Is There Value in Your Inpatient Rehabilitation Facility?

Inpatient rehabilitation utilization has experienced remarkable growth over the past decade, fueled by a demographic boom in the industry's primary patient population, stable regulations, and continued Medicare reimbursement increases. Per the 2022 MedPac Report [1], inpatient rehabilitation facilities (IRFs) accounted for $8 billion of Medicare spending in 2020, and paid out to about 1,160 IRFs and inpatient rehabilitation units (IRUs) nationwide. IRUs are operated as distinct part units of an acute hospital compared to an IRF which is a licensed freestanding facility.

As the Medicare population continues to grow [2], and industry data increasingly demonstrates both the clinical efficiency and cost effectiveness [3] of inpatient rehabilitation as compared to alternative post-acute alternatives, inpatient rehabilitation utilization is expected to continue to climb. Additionally, with the low cost of capital and proliferation of strategic post-acute buyers available, it is a seller's market for IRFs. These trends are causing many acute care operators to question whether they should monetize their hospital based IRU by selling or partnering with a third party.

Selling or partnering an IRU can provide numerous benefits to an acute care provider, including the following:

- An infusion of cash on their balance sheet for selling a portion of or all of a non-core service line
- Turning facility and support services into revenue from the IRF joint venture
- Gaining IRF management expertise to improve acute care discharges and assist with acute length-of-stay
- Freeing up acute care beds
- Improving strategic focus for operational excellence
- Freeing up hospital management time while providing host hospital cash flow
- Protecting from future inpatient rehabilitation regulatory burdens and risks

Benefits of a Joint Venture/Sale of an IRU

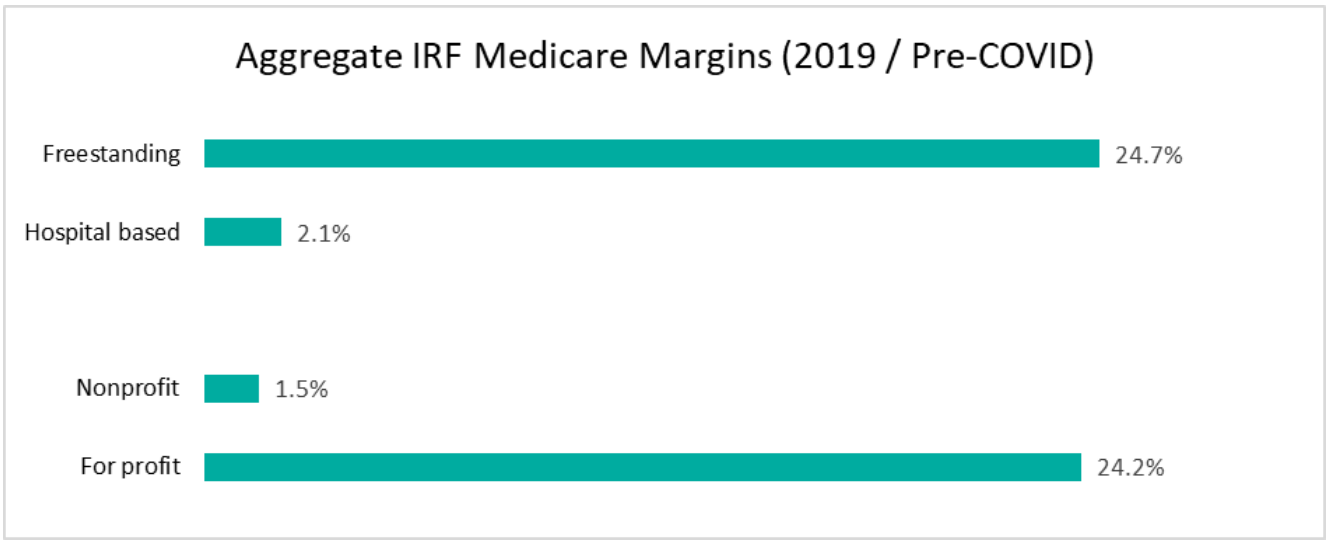
The healthcare provider market saw a decrease in the number of transactions in 2020 due to the global pandemic, but according to Irving Levin's 4th Quarter 2020 M&A report [4] Q4 2020 saw a dramatic recovery in both healthcare deal volume and spending. [3] Based on VMG Health's 20-year IRF-specific transaction database, IRF average values per occupied bed are trending at a 10-year high. Favorable returns for sellers and buyers are fueling this growth. Post-acute management companies such as Encompass Corp., Kindred Healthcare, and Select Medical have made public their IRF-focused growth objectives and their demand for strategic partnerships with IRFs in markets across the US.

