CMS proposed updates to the inpatient rehabilitation facility (IRF) prospective payment system (PPS) payment rates for fiscal year (FY) 2017 resulting in a 1.6 percent increase from FY 2016. It also proposed the addition of four claims-based measures for inclusion in the quality reporting program (QRP) payment determinations for FYs 2018 and beyond, and one assessment-based quality measure for inclusion in the QRP for FY 2020 and beyond. Stakeholders may comment on the rule no later than June 20, 2016 (Proposed rule, 81 FR 24178, April 25, 2016).

Payment update. The agency proposed updating the IRF FY 2017 PPS payments to reflect an estimated 1.6 percent increase since FY 2016, based on an estimated 1.45 percent increase factor, along with a 0.2 percent increase to aggregate payments resulting from updating outlier threshold results. The estimated 1.45 percent increase factor will reflect an estimated IRF-specific market basket of 2.7 percent, reduced by a 0.5 percent multi-factor productivity adjustment and a 0.2 percent reduction required by section 3401(d) of the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148). Should more recent data become available, it would be used to calculate the update in the Final rule.

Facility, rural adjustments. CMS froze the facility-level adjustment factors at FY 2014 levels for FYs 2015 and beyond, until such time as they are updated via notice-and-comment rulemaking. The Proposed rule suggested no changes to these factors.

The FY 2016 Final rule utilized updated core-based statistical areas (CBSAs) based on Office of Management and Budget (OMB) delineations of Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas (see More than just payment updates; IRF Final rule implements policy changes, August 12, 2015). All IRF facilities were allowed to transition to the new CSBAs by being subject to a wage index in FY 2016 that was a blend of 50 percent of the FY 2016 wage index using current OMB delineations and 50 percent of the wage index using the revised OMB delineations. That transitional period will not continue into FY 2017.

The FY 2016 Final rule also outlined a three-year transitional period for the 19 providers whose status changed from rural to urban as a result of the OMB delineations. In FY 2017, that means that those 19 IRFs will receive one-third of the FY 2015 rural adjustment.

Quality Reporting Program. Section 3004(b) of the ACA required the establishment of the IRF QRP that required a 2 percent reduction in the market basket increase factor for IRFs that do not comply with quality data submission requirements beginning in FY 2014. The FY 2017 proposed rule would implement changes to the IRF quality reporting program (QRP) mandated by the improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 (P.L. 113-185), adopting four claims-based measures to satisfy IMPACT Act requirements:

1. Discharge to Community—Post Acute Care (PAC) IRF QRP;
2. Medicare Spending Per Beneficiary (MSPB)—Post-Acute Care (PAC) IRF QRP;
3. Potentially Preventable 30 Day Post-Discharge Readmission Measure for IRFs; and
4. Potentially Preventable Within Stay Readmission Measure for IRFs.

It also proposed an assessment-based measure, Drug Regimen Review Conducted with Follow-Up for Identified Issues, which addresses the IMPACT Act quality domain of Medication Reconciliation. Data collection for the measure would begin October 1, 2018 for the FY 2020 payment determinations and subsequent years.

Sociodemographic factors. CMS noted ongoing concerns about the role of sociodemographic status in the risk adjustment of the resource use and other measures, noting that it is wary of holding to providers to
different standards based on the sociodemographic status of their patients. However, the National Quality Forum (NQF) is in the midst of a two-year trial period in which it will assess new measures and measures undergoing maintenance review by temporarily allowing inclusion of such factors for some performance measures.