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Special Bulletin

July 28, 2022

CMS Releases FY 2023 Inpatient Rehabilitation Facility PPS Proposed Rule

The Centers for Medicare & Medicaid Services (CMS) late yesterday issued the final rule for the inpatient rehabilitation facility (IRF) prospective payment system (PPS) for fiscal year (FY) 2023.

AHA TAKE

We appreciate CMS' streamlined approach to the rule, which allows providers to focus on responding to patient care needs and challenges related to the COVID-19 pandemic. While we are pleased that the final net increase for FY 2023, $275 million, is more than the proposed amount of $170 million, we remain concerned that the agency fell short in fully recognizing the impact of broader economic pressures on IRFs and the delivery system as a whole.

KEY HIGHLIGHTS

The final rule:

- Increases IRF payments by an estimated 3.2% in FY 2023.
- Caps annual decreases in wage index updates.
- Updates current policy affecting displaced medical residents.
- Requires IRFs to collect quality data on all patients, regardless of payer, beginning in October 2023.

Highlights from the rule follow.

IRF PPS PAYMENT CHANGES

FY 2023 Payment Update. CMS finalizes an overall increase in FY 2023 payments to IRFs, relative to FY 2022, of 3.2%, or $275 million. This includes a 4.2% market basket update offset by a statutorily-mandated cut of 0.3 percentage point for productivity, and a 0.6 percentage point cut for high-cost outlier payments. The latter would reduce the number of cases that qualify for an outlier payment with the goal of limiting total FY 2023 outlier payments to 3.0% of all IRF PPS payments that year, per current policy.

Permanent Cap on Wage Index Decreases. As proposed, CMS adopts a permanent policy that would cap wage index decreases from year-to-year at 5%. CMS anticipates

that this cap would rarely be used, but, when needed, would improve the stability of this payment system.

CHANGES RELATED TO THE FACILITY-LEVEL ADJUSTMENT FOR "TEACHING IRFS"

Changes Regarding Displaced Medical Residents. The rule updates and clarifies current policy addressing medical residents (and interns) who are displaced when a teaching IRF closes. In addition, the status of a relocating resident will be based on the date that the originating IRF publicly announces its closure (for example, via a press release), rather than the actual closure date, to mitigate delayed transfers of a displaced resident to a new IRF. The rule also allows the receiving IRF to increase its FTE resident cap by submitting a letter to its Medicare Administrative Contractor (MAC) within 60 days after beginning to train the displaced residents.

Codification of IRF Teaching Status Adjustment. To improve clarity, CMS will codify and consolidate existing policies related to reimbursement for IRFs providing graduate medical education.

IRF QUALITY REPORTING PROGRAM (QRP)

CMS finalized its proposal to require IRFs to report quality data, including the standardized patient assessment data in the IRF Patient Assessment Instrument (PAI), on all patients regardless of payer. However, CMS will delay the implementation of this requirement by one year; as finalized, IRFs will be required to collect the IRF PAI for all patients beginning Oct. 1, 2024. The agency estimates that the increased burden will result in an additional average cost of nearly $29,000 per IRF annually, at a total cost of over $31 million for the field per year.

CMS did not propose any other changes to the QRP, including any new quality measures.

FURTHER QUESTIONS

AHA's IRF members will receive an invitation for a call to discuss the rule. Please direct any questions to Caitlin Gillooley, AHA director of policy, at cgillooley@aha.org.