In their September 2020 presentation at the Baird 2020 Global Healthcare Conference, Encompass CEO Mark Tarr reiterated Encompass's aim to add 100 to 150 beds per year starting in 2021 through de novos and acquisitions. [5] Kindred also stated in a December 1, 2020 press release that they expect "to open 20 new rehabilitation hospitals, acute rehabilitation units, and behavioral health hospitals with leading strategic hospital partners over the next two years." [6] These factors suggest an opportunity for acute care providers to capitalize on their rehabilitation units through a sale or joint venture model.

Through a sale or partnership, the acute care provider can drive operational excellence for the host hospital by generating additional bed capacity within the health system and potentially lowering the hospital's average length of stay. An IRF management company with access to best practices in patient admission criteria and IRF regulatory rules could allow for quick patient assessment and

discharge from an acute setting to an inpatient rehabilitation facility. If bed capacity or length of stay are not issues for the host hospital, a partnership with a management company could provide additional revenue from facility lease arrangements and patient service contracts. Also, if market demand is present for additional IRF beds, the IRF partnership could use additional nonoperational beds from the host hospital to provide income from otherwise nonprofitable hospital space. Finally, the partnership could license the host hospital's tradename as another opportunity to capitalize on an existing asset for revenue or joint venture equity.

In addition to driving operational excellence for the host hospital, a sale or partnership with a strategic buyer can advance the IRF's top-notch quality care and clinical effectiveness at efficient costs. Using knowledge of clinical best practices, therapy recruiting and training, and economies of scale, strategic post-acute providers can drive high-quality care at a more profitable rate and obtain additional returns for the hospital partner. MedPac data corroborates this claim with for-profit aggregate IRF Medicare margins at 24.2% of revenue as compared to nonprofit margins at just 1.5% (see table below).



Source: MedPac 2022 Annual Report to Congress, (Footnote 1, page 323)

Additionally, a sale or partnership can insulate an acute care provider from future regulatory burdens or risks. Historically, the inpatient rehabilitation industry has dealt with material legislative changes to patient admissions and quality reporting standards. Specialized post-acute care providers can navigate industry requirements like the Centers for Medicare & Medicaid Service ("CMS") 60% Rule [7] and the three-hour therapy care rule [8] while providing additional patient access and quality patient care.

As new developments arise, such as continual revisions to the CMS Inpatient Rehabilitation Quality Reporting Program and patient admission criteria, inpatient rehabilitation-specific operators have the concentration and corporate strategy teams in place to study new legislation and its potential impact on operations. Additionally, a sale or partnership can provide a health system with some protection against future reimbursement risks in the industry. MedPac's annual report to Congress has suggested a 5.0% reduction in the Medicare reimbursement rates for inpatient rehabilitation reimbursement every year from 2017 to the latest report published in March 2022.1 This was in response to the climbing aggregate Medicare margins in the industry, which in 2020 were 13.5% across all IRFs (freestanding and hospital-based, excluding Medicare COVID relief funds), according to the 2022 MedPac report. [1] MedPac estimates the 2020 aggregate Medicare margin was 14.9% including estimated Medicare share of federal relief funds. Although CMS has continued to project positive reimbursement growth in the final rule, if margins continue to rise it is expected that reimbursement may eventually be reduced. Based on the 2020 -0.7% aggregate Medicare margin for nonprofits (2.6% inclusive of federal relief funds) and the 1.6% aggregate Medicare margin for hospital-based IRFs (4.0% inclusive of federal relief funds), it is unlikely that a 5% Medicare reimbursement cut would be viable for many hospital-based IRFs in these settings.

Finally, the sale or partnership of a rehabilitation unit allows the hospital to continue its integrated delivery model with a partner in post-acute care or have a partner ready to implement an integrated network. As CMS transitions to value-based payments and outcome focus, aligning with or selling to a strategic partner could provide the hospital with focused expertise in managing patient readmission. Multiple management companies, such as Encompass, Kindred, and Select, have proven success with risk-sharing models with acute care providers. This could help the health system with both care quality and profitability.

