussed above).

- *Differences in patient mix not accounted for by the payment system:* As noted previously, there are also marked differences in hospital-based and freestanding IRFs' mix of stays. In 2023, compared with hospital-based IRFs, freestanding IRFs admitted a smaller share of patients with stroke as the primary reason for rehabilitation and a larger share of patients with a diagnosis in the "other neurological conditions" category (Table 8-3, p. 255).[12] The Commission previously reported on profitability differences among different types of stays: Notably, "other neurological" stays were among the most profitable, with payments in aggregate exceeding costs by 26 percent in 2019 (Medicare Payment Advisory Commission 2024). In contrast, stroke stays were among the least profitable case types in IRFs. As we noted in our March 2024 report, using an alternative method to set payment weights in the IRF PPS would yield more uniform profitability across case-mix groups (Medicare Payment Advisory Commission 2024).[13] This change could also help to reduce providers' incentives to code patients as more functionally impaired (thereby increasing case-mix severity and payment rates). The Commission has previously reported findings that were suggestive of such differential coding between freestanding and hospital-based IRFs.[14]
- *Differential prevalence of outlier stays:* Hospital-based IRFs' higher costs and patient mix may contribute to their increased likelihood of outlier stays, which are stays with extraordinarily high costs. In 2023, hospital-based IRF providers accounted for about 40 percent of FFS stays in 2023 and 78 percent of high-cost outlier stays. Although outlier payments diminish the financial loss per outlier stay, by design, outlier payments do not completely cover facilities' costs. Since outlier payments cover only a portion of the excess costs, having more outliers has the potential to lower margins.

Despite hospital-based IRFs' higher costs and lower margin compared with freestanding IRFs, they have a financial incentive to admit Medicare patients. The FFS margin among hospital-based IRFs is about 1 percent, which is substantially higher than the ACH margin (about –13 percent in 2023 as reported in Chapter 3). Moreover, ACHs can discharge eligible patients to their IRF subunits, enabling the hospital to open beds to additional acute care patients. Indeed, the FFS margin among ACHs with IRF subunits is slightly higher than the margin among ACHs without IRF subunits.

How should FFS Medicare payments change in 2026?

Under current law, Medicare's IRF PPS base payment rate is increased annually based on the projected increase in the IRF market basket, less an amount for productivity improvement. The final update for 2026 will not be set until summer 2025; however, using CMS's third-quarter 2023 projections of the market basket and productivity, the update would increase IRF payment rates by 2.6 percent.

The payment-adequacy indicators for Medicare IRF services are positive and show that FFS Medicare payments continue to substantially exceed costs, as they have for many years. The high FFS Medicare margin indicates that the IRF PPS exerts too little pressure on providers to control costs.

RECOMMENDATION 8

For fiscal year 2026, the Congress should reduce the 2025 Medicare base payment rate for inpatient rehabilitation facilities by 7 percent.

RATIONALE 8

Our indicators of access to care are positive. In 2023, the number of IRFs and stays per FFS beneficiary increased. The FFS Medicare marginal profit remained robust in 2023, at 18 percent for hospital-based IRFs and 40 percent for freestanding IRFs. IRFs' FFS Medicare margin of 14.8 percent in 2023 and our projected margin of 16 percent for 2025 indicate that FFS Medicare payments continue to substantially exceed the costs of caring for beneficiaries. The IRF

PPS base payment rate must be reduced to better align aggregate payments to aggregate costs.

IMPLICATIONS 8

Spending

- Current law is expected to increase the IRF base payment rate by 2.6 percent. This recommendation would decrease Medicare spending relative to current law by between $750 million and $2 billion in one year and by between $10 billion and $25 billion over five years.

Beneficiary and provider

- We do not expect this recommendation to have an adverse effect on FFS Medicare beneficiaries' access to care or out-of-pocket spending. Given the current level of payments, we expect that the recommendation may increase financial pressure for some providers. ■

Endnotes

1 In markets without IRFs, beneficiaries who need skilled nursing care or therapy services on an inpatient basis are usually admitted to skilled nursing facilities, which have less extensive requirements regarding the amount of therapy and the frequency and level of medical supervision their patients must receive.

