Utilization Trends in Inpatient Rehabilitation: Update Through Q II 2006

September 2006

THE MORAN COMPANY
Utilization Trends in Inpatient Rehabilitation:  
Update Through Q II 2006

EXECUTIVE SUMMARY

The Moran Company was engaged by the Federation of American Hospitals, the American Hospital Association, and the American Medical Rehabilitation Providers Association to update prior analyses we had performed evaluating the impact of changes in provider qualification rules for inpatient rehabilitation facilities (IRFs) under Medicare. In this follow-on study, we have:

- Acquired data on discharges of IRF patients (from Medicare and other payers) through the end of the second quarter of CY 2006.

- Extended our prior analysis by acquiring data from both of the largest data benchmarking services used by IRFs (UDSMR and eRehabData®), which together represent data on more than 75% of all Medicare IRF discharges.

The findings of this analysis confirm the findings of our prior analyses. Specifically, we find that:

- Immediately following implementation of the new enforcement regime in the Final Rule of May, 2004, the prior growth trend in IRF discharges ended, and volume declined steadily over all but one of the ensuing quarters.

- In the second quarter of calendar year 2006—the final quarter in the IRF Program Year 2006—Medicare caseload in our sample continued to decline. Medicare discharges in our sample fell to 66,859, the lowest level observed in our 18 quarters of data.

- In program year 2006, caseload in our sample was 277,807, which is down 12.6% from PY 2005, and by 19.2% relative to PY 2004. Since our sample comprises approximately 75% of all Medicare IRF discharges, we estimate that total Medicare caseload declined by 87,900 cases over this two-year span.

- As has been the case since 2004, this caseload decline is highly concentrated in about one third of the Rehabilitation Impairment Code categories, particularly those areas that CMS has indicated will be subject to the greatest degree of scrutiny in determining compliance with the “75% Rule.” In areas, such as neurological cases, which CMS lists as qualifying conditions, caseload is growing steadily.
• Given the correlation between the stated policy and the concentrated impact of the caseload decline, it is difficult to reach the conclusion that this is a coincidence; the observed caseload decline is obviously the direct consequence of the policy.
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Update Through Q II 2006

In May 2004, the Centers for Medicare and Medicaid Services (CMS) published a Final Rule implementing changes in its policies regarding the criteria used to determine which facilities are eligible to receive reimbursement as Inpatient Rehabilitation Facilities (IRFs).\(^1\) In that rule, CMS implemented a three-year transition to full enforcement of the so-called “75 % Rule,” under which qualifying facilities would have to demonstrate that, by 2007, 75% of their admissions were for cases requiring intensive rehabilitation of impairments caused by one or more of thirteen qualifying conditions. Concerns about the potential impact of this policy induced Congress to stay reclassification of facilities based on the rule pending submission of a Government Accountability Office (GAO) study. Within sixty days after submission of that study, which occurred on April 22, 2005, CMS was required to determine whether to modify the Rule or to leave it in place without change.

After the report, CMS finalized its policy to require IRFs to meet the 75% rule test by July 1, 2007 (with a transition to that percentage during intervening years). In §5005 of the Deficit Reduction Act of 2005 (DRA), the Congress enacted a revised timeline for full implementation. Under the DRA policy, the 60% compliance threshold temporarily adopted by CMS in its Final Rule is extended for an additional year, effective July 1, 2006, followed by a 65% threshold beginning July 1, 2007. The threshold will be fully phased-in to 75% on July 1, 2008.\(^2\)

The controversy over this policy, in part, results from disparities in estimates of its impact. In its Final Rule, CMS projected a caseload change of only 1,170 admissions in FY 2005—or roughly 0.2% of projected Medicare case volume. In early 2005, the Federation of American Hospitals prepared a series of estimates, based on time series data on actual experience during early FY 2005, suggesting that overall Medicare caseloads in rehabilitation hospitals might drop by as much as 25,000-40,000 annually.

In a prior study, The Moran Company was engaged to assess those estimates, and present findings of our own analysis of the data then available, through the first calendar quarter of 2005, from the UDSMR data service.\(^3\) In subsequent reports, we expanded the analysis to include additional data from eRehabData®, and updated the analysis employing data through the first quarter of 2006.\(^4\)

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\(^1\) Federal Register, Vol. 69, No. 89 (Friday, May 7, 2004), pp. 25752-25776.
\(^2\) The conference report accompanying the DRA notes that “The conferees encourage CMS to conduct additional research and study on this issue.” See House Report 109-362 at 212 (December 18, 2005).
In August, 2006, we were engaged jointly by the Federation, the American Hospital Association, and the American Medical Rehabilitation Providers Association to update our analysis employing data on utilization through the second calendar quarter of 2006.