Downsides to a Joint Venture/Sale of IRU

Although there can be many benefits to selling or partnering an IRU, as with any business transaction, there are also some drawbacks. For an acute care provider, a key downside can be the loss of control. The acute care provider would lose the ability to flex its bed use if the inpatient rehabilitation beds were sold or contributed to a joint venture. The ability to flex beds became an important capability during the COVID-19 outbreak in the US. Additionally, under a joint venture partnership, the acute care provider opens itself up to reputation risk since control and management of the IRU is entrusted to a third party. Through a sale or partnership, the acute care provider sells forward profits, and the host hospital needs to account for the overhead expenses that were historically allocated to the IRU.

Conclusion

In summary, many acute care providers should ask, “Are they generating the most value from their IRU as they could or should?” A sale or partnership of the IRF could add value to the health system beyond the initial cash flow from a transaction. The relationship between an acute care host hospital and the IRF is considered a referral relationship with Medicare patients. Therefore, whether through a sale or contribution, healthcare transactions must be properly established at fair market value. Based on VMG Health’s experience with hundreds of IRF transactions, the departmental operational reports never represent IRF’s real economic impact on the host hospital. As many IRUs operate as departments of hospitals and utilize allocated cost methodologies, it can be a highly technical undertaking to assess the profitability and overall value of an IRU. Specific knowledge and insight into key industry value drivers, such as reimbursement/payor mix, staffing metrics, unit size/bed configuration, and utilization, should be considered. A credible valuation with access to a detailed national IRF benchmark analysis9 for revenue and expenses can help ensure a successful transaction.

To provide some IRF value perspective, VMG Health has observed IRF transactions per occupied bed as high as $800,000, with common value ranges per licensed bed between $200,000 and $400,000, and revenue multiples typically falling in the 0.8–1.4x range. This year might be a great time to ask, “Is your IRU generating the value your patients have come to expect, supporting your healthcare strategy, and adding value to your bottom line?”

Footnotes

1 MedPac 2022 Report (https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch9_SEC.pdf

2 Medicare population projected at 5% annually over the next several years.

3 Census projections for 2018 to 2022 and 2022 to 2026. https://www.census.gov/data/datasets/2017/demo/popproj/2017-popproj.html

4 Encompass Health Investor Reference Book (https://s22.q4cdn.com/748396774/files/doc_downloads/investor_reference/2020/11/EHC-Q3-2020-Investor-Reference-Book_11-13-20_As-Filed.pdf)

5 Irvin Levin's 4th Quarter 2020 M&A Report

6 Baird 2020 Global Healthcare Conference (https://investor.encompasshealth.com/events-and-presentations/other-events-and-presentations/event-details/2020/Baird-2020-Global-Healthcare-Conference/default.aspx)

7 Kindred Healthcare December 1, 2020 Press Release (https://www.kindredhealthcare.com/about-us/news/2020/12/01/kindred-healthcare-advances-growth-strategy-completes-sale-of-rehabcare

8 Medicare reimbursement per episode of care for inpatient rehabilitation is generally higher as compared to other post-acute facilities because IRFs are designed to offer intensive rehabilitation services to patients that cannot be served in other less intensive rehabilitation settings, such as skilled nursing facilities or home health. Due to the higher reimbursement, CMS became concerned that patients who did not require intensive rehabilitation services were being treated in an IRF setting. Therefore, CMS implemented the 75% rule which required that 75% of patients admitted to an IRF have a primary diagnosis or comorbidity in one of the 13 qualifying medical conditions listed in the table below. After implementing, Medicare adjusted the 75% rule to a new compliance threshold of 60% by the Medicare, Medicaid, and SCHIP Extension Act of 2007 ("MMSEA"). In addition, MMSEA also permitted IRFs to use patient's secondary medical conditions & comorbidities to determine whether a patient qualifies for inpatient rehabilitative care. The legislation is referred to as the "60% Rule."

9 In addition to the 60% rule, to be eligible for payment as an IRF under CMS, patients must attend three hours of therapy in 5 of 7 consecutive days.

10 VMG Health's proprietary inpatient rehabilitation database includes 20 years of inpatient rehabilitation analyses with over 100 IRF transactions.

Authors

Sydney Richards, CVA
Manager
Valuation & Transaction Advisory
972-616-5916
sydney.richards@vmghealth.com

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