AMERICAN BANKRUPTCY INSTITUTE
JOURNAL
The Essential Resource for Today's Busy Insolvency Professional

Intensive Care II

By Ronald Winters

IRFs: A Health Care Subsector Vulnerable to Financial Distress

Ronald Winters
Healthcare Management Partners, LLC
Nashville, Tenn.

Ronald Winters is managing director of Healthcare Management Partners, LLC. He specializes in advising companies and creditors in financial and operational turnarounds and restructurings, with experience in the health care, higher education and nonprofit sectors, as well as labor relations, retiree health and pension matters.

Bankruptcy professionals focusing on the health care industry may expect to see more future cases involving inpatient rehabilitation facilities (IRFs). IRFs provide intensive rehabilitation services to patients after illness, injury or surgery. Medicare spends more than $7.5 billion on 350,000 patients annually in approximately 1,200 IRFs. This represents about 60 percent of all IRF patient volume.[1]

In March,[2] the Medicare Payment Advisory Commission (MedPAC)[3] recommended that IRF rates be decreased by 5 percent, which would have resulted in a $250 million to $750 million decrease in fiscal 2019 spending and a reduction of $1 billion to $5 billion over the next five years. MedPAC made this recommendation for three principal reasons:

1. MedPAC's research indicated that there is an adequate supply of IRF services to satisfy necessary patient access to care;
2. Quality measures are generally improving; and
3. Providers' access to capital and IRF profitability (across the universe of providers) are generally increasing.

Notwithstanding MedPAC's recommendation, the Medicare final rule issued in late July will increase IRF Prospective Payment System[4] pay-

1 Report to Congress; Medicare Payment Policy; Chapter 10 (March 2018); Medicare Payment Advisory Commission ("MedPac 2018 Report"), p. 267.
2 *Id.* at p. 269.
3 "MedPAC" is a nonpartisan legislative branch agency that provides Congress with analysis and policy advice on the Medicare program.
4 A PPS is a method of reimbursement in which a Medicare payment is made based on a predetermined fixed amount. *See* "General Information," CMS, *available at* cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/index.html (last visited on Oct. 29, 2018).

Exhibit 1: Medicare Case Trends

	Percent of Medicare FFS Cases			
Condition	**2004**	**2008**	**2015**	**2016**
Stroke	16.6%	20.4%	19.6%	20.1%
Other Neurological Conditions	5.2%	8.0%	13.0%	13.7%
Fracture of Lower Extremity	13.1%	16.0%	11.5%	10.8%
Debility	6.2%	9.1%	10.7%	10.7%
Brain Injury	3.9%	7.0%	9.3%	9.9%
Other Orthopedic Conditions	5.2%	6.1%	7.9%	8.2%
Cardiac Conditions	5.3%	4.6%	6.0%	6.1%
Major Joint Replacement of Lower Extremity	24.1%	13.1%	6.8%	5.5%
Spinal Cord Injury	4.2%	4.3%	4.7%	4.9%
All Other (and Rounding Correction)	16.2%	11.4%	10.5%	10.1%
	100.0%	100.0%	100.0%	100.0%

The dark green shading reflects conditions that meet compliance threshold. The light green shading reflects conditions that meet compliance threshold under certain additional qualifiers. Source: Medicare Payment Commission Report to Congress: Medicare Payment Policy, March 2018 (MedPAC analysis of Inpatient Rehabilitation Facility — Patient Assessment Instrument data from CMS).

ments by 1.3 percent or approximately $105 million in 2019. MedPAC's recommendations on this and other matters are not universally accepted, and MedPAC might reiterate or modify its recommendations next year.

There has been a tension between the approach by MedPAC and the Centers for Medicare and Medicaid Services (CMS) to IRF reimbursement, but it is reasonable to expect the subsector to be under scrutiny and that some IRFs will be financially vulnerable, particularly nonprofit providers, government-owned facilities, smaller IRFs (particularly those with less than 25 beds) and IRFs in rural settings. IRFs that fall into these categories have historically been either less efficient or less adept at attracting patients who can be profitably treated.

Restructuring professionals might expect to see certain IRFs struggle to contain costs for certain high-cost cases and also be challenged by unfavorable demographic trends and weak balance sheets in some cases. Industry consolidation can be expected with some portion distressed in a bankruptcy or out-of-court environment.

IRF Overview

Some patients need intensive inpatient rehabilitative care following an illness, injury or surgery. This care can include physical, occupational and speech therapy, and many patients can receive treatment at a skilled nursing facility, but rehabilitation services can also be provided at an IRF, which focus primarily on treating conditions that typically require such intensive rehabilitation.

To qualify for a Medicare-paid IRF stay, a patient must be able to participate in and benefit from intensive therapy and must have a condition that requires frequent and face-to-face supervision by a rehabilitation physician. Exhibit 1 illustrates the trend in Medicare fee-for-service (FFS) cases[5] since 2004. From 2004-08, the number for all cases dropped by nearly 140,000 discharges annually. Since 2008, the number of discharges has trended upward (more than 34,000 cases per year in 2016 versus 2008).[6] Since 2004, there has been a pronounced shift away from certain orthopedic conditions in favor of neurological conditions and brain injury, as shown in Exhibit 1.

