INPATIENT REHABILITATION FACILITY PROSPECTIVE PAYMENT SYSTEM AND THE 75 PERCENT RULE

Medicare is expected to pay inpatient rehabilitation facilities (IRFs) approximately $7 billion in 2005. In managing the IRF payment system, CMS is primarily concerned with ensuring that beneficiaries have access to high quality care in the most appropriate setting and that Medicare payments are appropriate for the services provided. The "75 percent rule" works to do this by insuring that IRFs continue to provide care to patients who have a need for a more intensive level of therapy than is generally required. During the gradually phased-in enforcement of the 75 percent rule, Medicare claims data show that patients, who might have been treated in an IRF but who have clinical conditions appropriate for care outside of an IRF, are now getting needed care in other more appropriate and less costly settings.

Background

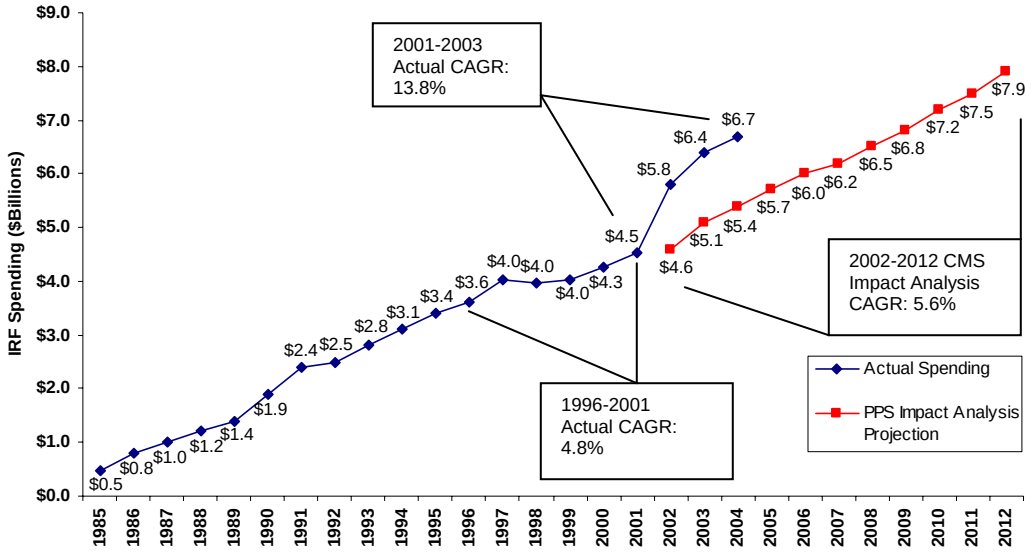
- Medicare pays IRFs at a higher rate than other hospitals because IRFs are designed to offer specialized rehabilitation care to patients with the most intensive needs.
- The "75 percent rule" has been part of the criteria for defining IRFs since the implementation of the hospital inpatient prospective payment system (PPS)in 1983. The purpose of the criteria is to ensure that IRFs, which are exempt from the hospital inpatient PPS, are primarily involved in providing intensive rehabilitation services to patients that cannot be served in other, less intensive rehabilitation settings.
- In order for an IRF to be paid under the IRF PPS instead of the acute care hospital inpatient PPS, the 75 percent rule previously required that a certain percentage of the facility's patients require intensive multidisciplinary inpatient rehabilitation and have one or more of 10 medical conditions. In 2004, CMS updated the 75 percent rule, expanding the qualifying medical conditions to 13.

Payments and Expenditures at IRFs

- Preliminary estimates by the CMS Office of the Actuary show that industry margins comparing payments to costs for hospital-based IRF units are in the low-to-mid teens (i.e., 12.2 to 14 percent for FY 2003).
- The RAND Corporation has estimated that, for all IRFs in 2002, payments exceeded costs by 17 percent.
- Further, the RAND analysis shows that, by 2002, most IRFs had shifted their patient population from patients with the 10 medical conditions that had been used to determine compliance as an IRF to hip and knee joint replacement patients. However, these patients can generally be managed effectively in other, less intensive rehabilitation settings, according to numerous clinical reviews.
- For the 5 years prior to implementation of the IRF PPS, payments under the cost-based system grew at a compound annual growth rate (CAGR) of 4.8 percent. This expenditure increase correlates with significant increases in both the number of IRFs and the volume of IRF claims.

- IRF payments in the first 3 years of the new IRF PPS were in excess of CMS projections by about 25 percent each year and grew at an annual growth rate of over 13 percent.

IRF Spending 1985-2004 and PPS Estimates 2002-2012



Source: MedPAC: 1985-1996, CMS/OACT: 1997-2004 and projections 2002-2012

Access to Rehabilitation Care

- CMS's primary concerns in managing the IRF payment system are ensuring that:
  - beneficiaries have access to high quality care in the most appropriate setting and
  - Medicare payments are appropriate for the services provided.