This report presents the findings of that analysis.

**Data Employed in the Analysis**

We requested and received eighteen quarters of confidential data. Both data services sent us data on only those providers who had participated continuously in the respective services for each of the eighteen quarters ending with the second quarter of 2006—i.e., so-called “same store” tabulations. Because rehabilitation hospitals use only one data service at a time, the provider lists underlying these samples represent unduplicated counts of discharges. In the four quarters of program year 2006 (ending Q II :06), these two sources reported “same store” discharges of 277,807 Medicare beneficiaries, and 435,617 cases from all payers. Collectively, this cohort represents approximately 75% of all Medicare IRF discharges.

**Overall Volume Trends**

Figure one depicts the steady downward trend of IRF caseloads in Medicare since enforcement of the 75% Rule began.

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5 Providers who changed data services during this period are, therefore, excluded from this analysis.
As the figure shows, immediately following implementation of the new enforcement regime in the Final Rule of May, 2004, the prior growth trend in IRF discharges ended, and volume declined steadily over all but one of the ensuing quarters.

In the second quarter of calendar year 2006—the final quarter in the IRF Program Year 2006—Medicare caseload in our sample continued to decline. Medicare discharges in our sample fell to 66,859, the lowest level observed in our 18 quarters of data.

In program year 2006, caseload in our sample was 277,807, which is down 12.6% from PY 2005, and by 19.2% relative to PY 2004. Since our sample comprises approximately 75% of all Medicare IRF discharges, we estimate that total Medicare caseload declined by 87,900 cases over this two-year span.
As shown in Figure Two, Medicare discharge volumes have been moving in tandem with the total discharge volume trend. This is hardly surprising, since the Medicare discharge volumes comprise more than 64% of the total caseload volume in the data we analyzed for the four quarters of program year 2006.
Figure Three presents a comparison of Medicare IRF discharges on a program year basis. From a peak of 343,734 cases in program year 2004, the total number of Medicare IRF cases has fallen to 277,807 in program year 2006. In the second quarter of 2006, Medicare discharges in our sample fell to 66,859, the lowest level observed in our 18 quarters of data.

Trends by Diagnostic Type

The UDS\textsuperscript{MR} and eRehabData\textsuperscript{®} data we requested and received provide subsidiary volume detail by patient diagnosis. These data are presented by Rehabilitation Impairment Category codes, which are standard across the industry and are therefore uniform across these data sources.

Table One presents our analysis of the shift in volume by Rehabilitation Impairment Code. The table shows a comparison of the quarterly volume in the second quarter of 2004, when the CMS final rule was published, and the second quarter of 2006, the last quarter for which we have data.