IRFs can be freestanding facilities or specialized units within acute-care hospitals. In order to qualify for Medicare treatment, an IRF must meet Medicare's conditions for participation for acute-care hospitals and must also meet a series of performance and procedural criteria. From a purely financial perspective, an IRF must meet a compliance threshold in order to be paid on an IRF prospective payment system (PPS) basis. The threshold causes the IRF to demonstrate that its principal focus is intensive rehabilitation services. If an IRF fails to meet the compliance threshold, it will be paid for services on an inpatient hospital PPS basis. The compliance threshold requires that 60 percent of the IRF's Medicare and other patients have a primary diagnosis or comorbidity of at least one of 13 conditions.[7] For Medicare to reimburse for IRF services, the patient at admission must also be expected to require and participate in intensive therapy and the supervision of a rehabilitation physician. CMS removed certain diagnosis codes from eligibility in the compliance threshold because of concerns that absent specific supporting documentation, the diagnosis codes did not provide evidence that the patient would require intensive inpatient rehabilitation.

The Universe of IRFs

Although hospital-based IRFs account for half of all Medicare fee-for-service (FFS) discharges, they account for more the three-quarters of all IRFs. Exhibit 2 summarizes the trend of IRF profiles since 2004.

More important is the substantial variation in profitability among IRFs, which has caused MedPAC to make recommen-

5 Medicare FFS does not include Medicare Advantage Plans provided through private insurance companies.

6 MedPAC 2018 Report at p. 278.

7 Stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, hip fracture, brain injury, certain neurological conditions, burns, certain arthritis conditions where outpatient therapy has failed and hip or knee replacement (with certain further conditions).

Exhibit 2: Number of IRFs

	2004	2006	2008	2010	—	2013	2014	2015	2016	% of FFS 2016 Discharges
Urban	1,024	1,018	1,001	981		977	1,013	1,020	1,026	93%
Rural	197	207	201	198		184	164	162	162	7%
	1,221	1,225	1,202	1,179		1,161	1,177	1,182	1,188	100%
Freestanding	217	217	221	233		243	251	262	273	50%
Hospital-Based	1,004	1,008	981	946		918	926	920	915	50%
	1,221	1,225	1,202	1,179		1,161	1,177	1,182	1,188	100%
Nonprofit	768	758	738	729		677	681	681	676	41%
For-Profit	292	299	291	294		322	338	352	370	52%
Government	161	168	173	156		155	149	138	133	7%
Not Categorized						7	9	11	9	
	1,221	1,225	1,202	1,179		1,161	1,177	1,182	1,188	100%

Source: Medicare Payment Commission Report to Congress: Medicare Payment Policy, March 2018 (MedPAC analysis of Medicare Provider Analysis and Review data from CMS).

dations that might adversely impact at least some participants in the sector. MedPAC notes that high-margin IRFs have patients who are less severely ill prior to discharge to the IRF from an acute-care hospital but appear functionally disabled at the IRF. MedPAC recommends an intensified effort to review coding practices and ensure consistent patient assessment across providers. MedPAC also notes that high-margin IRFs might target certain case mix groups (CMGs), which might not match cost to acuity, suggesting an imbalance in costs versus Medicare reimbursement. To address this, MedPAC proposes to expand the outlier pool to redistribute payments more equitably. Exhibit 3 illustrates margin trends across different IRFs. Alas, there are very large variances in profitability: *larger, freestanding, for-profit* IRFs with a *high Medicare case percentage* are materially more profitable than others.

Where Trouble Might Loom

To eliminate the "noise" and focus exclusively on facilities that are the most vulnerable, an analysis was performed from a database of 611 providers[8] for the 2016 cost-report year. From that analysis, the following providers were removed: acute-care and critical-access hospitals and all freestanding IRFs believed to be part of a "system."[9] This resulted in a remaining group of 61 freestanding[10] providers with approximately 54,000 discharges and $1.177 billion of liabilities.

Of these, 30 facilities (with liabilities of $892 million) were not profitable, and another 11 facilities (with liabilities of more than $160 million) had a profit margin of under 6 percent. These 41 facilities had revenues per discharge of more than $27,000,[11] which was nearly 50 percent greater than the revenues per discharge received by large for-profit operators such as Kindred, Healthsouth and Select. In the case of nonprofit operators, this might reflect a mission-based effort to address patients with the greatest rehabilitation need, coupled with greater challenges in controlling costs. In the case of for-profit operators, the strategic focus might be on higher acuity as a means to compete, potentially to offset occupancy shortfalls and meet the compliance thresholds.

Moreover, freestanding IRFs are disadvantaged when competing with hospital-based IRFs. IRFs within acute-care hospitals are likely to be viewed by hospital management in the context of the entire hospital enterprise, and the financial success of the IRF independently might not be a primary

8 "Modern Healthcare Metrics," Daniel Evans, director of Healthcare Management Partners's information technology and data analytics.

9 Healthsouth, Kindred and Select represent approximately half of all free standing IRFs, with Healthsouth owning more than 100 such facilities.

