Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for FY 2024 and Updates to the IRF Quality Reporting Program
[CMS-1781-P]

Summary of Proposed Rule

On April 3, 2023, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule on the Medicare inpatient rehabilitation facility prospective payment system (IRF PPS) for federal fiscal year (FY) 2024.[1] In addition to provisions that would update the IRF PPS payment rates and outlier threshold for FY 2024, the rule proposes two new and one modified measure proposals for the IRF Quality Reporting Program (QRP). This rule also proposes to rebase and revise the IRF market basket to reflect more recent data on IRF cost structures. In addition, CMS proposes a modification to the excluded unit regulation that would allow a hospital to open a new IRF unit and begin being paid under the IRF PPS at any time during the cost reporting period, provided the hospital meets certain requirements.

CMS estimates that the Medicare IRF PPS payments in FY 2024 will be about $335 million higher than in FY 2023.

The deadline for comments on the proposed rule is June 2, 2023.

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[1] It will be published in the Federal Register on April 7, 2023.

I. Introduction and Background

The proposed rule provides an overview of the IRF PPS, including statutory provisions, a description of the IRF PPS for FYs 2002 through 2023, and an operational overview. It also notes IRF-specific changes to IRF payment and conditions for participation adopted based on two interim final rules with comment period made in response to the COVID-19 Public Health Emergency (PHE).[2] This included, for example, certain changes to the IRF PPS medical supervision requirements. Some of these changes are set to expire at the end of the COVID-19 PHE.[3] In addition, CMS highlights efforts at promoting adoption of interoperable health information technology and health information exchange in post-acute settings. It highlights a significant milestone through the release of the Trusted Exchange Framework and Common Agreement Version 1 on January 18, 2022. This establishes the technical infrastructure model and governing approach for different health information networks and their users to securely share clinical information with each other. It also recognized on February 13, 2023 the first set of applicants accepted for onboarding to the Common Agreement as Qualified Health Information Networks (QHINs) that will connect directly to each other to serve as the core for nationwide interoperability.

II. Update to the CMG Relative Weights and Average Length of Stay Values

Under the IRF case-mix classification system, a patient's principal diagnosis or impairment is used to classify the patient into a Rehabilitation Impairment Category (RIC). The patient is then placed into a case mix group (CMG) within the RIC based on the patient's functional status (motor and cognitive scores) and sometimes age. Other special circumstances (e.g., very short stay or patient death) are also considered in determining the appropriate CMG. CMGs are further divided into tiers based on the presence of certain comorbidities; the tiers reflect the differential cost of care compared with the average beneficiary in the CMG.

Updates to the CMG relative weights and average length of stay values are proposed for FY 2024, continuing the same methodologies used in past years, and now applied to FY 2022 IRF claims and FY 2021 IRF cost report data. (More recent data from these sources will be used for the final rule, if available.) Changes to the CMG weights are made in a budget neutral manner; the proposed budget neutrality factor is 0.9999.

Table 2 in the proposed rule displays the proposed relative weights and length of stay values by CMG and comorbidity tier. Table 3 displays the distributional effect of changes in CMS weights across cases. It shows that 99.4 percent of IRF cases are in CMGs for which the proposed FY 2024 weight differs from the FY 2023 weight by less than 5 percent (either increase or decrease).

[2] These are referred to as the April 6, 2020 IFC (85 FR 19230) and the May 8, 2020 IFC (85 FR 27550).
[3] The Secretary of HHS has announced, consistent with the Biden administration announcement, that the Department will not further renew the Public Health (PHE) Emergency declaration for COVID-19 under section 319 of the Public Health Service Act, and therefore the PHE emergency declaration would expire at the end of May 11, 2023. Waivers and flexibilities authorized for the emergency period under 1135(g)(1) of the Social Security Act, would consequently expire on that date.

CMS says that the proposed changes in the average length of stay values from FY 2023 to FY 2024 are small and do not show any trends in IRF length of stay patterns.

Column 6 of Table 21 in the impact section of the proposed rule (section VII below) shows the distributional effects of the changes in the CMGs by type of facility. CMS posted the accompanying provider-specific files on the IRF PPS web page.[4]

III. FY 2024 IRF PPS Payment Update

For FY 2024 payment, CMS proposes to rebase and revise the IRF PPS market basket; apply the annual market basket update and productivity adjustment; update the labor-related share of payment; and update the wage index based on the most recent IPPS hospital wage index data.

A. Rebasing and Revising of the IRF PPS Market Basket

Beginning with FY 2024, CMS is proposing to rebase and revise the 2016-based IRF market basket cost weights to a 2021 base year reflecting 2021 Medicare cost report data submitted by both freestanding IRFs and distinct part IRF units within hospitals. CMS believes that 2021 represents the most recent and complete set of Medicare cost report data available. The cost reports are for providers with cost reporting periods beginning on or after October 1, 2020 and before October 1, 2021.