<table>
<thead>
<tr>
<th>Category Description</th>
<th>QII 2004</th>
<th>QII 2006</th>
<th>Change</th>
<th>% Change</th>
<th>Cumulative Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>08 Lower Extremity Joint Replacement</td>
<td>17,202</td>
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<td>-37.5%</td>
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<tr>
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<td>5,670</td>
<td>-3,059</td>
<td>-35.0%</td>
<td>-9,518</td>
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<tr>
<td>07 Lower Extremity Fracture</td>
<td>14,357</td>
<td>12,286</td>
<td>-2,071</td>
<td>-14.4%</td>
<td>-11,589</td>
</tr>
<tr>
<td>14 Cardiac</td>
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<td>2,650</td>
<td>-1,811</td>
<td>-40.6%</td>
<td>-13,400</td>
</tr>
<tr>
<td>09 Other Orthopedic</td>
<td>4,573</td>
<td>3,638</td>
<td>-935</td>
<td>-20.4%</td>
<td>-14,335</td>
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<tr>
<td>19 Guillain-Barre</td>
<td>2,597</td>
<td>1,827</td>
<td>-770</td>
<td>-29.6%</td>
<td>-15,105</td>
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<tr>
<td>12 Osteoarthritis</td>
<td>1,254</td>
<td>527</td>
<td>-727</td>
<td>-58.0%</td>
<td>-15,832</td>
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<td>13 Rheumatoid and Other Arthritis</td>
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<td>1,191</td>
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<td>-36.2%</td>
<td>-16,532</td>
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<tr>
<td>15 Pulmonary</td>
<td>1,875</td>
<td>1,269</td>
<td>-606</td>
<td>-32.3%</td>
<td>-17,115</td>
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<tr>
<td>16 Pain Syndrome</td>
<td>1,391</td>
<td>897</td>
<td>-494</td>
<td>-35.5%</td>
<td>-17,609</td>
</tr>
<tr>
<td>05 Spinal Cord Dysfunction, Non-Traumatic</td>
<td>3,308</td>
<td>2,894</td>
<td>-414</td>
<td>-12.5%</td>
<td>-18,023</td>
</tr>
<tr>
<td>11 Amputation, Non-Lower Extremity</td>
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<td>140</td>
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<td>1,589</td>
<td>-249</td>
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<tr>
<td>17 MMT without Brain/Spinal Cord Injury</td>
<td>772</td>
<td>664</td>
<td>-108</td>
<td>-14.0%</td>
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<tr>
<td>04 Spinal Cord Dysfunction, Traumatic</td>
<td>1,219</td>
<td>1,126</td>
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<td>-18,725</td>
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<tr>
<td>18 MMT with Brain/Spinal Cord Injury</td>
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<td>189</td>
<td>-3</td>
<td>-1.6%</td>
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<td>21 Burns</td>
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<td>32.7%</td>
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<tr>
<td>01 Stroke</td>
<td>10,992</td>
<td>11,377</td>
<td>385</td>
<td>3.5%</td>
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<tr>
<td>02 Brain Dysfunction, Traumatic</td>
<td>1,584</td>
<td>1,993</td>
<td>409</td>
<td>25.8%</td>
<td>-17,916</td>
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<td>03 Brain Dysfunction, Non-Traumatic</td>
<td>1,761</td>
<td>2,170</td>
<td>409</td>
<td>23.2%</td>
<td>-17,507</td>
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<td>06 Neurological Conditions</td>
<td>5,765</td>
<td>6,289</td>
<td>524</td>
<td>9.1%</td>
<td>-16,983</td>
</tr>
</tbody>
</table>

Overall, volume declined by 16,983 cases, or 19.7%, over this period. As has been the case since 2004, this caseload decline is highly concentrated in about one third of the Rehabilitation Impairment Code categories, particularly those areas that CMS has

\textit{Moran Company Analysis of Data Furnished by UDS\textsuperscript{MR} and eRehabData\textsuperscript{®}}
indicated will be subject to the greatest degree of scrutiny in determining compliance with the “75% Rule.” In areas, such as neurological cases, that meet the diagnostic criteria CMS has established, caseload is growing steadily.

**Conclusion**

Summing up, the conclusions we draw from this analysis are as follows:

- Immediately following implementation of the new enforcement regime in the Final Rule of May, 2004, the prior growth trend in IRF discharges ended, and volume declined steadily over all but one of the ensuing quarters.

- In the second quarter of calendar year 2006—the final quarter in the IRF Program Year 2006—Medicare caseload in our sample continued to decline. Medicare discharges in our sample fell to 66,859, the lowest level observed in our 18 quarters of data.

- In program year 2006, caseload in our sample was 277,807, which is down 12.6% from PY 2005, and by 19.2% relative to PY 2004. Since our sample comprises approximately 75% of all Medicare IRF discharges, we estimate that total Medicare caseload declined by 87,900 cases over this two-year span.

- As has been the case since 2004, this caseload decline is highly concentrated in about one third of the Rehabilitation Impairment Code categories, particularly those areas that CMS has indicated will be subject to the greatest degree of scrutiny in determining compliance with the “75% Rule.” In areas, such as neurological cases, which CMS lists as qualifying conditions, caseload is growing steadily.

