FACTSHEET

Inpatient Rehabilitation Facilities

THE ISSUE

Inpatient rehabilitation facilities (IRFs) have faced significant scrutiny from Congress and the Centers for Medicare & Medicaid Services (CMS) in recent years, which has led to multiple interventions, including strict criteria for IRF patients, multiple payment cuts and other policy restrictions. Collectively, these interventions have reshaped the population treated in IRFs by dramatically reducing the overall volume and steadily increasing the medical complexity of IRF patients. The president's fiscal year (FY) 2016 budget proposes two IRF cuts: returning the "60% Rule" threshold back to 75 percent and cutting the annual market-basket update. The 60% Rule is a Medicare facility criterion that requires each IRF to discharge at least 60 percent of its patients with one of 13 qualifying conditions. Inpatient rehabilitation hospitals or units that do not comply with the 60% Rule will lose the IRF payment classification and will instead be categorized as general acute care hospitals. The Medicare Payment Advisory Commission (MedPAC) also recommended at its January meeting, paying IRFs a lower rate for selected patients also treated in skilled nursing facilities (SNFs). These proposals ignore these fundamental IRF shifts and are now, in fact, unnecessary and detrimental to patients' access to the unmatched services provided by IRFs.

AHA POSITION

Reject further payment cuts for inpatient rehabilitation hospitals and units.

WHY?

- **Raising the "60% Rule" threshold is unnecessary since existing IRF admission rules strictly control who is admitted into an IRF.** These rules, implemented in January 2010, clearly set the IRF patient population apart from that of other post-acute settings, as shown in the table below. In addition, Medicare ensures that IRFs are admitting the right patients through audits. The president's proposal overlooks the substantial reduction in the number of beneficiaries admitted annually to IRFs over the last 10 years – 122,000 fewer cases per year. It also ignores the fact that IRFs continue to treat sicker patients every year and produce better outcomes than SNFs. Further, compliance with the 60% Rule will become more challenging beginning October 2015, when CMS reduces by more than 20% the ICD-9-CM codes that qualify under the 60% Rule.
- **Medicare must not require IRFs to provide hospital-level services, but pay them SNF rates.** IRFs provide unique clinical value for patients who require hospital-level care and intensive rehabilitation after an illness, injury or surgery. Only in an IRF do beneficiaries receive three or more hours of therapy per day as part of a plan of care that is developed and overseen by a specialty physician and carried out by an interdisciplinary medical team. As a result, the patient population and scope of services found in IRFs are highly distinct from those found in SNFs. IRF patients are medically complex and must require both hospital-level care and intensive rehabilitation services, which are not found in SNFs.

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KEY FACTS

IRFs treat clinically appropriate patients and offer higher intensity services than SNFs.

IRFs Treat Hospital-level Patients Only:

- In 2010, CMS implemented strict IRF admission criteria mandating that every patient require both hospital-level care and intensive rehabilitation. Therefore, IRFs are not allowed to admit SNF-level patients.
- The new criteria make the IRF patient population unique from patients in all other post-acute settings. SNFs and other post-acute settings do not have similarly rigorous admission criteria.

IRFs and SNFs Are Not Interchangeable:

- MedPAC reported that, in 2013, IRFs had a far higher rate of discharging patients to the community (IRFs: 70%; SNFs: 33%).
- IRFs also have a far better record on avoidable rehospitalizations. MedPAC reports that, in 2013, 2.5% of patients were readmitted during an IRF stay, with 11.1% of SNF patients readmitted during their stay.
- Medicare mandates that IRF physicians direct care delivery by interdisciplinary medical teams, which are not present in SNFs.
- Most nursing care in IRFs is provided by specially trained registered nurses (RNs), a far higher level of nursing care than is provided in most SNFs.
- IRF patients must need and receive at least three hours of therapy per day, five days per week.
- IRFs, unlike other post-acute settings, submit admission and discharge data that demonstrate their value to beneficiaries. These data show IRF patients are continuing to experience improved functional outcomes – even as overall IRF patient complexity has increased.

IRF Volume Has Dropped Due to Regulatory Interventions:

- Through the 60% Rule, payment cuts, and new patient/facility criteria, Congress and CMS have significantly decreased the number of Medicare patients and payments for IRFs.
- The volume of IRF discharges has dropped significantly from 2004 through 2013 – 122,000 fewer cases per year.

IRFs vs. SNFs

Required by Medicare	IRFs	SNFs
Close medical supervision by a physician with specialized training	Yes	No
24-hour rehabilitation nursing	Yes	No
Multidisciplinary team approach	Yes	No
3 hours of intensive therapy; 5 days per week	Yes	No
Patients must require hospital-level care	Yes	No
Physician approval of preadmission screen and admission	Yes	No
Medical care and therapy provided by a physician-led multidisciplinary medical team including specialty trained registered nurses	Yes	No
Discharge rate to community	70%	33%
2013 Medicare fee-for-service spending	$6.8 billion	$26.6 billion

Data source: Medicare Payment Advisory Commission.