CAPITOL STREET

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Proposed FY '27 Inpatient Rehab Facility Pay +2.8%

No Transfer Policy is a Positive as CMS Releases RFI Indicating Structural Pay Change Is Afoot

Relevant Companies

Our Take & Next Up

Medicare Inpatient Rehab Facility (IRF) 2027 proposed pay is +2.8% in 2027, per a rule released yesterday (here), with no transfer policy proposed. The lack of a transfer policy is likely good news for inpatient rehab facilities (IRFs) for now, but the agency emphasizes the need for reform to the outdated payment structure for IRFs. The agency will seek comments for the next few months and provide commentary on where it is headed. Notably, the agency discusses applying the SNF PDPM to IRFs. We note that one payment system likely does *not* transfer to another, and that analysis is needed before anything of this nature is applied to IRF payment (the net effect would be to ratchet rates down over time).

Key Points

The pay increase for all inpatient rehab facilities (IRFs) in FY27 would be +2.8%. For 2027, CMS proposes updates to the IRF pay by +2.4% based on the IRF market basket % increase of +3.2%, minus a 0.8% point productivity adjustment. CMS proposes updates to the "outlier threshold" to maintain outlier payments at 3% of total payments. The agency estimates the technical rate setting changes will result in an estimated increase in IRF payments of $355 M for 2027.

Urban for-profit facilities would see updates of +2.5% and rural for-profits will be paid +3.2% respectively, in FY 2027. As a reminder the government FY starts Oct 1. In the proposed rule, the much-feared IRF "transfer rule" was not proposed, though we do not rule it out from being proposed in the future.

CMS did not propose the 'transfer rule' here (our take here), as Rehab facilities live to fight another day, though the agency tips its hand that changes are coming. As a reminder, MedPAC recommended a 7% base rate cut for fiscal year 2027, which CMS/Capitol Hill have rejected. Short-stay payment adjustments can significantly influence facility behavior around patient selection and length of stay, and CMS may be reserving that lever for a future rulemaking tied to the broader payment reform overhaul floated in the RFI.

Importantly the proposed rule includes an RFI (request for information) on a potential structural overhaul of the IRF payment system.

- The agency views IRF payment structure as outdated, emphasizing that the 2002 classification structure, which routes patients through a multi-step process of impairment group codes (IGCs), rehabilitation Impairment categories (RICs), and case mix groups (CMGs), has created payment misalignments.
- Under the current IGC/RIC/CMG framework, a patient's primary diagnosis is first assigned an IGC, one of 85 specific codes across 17 categories, which then maps to one of 21 RICs, which in turn determines the patient's CMG based primarily on functional status at admission and, in some cases, age.
- CMS notes that the layered classification process has created opportunities for misalignment between the patient's primary reason for IRF admission, the clinical care delivered, and the resulting payment.

NEW: CMS is exploring replacing the IRF payment system with a PDPM (patient driven payment model)-style approach using 15 diagnosis-based clinical categories mapped directly from ICD-10-CM codes. The proposal would swap the current 3-tier comorbidity adjustment for a weighted 6-bin scoring system similar to the SNF (skilled nursing facility) non-therapy ancillary (NTA) component, which accounts for both the severity and cumulative burden of multiple comorbid conditions. The goal is better alignment between payments and actual patient complexity and resource use, rather than an across-the-board rate cut like MedPAC recommends. MedPAC has pushed more broadly for a unified PAC payment system, which is a more ambitious change than what CMS is contemplating here.

No payment system can be applied to another setting without robust validation of data accuracy. This includes reliability for patient-level clinical data collected by nurses and therapists. Such validation is needed for both the payment system elements as well as for the related quality measures. CMS often takes short cuts, but when applying non-hospital-level metrics and measures to hospital-level patients and payments—such tactics could yield materially inaccurate payments. It's reasonable to expect underpayments since the SNF PPS is not designed to capture the clinical characteristics of hospital inpatients.

Other key provisions include:

- **A proposal to clarify the 36-hour rule clarification**. CMS is proposing to codify a long-standing ambiguity around therapy initiation. Older guidance created confusion on if just one therapy discipline or all ordered therapies needed to begin within 36 hours of midnight on the day of admission. The proposed rule makes clear it applies to all ordered therapy treatments and/or evaluations, not just one.
- **The agency proposes a modest, but meaningful, addition to preadmission screening documentation requirements.** Currently, inpatient rehabilitation facilities must document a patient's prior level of function; the proposed rule would also require documentation of the patient's current functional status at the time of admission.
- **The proposed rule would require the first interdisciplinary team meeting, where the full care team coordinates on a patient's treatment plan and progress, to occur by day 4 of admission rather than the current policy which allows it as late as day 7.** CMS argues that waiting up to a week is problematic given that the average inpatient rehabilitation stay is only 12-14 days.
- **Beginning with the fiscal year 2029 payment determination, CMS is proposing to shorten data submission deadlines for quality reporting from 4.5 months to roughly 45 days after the end of each calendar quarter.** The change is intended to reduce the roughly nine-month lag between data collection and public reporting, making performance data more timely and useful for both patients and facilities.
- **CMS is proposing to increase the bid surety bond, a financial guarantee suppliers must post when submitting DME bids, from $50K to $100K for suppliers bidding under remote Item delivery programs, which can cover multiple states or even the entire country.** The higher bond amount is

intended to deter non-serious bids given the significantly larger geographic scope of these programs compared to traditional local competitive bidding areas. The $50K requirement would be maintained for all other competitions.

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