- Given the correlation between the stated policy and the concentrated impact of the caseload decline, it is difficult to reach the conclusion that this is a coincidence; the observed caseload decline is obviously the direct consequence of the policy.
**THE MORAN COMPANY**

Inpatient Rehabilitation Discharges by Rehabilitation Impairment Category (RIC)

<table>
<thead>
<tr>
<th></th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
<td>N</td>
</tr>
<tr>
<td>01 Stroke</td>
<td>11,455</td>
<td>11,731</td>
<td>11,484</td>
<td>11,328</td>
<td>10,992</td>
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<tr>
<td>02 Brain Dysfunction, Traumatic</td>
<td>1,301</td>
<td>1,379</td>
<td>1,353</td>
<td>1,425</td>
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<td>03 Brain Dysfunction, Non-Traumatic</td>
<td>1,472</td>
<td>1,504</td>
<td>1,510</td>
<td>1,530</td>
<td>1,467</td>
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<td>04 Spinal Cord Dysfunction, Traumatic</td>
<td>1,180</td>
<td>1,234</td>
<td>1,241</td>
<td>1,254</td>
<td>1,182</td>
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<td>05 Spinal Cord Dysfunction, Non-Traumatic</td>
<td>2,702</td>
<td>2,962</td>
<td>2,842</td>
<td>2,842</td>
<td>3,086</td>
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<td>06 Neurological Conditions</td>
<td>5,226</td>
<td>5,308</td>
<td>5,373</td>
<td>5,585</td>
<td>5,763</td>
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<tr>
<td>07 Lower Extremity Fracture</td>
<td>12,232</td>
<td>12,958</td>
<td>13,112</td>
<td>13,580</td>
<td>13,373</td>
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<tr>
<td>08 Lower Extremity Joint Replacement</td>
<td>15,084</td>
<td>15,736</td>
<td>15,703</td>
<td>16,754</td>
<td>15,796</td>
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<tr>
<td>09 Other Orthopedic</td>
<td>3,752</td>
<td>3,980</td>
<td>4,061</td>
<td>4,344</td>
<td>4,394</td>
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<td>1,849</td>
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<td>451</td>
<td>480</td>
<td>436</td>
<td>401</td>
<td>443</td>
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<tr>
<td>12 Osteoarthritis</td>
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<td>1,509</td>
<td>1,499</td>
<td>1,470</td>
<td>1,404</td>
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<td>1,870</td>
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<td>14 Cardiac</td>
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<td>4,613</td>
<td>4,233</td>
<td>4,544</td>
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<td>15 Pulmonary</td>
<td>2,461</td>
<td>2,140</td>
<td>1,646</td>
<td>1,840</td>
<td>2,141</td>
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<td>16 Pain Syndrome</td>
<td>1,639</td>
<td>1,708</td>
<td>1,666</td>
<td>1,760</td>
<td>1,606</td>
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<td>17 MMT without Brain/Spinal Cord Injury</td>
<td>699</td>
<td>803</td>
<td>797</td>
<td>811</td>
<td>782</td>
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<tr>
<td>18 MMT with Brain/Spinal Cord Injury</td>
<td>194</td>
<td>188</td>
<td>188</td>
<td>204</td>
<td>202</td>
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<td>2,393</td>
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<td>21 Burns</td>
<td>52</td>
<td>44</td>
<td>33</td>
<td>36</td>
<td>50</td>
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**Discharges, Medicare**

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<thead>
<tr>
<th></th>
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<th>2005</th>
<th>2006</th>
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<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
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<td>01 Stroke</td>
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<td>82,539</td>
<td>81,470</td>
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<td>12,458</td>
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<td>12,645</td>
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<td>05 Spinal Cord Dysfunction, Non-Traumatic</td>
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<td>13,328</td>
<td>13,458</td>
<td>13,584</td>
<td>13,645</td>
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<td>06 Neurological Conditions</td>
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<td>14,328</td>
<td>14,458</td>
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<td>17,961</td>
<td>18,944</td>
<td>18,444</td>
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<td>24,980</td>
<td>24,961</td>
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<td>25,444</td>
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<td>26,444</td>
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<td>28,444</td>
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<td>28,980</td>
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<td>29,000</td>
<td>29,980</td>
<td>29,961</td>
<td>30,944</td>
<td>30,444</td>
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**Total**

80,000

*Moran Company Analysis of Data Furnished by UDS, Inc. and eRehabData®*
<table>
<thead>
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<th>Impairment Category</th>
<th>2002</th>
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<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
<td>Q1</td>
</tr>
<tr>
<td>01 Stroke</td>
<td>21,603</td>
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<td>21,571</td>
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<td>02 Brain Dysfunction, Traumatic</td>
<td>2,882</td>
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<td>3,245</td>
<td>3,320</td>
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Discharges, All Payers