2 More information about the prospective payment system for IRFs is available at https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_24_IRF_FINAL_SEC.pdf.

3 Among freestanding IRFs in 2023, about 48 percent of all payments were for FFS Medicare patients. The FFS Medicare share of total IRF payments could not be calculated for hospital-based IRFs due to data limitations on the cost reports.

4 The 13 conditions are stroke; spinal cord injury; congenital deformity; amputation of a lower limb; major multiple trauma; hip fracture; brain injury; certain other neurological conditions (multiple sclerosis, Parkinson's disease, cerebral palsy, and neuromuscular disorders); burns; three arthritis conditions for which appropriate, aggressive, and sustained outpatient therapy has failed; and hip or knee replacement when it is bilateral, the patient's body mass index is greater than or equal to 50, or the patient is age 85 or older. In fiscal years 2014, 2015, and 2018, CMS updated its lists of International Classification of Diseases, 10th Revision, Clinical Modification, codes, replacing certain general codes (such as the arthritis codes) with more specific ones for patients who would be likely to require intensive rehabilitation therapy. The algorithm is described at https://www.cms.gov/files/document/specifications-determining-irf-60-rule-compliance.pdf, but changes to the diagnosis lists were made in the fiscal year 2023 rule and are posted on the CMS website.

5 During the PHE, some exceptions were made to IRF requirements. These included flexibility in applying the 60 percent rule, freezing the IRF's teaching-status payments at levels prior to the PHE, and flexibility for facilities responding to information requests related to appeals (Centers for Medicare & Medicaid Services 2020).

6 During the PHE, some exceptions were made to IRF Medicare coverage criteria for beneficiaries. These included waiver of the rule requiring three hours of therapy five days a week, allowing telehealth visits to replace the face-to-face visits required at least three times per week, and allowing weekly interdisciplinary team meetings to take place electronically (Centers for Medicare & Medicaid Services 2020).

7 HSAs are local health care markets for hospital care. An HSA is a collection of ZIP codes where Medicare residents receive most of their hospitalizations from hospitals in that area. There are 3,435 HSAs. See https://www.dartmouthatlas.org.

8 "Community," for this measure, is defined as home/self-care, with or without home health services, based on Patient Discharge Status Codes 01, 06, 81, and 86 on the FFS Medicare claim.

9 https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility/irf-patient-experience-care.

10 Hospital cost reports do not require hospitals to report an all-payer margin specifically for their IRFs or other hospital-based units.

11 We use CMS's definition of the low-income patient adjustment. CMS defines an IRF's low-income patient share as the sum of two ratios: the share of all Medicare days devoted to patients on Supplemental Security Income plus the share of Medicaid days out of all inpatient days.

12 Compared with hospital-based IRFs, freestanding IRFs (which are mostly for profit) are more likely to have stays in certain subcategories of the "other neurological conditions": neuromuscular conditions (such as myasthenia gravis, motor neuron disease, post-polio syndrome, muscular dystrophy, and other myopathies) and other neurological disorders (such other extrapyramidal disease, abnormal movement disorders, and hereditary ataxia).

13 We simulated the effect of replacing CMS's current hospital-specific relative-value method for setting payment weights in the IRF PPS with the "average-cost" method that is used in other Medicare payment systems (Medicare Payment Advisory Commission 2024).

14 In an analysis of data from 2013, we found that, within case types, patients cared for by high-margin IRFs, compared with those in low-margin IRFs, were less severely ill during their preceding acute care hospitalization but appeared to be more functionally disabled upon assessment in the IRF (Medicare Payment Advisory Commission 2016). This pattern persisted across case types and suggested that assessment and coding practices might contribute to greater profitability in some IRFs. Based on these findings, the Commission recommended that the Secretary conduct analyses of IRF coding and reassess the interrater reliability of the IRF Patient Assessment Instrument to help ensure payment accuracy and improve program integrity.

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