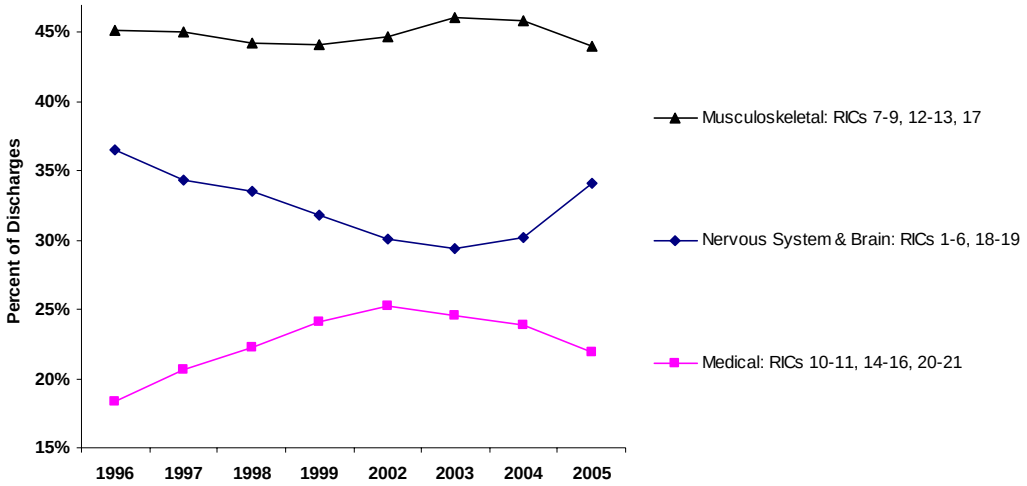
- There are significant state and regional differences in the distribution of IRFs. More than one-third of IRFs are located in just a handful of states, including Texas, Pennsylvania, California, New York, Louisiana, and Ohio. Further, IRFs are distributed unevenly across the Medicare population with densities that vary from less than one IRF per 100,000 Medicare beneficiaries to over ten per 100,000 Medicare beneficiaries.
  - Despite this variation in IRF distribution, patients requiring post-acute rehabilitation who reside in areas where there are no IRFs have access to such services, receiving care in other post-acute care settings, including skilled nursing facilities, long-term care hospitals, outpatient rehabilitation facilities, and in the home via home health care.

- It is also important to ensure that beneficiaries are receiving the appropriate level of rehabilitation care in the right setting. The 75 percent rule works to do this by insuring that IRFs continue to provide care to patients who have a need for a more intensive level of therapy than is generally required.

- During the gradually phased-in enforcement of the 75 percent rule, Medicare claims data show that patients, who might have been treated in an IRF but who have clinical conditions appropriate for care outside of an IRF, are now getting needed care in other more appropriate and less costly settings.

- For example, industry data analysis has shown that the five categories of IRF diagnoses experiencing the greatest decrease in claims volume between 2003 and 2005 are: lower extremity joint replacement, miscellaneous, cardiac, osteoarthritis, and pain syndrome.
- These five categories are associated with conditions that are not generally considered to require the intensive rehabilitation provided by IRFs and can often be more appropriately cared for in other less intensive settings.
- Please see the figure below, which shows that Medicare admissions for musculoskeletal conditions (e.g., single joint replacements) and medical conditions (e.g., pain, pulmonary, miscellaneous, etc.) increased rapidly prior to and during the period of IRF PPS implementation and suspension of the 75 percent rule. Once monitoring procedures were reinstituted using the updated 75 percent rule, Medicare admissions for these conditions have appropriately decreased.
- Admissions for nervous system and brain conditions, which are generally assumed to require intensive rehabilitation, decreased prior to and during this same period. Admissions for these complex conditions are now appropriately increasing.

Changes in IRF Patient Mix by Type of Service



Note: underlying data shown in Appendix D. 1996-1999 from RAND Sample, 2002-2005 from CMS Medicare claims, 2000 and 2001 claims not available.

Impact Analysis of the 75 Percent Rule

- In recent months, IRF industry stakeholders have used differences between the regulatory impact analysis included in the IRF classification criteria final rule (published on May 7, 2004) and actual provider experience since July 2004 to question the validity of the updated IRF classification criteria. It appears that some of the assumptions made by industry stakeholders are based on a misunderstanding of the purpose and scope of a regulatory impact analysis.

- CMS does not use impact analyses as expenditure targets and does not manage Medicare programs to meet the estimates set forth in regulatory impact analyses. Instead, CMS regularly conducts reviews and analyses of program data *after* the policy implementation in order to evaluate the actual impact and effectiveness of the policy change.

- The reality of the situation is that very few IRFs have been reclassified since enforcement of the criteria was reintroduced in 2004.