10 Not associated with an acute-care hospital.

11 Two providers with very large revenues per discharge (requiring further review) were removed from this calculation to avoid further skewing the difference.

Exhibit 3: Average IRF Margins

	2004	2006	2008	2010	2012	2013	2014	2015	2016	% of FFS 2016 Discharges
All IRFs	**16.7%**	**12.5%**	**9.4%**	**8.6%**	**11.2%**	**11.5%**	**12.4%**	**13.8%**	**13.0%**	**100%**
Urban	17.0%	12.8%	9.6%	9.0%	11.6%	11.9%	12.8%	14.2%	13.2%	**93%**
Rural	13.2%	10.0%	6.9%	4.7%	6.5%	6.0%	6.2%	8.3%	9.5%	**7%**
										100%
Freestanding	24.7%	15.0%	18.2%	21.4%	23.9%	24.7%	25.3%	26.7%	—	**50%**
Hospital-Based	12.2%	9.9%	3.9%	-0.5%	0.7%	-0.1%	0.9%	1.9%	1.2%	**50%**
										100%
Nonprofit	12.8%	11.0%	5.3%	2.1%	2.1%	1.1%	2.0%	3.5%	2.0%	**41%**
For-Profit	24.4%	16.3%	16.9%	19.6%	22.9%	23.4%	23.8%	24.8%	23.9%	**52%**
Government	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**7%**
										100%
Beds										
1-10	3.7%	-3.6%	-4.9%	-10.3%	-6.9%	-11.2%	-10.8%	-7.1%	-10.3%	**2%**
11-24	10.5%	7.3%	1.2%	-3.3%	-1.2%	-0.8%	-0.2%	-0.4%	0.3%	**22%**
25-64	18.3%	13.7%	10.1%	10.6%	12.3%	13.2%	14.2%	15.8%	14.6%	**48%**
65 or More	21.5%	17.8%	17.3%	17.5%	21.0%	20.0%	20.7%	22.9%	22.0%	**28%**
										100%
Medicare Share										
Less than 50%	12.9%	11.1%	5.1%	0.3%	1.5%	0.6%	1.2%	2.9%	2.0%	**22%**
50% to 75%	17.1%	12.6%	9.5%	9.6%	13.3%	14.0%	15.4%	16.6%	15.8%	**56%**
Greater than 75%	19.6%	13.9%	13.5%	13.6%	18.6%	18.5%	17.9%	19.2%	18.2%	**22%**
										100%

Source: Medicare Payment Commission Report to Congress: Medicare Payment Policy, March 2018 (MedPAC analysis of cost report data from CMS).

concern. In addition, hospital-based IRFs might have more "tools" available to ensure that they are meeting the compliance threshold by tapping into their normal acute-care throughput. Each of these are factors freestanding IRFs face, which can make profitability difficult for less sophisticated market participants.

Relief for struggling IRFs is possible, but far from assured. On the one hand, this group might benefit from a redistribution of CMS payments through outlier payments (as previously discussed), but that relief has not yet gained traction. On the other hand, a rigorous review of coding, as prescribed by MedPAC, is more likely to be a risk to providers already receiving higher payments and might result in reduced revenue with no offsetting reduction to expenses. A determination that providers were overpaid by CMS or others might result in greater liabilities and pressure on liquidity. Exhibit 4 highlights data for the selected provider group potentially at the greatest risk and under the greatest financial pressure.

Finally, even if there is a redistribution of CMS payments, the more fragile IRFs are unlikely to see reduced pressure. The industry has attracted a series of large, well-capitalized and well-managed data-driven participants that are able to react to a changing environment. It is reasonable to expect that they will be mindful of consolidating the market by the elimination of weaker competitors or purchases under opportunistic terms. abi

Reprinted with permission from the ABI Journal, Vol. XXXVII, No. 12, December 2018.

Exhibit 4: Drill-Down on Vulnerable IRFs

A look at the universe of freestanding non-system IRFs:

	Facilities	Total Discharges	Revenue Discharges		Total Liabilities ($M)
Investor-Owned	43	33,158	$19,441	[1]	$1,177.469
Charitable/Tax-Exempt	15	19,993	$35,054	[2]	$798.119
Governmental	3	1,035	$19,671		$0.057
	61	54,186			$1,975.645

The subset below might be more vulverable to competition and economic stress:

	Facilities	Total Discharges	Revenue Discharges		Total Liabilities ($M)	Total Agg. Operating Profit ($M)
Investor-Owned	24	14,593	$17,574	[3]	$254.604	$(15.659)
Charitable/Tax-Exempt	14	19,256	$36,234	[4]	$798.119	$(111.080)
Governmental	3	1,035	$19,671		$0.057	$(6.798)
	41	34,884			$1,052.780	$(133.537)

[1] Two outlier facilities removed for this analysis. [2] Three outlier facilities removed for this analysis. [3] Might be skewed; includes one facilty with operating profit (loss) of ($16.1 million). [4] Might be skewed; includes two facilities with combined operating profit (loss) of ($92.4 million). Source: Modern Healthcare Metrics selected data from Healthcare Cost Report Information System (HCRIS) (2016 cost reports).