
By Anthony H. Nguyen, J.D.

Inpatient rehabilitation facilities (IRF) will receive a net $145 million (1.9 percent) increase in payments under the IRF prospective payment system (PPS) for fiscal year (FY) 2017. The increase does not include the implementation of a required 2-percentage-point reduction of the market basket increase factor for any IRF that fails to meet the IRF quality reporting requirements. In an advance release of a final rule set to publish in the Federal Register August 5, 2016, and effective October 1, 2016, CMS also added four claims-based measures for FY 2018 and beyond to the quality reporting program (QRP).

Payment updates. IRF PPS payments for FY 2017 will reflect a 1.65 percent increase factor, which is derived from an IRF-specific market basket estimate of 2.7 percent, reduced by a 0.3 percentage point multi-factor productivity adjustment and a 0.75 percentage point reduction required by law. An additional approximate 0.3 percent increase to aggregate payments due to updating the outlier threshold results in an overall estimated update of approximately 1.9 percent (or $145 million), relative to payments in FY 2016 (see CMS proposes IRF payment, quality reporting measure updates, April 22, 2016). An additional 0.3 percent increase to aggregate payments due to updating the outlier threshold results in an overall update of approximately $145 million, relative to payments in FY 2016.

In addition to the overall payment increase, CMS will continue its phase out of the 14.9 percent rural adjustment for IRF providers in areas that had been changed to urban from a previous rural designation based upon updated core-based statistical areas (CBSAs) policies established by the Office of Management and Budget (OMB). The OMB policies for Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas, which CMS incorporated in the FY 2016 IRF IPPS Final rule, affected 19 providers based on their FY 2014 claims data (see More than just payment updates; IRF Final rule implements policy changes, August 6, 2015). In FY 2015 a new provider was determined to be eligible for the rural adjustment. As a result, 20 IRFs whose status changed from rural to urban will receive one-third of the rural adjustment for FY 2017, and no rural adjustment for FY 2018 and subsequent years.

CMS will not make changes to facility-level adjustment factors, noting that it needs to continue to monitor the most current IRF claims data to determine the impact from changes made in FY 2014.

Quality reporting. The Final rule adds various measures beginning in FY 2018 and subsequent years to meet the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT) requirements regarding resource use, medication reconciliation, and other domains. IMPACT added Section 1899B to the Social Security Act requiring IRFs report data on measures that satisfy specific measure domains, which must be aligned with measures implemented for long-term care hospitals (LTCH), IRFs, skilled nursing facilities (SNF), and home health agencies (HHAs). The three added claims-based measures related to resource use for FY 2018 are:

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

In addition, the measure Potentially Preventable within Stay Readmissions for IRFs is added for FY 2018. For FY 2020, the Drug Regimen Review Conducted with Follow-Up for Identified Issues measure will be added to meet the medication reconciliation domains. IRFs that fail to submit the required quality data to CMS will be subject to a 2 percentage point reduction to their applicable FY annual increase factor as required under Section 3004(b) of the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148).

CMS will begin reporting IFR quality data publicly in the fall of 2016.