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 strict criteria for IRF patients, multiple payment cuts and other policy restrictions. The "60% Rule" helps define IRFs by requiring 60 percent of admissions to have one of 13 qualifying medical conditions. In the *Medicare, Medicaid, and SCHIP Extension Act of 2007*, Congress lowered the threshold of the 60% Rule from the previous 75 percent level, and froze IRF payments for 18 months to fund this change. In addition, IRFs are subject to annual market-basket cuts. In response to these changes, IRF patient volume and payments from Medicare have steadily declined since 2004. The President's Plan for Economic Growth and Deficit Reduction would return the 60% Rule threshold to the 75 percent level, lower certain IRF payments to the skilled nursing facility (SNF) rate, and apply an across-the-board cut.

AHA POSITION

Reject further payment cuts for inpatient rehabilitation hospitals and units.

WHY?

- **Medicare should not require IRFs to provide hospital-level services, then pay them at 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-plus 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 inter-disciplinary medical team. As a result, the patient population and scope of services found in IRFs are unique from those found in SNFs and other settings.
- **Changing the "60% Rule" is unnecessary since existing Medicare rules already ensure a distinct IRF patient population.** Current rules already require IRF physicians to validate and document that a patient needs hospital-level treatment and intensive rehabilitation to be admitted; otherwise, the admission may be subject to payment denial. The president's proposal overlooks the reduction in the number of beneficiaries admitted to IRFs every year, the flat growth pattern for Medicare payments to IRFs, and the annual reductions in IRF Medicare margins. It also ignores the fact that IRFs continue to treat sicker patients every year and produce better outcomes than other settings. Raising the 60% Rule threshold would impose an excessive and unwarranted barrier to IRF services.

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KEY FACTS

Medicare Distinguishes IRFs from SNFs and Other Post-Acute Providers

IRFs Only Treat Hospital-level Patients

- In 2010, CMS implemented comprehensive regulations mandating that every IRF patient must require both hospital-level care and intensive rehabilitation.
- The new criteria require IRF patients to be unique from patients in all other post-acute settings. No other post-acute provider group is subject to Medicare criteria of this specificity or rigor.

IRFs and SNFs are not Interchangeable

- Medicare patient criteria require IRFs to exclusively treat hospital-level patients; and prohibit IRFs from treating SNF-level patients.
- CMS reported in the August 2011 SNF payment regulation that IRFs have a far higher rate of discharging patients to the community (IRFs: 81%; SNFs: 46%); and far lower readmission rate (IRF: 9.4%; SNF: 22.0%).
- Medicare mandates that IRFs provide hospital care through physician-led interdisciplinary medical teams, which are not present in SNFs.
- Most nursing care in IRFs is provided by specialty-trained registered nurses (RNs), a far higher level of nursing than provided in most SNFs.
- IRF patients must need and receive at least three hours of therapy per day, five days per week, which is a far higher standard than for other post-acute settings.
- IRFs, unlike the other post-acute settings, submit admission and discharge data that demonstrate their value to beneficiaries. These data show IRF patients are continuing to produce improved functional outcomes – even as the overall severity of IRF patients increases.

IRFs Have a Flat Cost Curve

- Through the 60% Rule, payment cuts, and new patient/facility criteria, Congress and CMS have significantly decreased the number of Medicare patients qualifying for IRFs.
- IRF discharges dropped by 136,000 cases per year from 2004 to 2010.
- Unlike other providers, Medicare spending on IRFs has remained stable since 2001 with modest growth ranging from 1.3 to 2.2% per year.
- Medicare margins for IRFs have declined every year since 2004.

Inpatient Rehabilitation Hospitals and Units vs. SNFs

Required by Medicare	Inpatient Rehabilitation Hospitals and Units	Nursing Homes
Close Medical Supervision By a Physician With Specialized Training	Yes	No
24-Hour Rehabilitation Nursing	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
3 hours of intensive therapy per day; 5 days per week	Yes	No
Readmission rates to general acute hospitals (2008 MedPAC Data Book)	9.5%	22.0%
Discharge rate to community	81.1%	45.5%
2010 Medicare fee for service spending	$6.4 billion	$26.4 billion
Increase in Medicare FFS spending from 2004 to 2010	No increase	52.5% increase

Unless another source is noted, the data cited in this document are drawn from the Medicare Payment Advisory Commission's March 2011 Report to Congress, June 2011 Data Book and December 16, 2011 Commissioners Meeting; and SNF Final Rule.