The proposed rule details the methodology used to rebase the market basket, which is generally the same methodology CMS used in creating the current 2016-based IRF market basket. That involves using Medicare cost report data to calculate weights for seven cost categories: Wages and Salaries; Employee Benefits; Contract Labor; Pharmaceuticals; Professional Liability Insurance; Home Office Contract Labor; and Capital.

A residual category captures all remaining costs. Detailed weights are calculated for 17 categories within this residual by using the 2012 Benchmark Input-Output (I-O) "Use Tables/Before Redefinitions/Purchaser Value" for North American Industry Classification System (NAICS) 622000, Hospitals, published by the Bureau of Economic Analysis (BEA). This data is publicly available at Input-Output Accounts Data | U.S. Bureau of Economic Analysis (BEA).

Table 7, reproduced below, compares the proposed 2021 to the current 2016-based market basket cost weights.

[4] https://www.cms.gov/files/zip/fy-2024-irf-pps-data-files-nprm.zip

Table 7: IRF Market Basket Cost Weights, Comparison of 2016 to 2021 Based Weights		
Cost Category	**Proposed 2021-based IRF Market Basket Cost Weight**	**2016-based IRF Market Basket Cost Weight**
Total	**100.0**	**100.0**
Compensation	**60.1**	**59.4**
Wages and Salaries	48.2	47.9
Employee Benefits	11.9	11.4
Utilities	**1.4**	**1.4**
Electricity and Other Non-Fuel Utilities	0.9	1.0
Fuel: Oil and Gas	0.5	0.4
Professional Liability Insurance	**0.8**	**0.7**
All Other Products and Services	**29.1**	**29.5**
All Other Products	**11.4**	**12.5**
Pharmaceuticals	4.7	5.1
Food: Direct Purchases	1.0	1.1
Food: Contract Services	1.2	1.2
Chemicals	0.4	0.4
Medical Instruments	2.5	2.9
Rubber and Plastics	0.4	0.4
Paper and Printing Products	0.6	0.6
Miscellaneous Products	0.8	0.8
All Other Services	**17.7**	**17.0**
Labor-Related Services	**9.5**	**9.2**
Professional Fees: Labor-related	5.6	5.0
Administrative and Facilities Support Services	0.7	0.7
Installation, Maintenance, and Repair Services	1.5	1.6
All Other: Labor-related Services	1.7	1.8
Nonlabor-Related Services	**8.2**	**7.9**
Professional Fees: Nonlabor-related	5.9	5.4
Financial Services	0.9	0.9
Telephone Services	0.3	0.3
All Other: Nonlabor-related Services	1.1	1.3
Capital-Related Costs	**8.6**	**9.0**
Depreciation	**6.0**	**6.5**
Building and Fixed Equipment	3.8	4.1
Movable Equipment	2.3	2.5
Interest Costs	**1.2**	**1.5**
Government/Nonprofit	0.6	0.9
For Profit	0.6	0.6
Other Capital-Related Costs	**1.3**	**1.0**

The proposed price proxies are the same as used for the 2016-based market basket.

Table 12 reproduced below, compares the percent change in the 2012-based and proposed 2016-based IRF market baskets for FYs 2019 through FY 2026. While there are small differences in a few years, there is no difference on average in the current or rebased IRF PPS market either historically or for the forecast years.

Table 12: Proposed 2021-Based IRF Market Basket and 2016-Based IRF Market Basket Percent Changes, FY 2019 through FY 2026			
	Fiscal Year (FY)	**Proposed 2021-Based IRF Market Basket Index Percent Change**	**2016-Based IRF Market Basket Index Percent Change**
Historical data	FY 2019	2.4	2.3
	FY 2020	2.1	2.1
	FY 2021	2.8	2.7
	FY 2022	5.3	5.3
	Average 2019-2022	3.2	3.1
Forecast	FY 2023	4.6	4.6
	FY 2024	3.2	3.2
	FY 2025	2.9	2.9
	FY 2026	2.8	2.8
	Average 2023-2026	3.4	3.4

Note that these market basket percent changes do not include any further adjustments as may be statutorily required.
Source: IHS Global Inc. 4th quarter 2022 forecast.

B. Market Basket Update and Productivity Adjustment

An update factor of 3.0 percent is proposed for the IRF PPS payment rates for FY 2024, composed of the following elements listed below.

Proposed FY 2024 IRF PPS Update Factor	
IRF market basket	3.2%
Total factor productivity (TFP)	-0.2%
Total	**3.0%**

The 3.0 percent FY 2024 with the proposed 2021-based IRF market basket increase factor is based on IHS Global Insight's (IGI's) forecast from the fourth quarter of 2022, based on actual data through the third quarter. Similarly, the statutorily required productivity adjustment is based on IGI's fourth quarter 2022 forecast of the 10-year moving average (ending in 2024) of changes in annual economy-wide private nonfarm business total factor productivity.[5] The update factor for IRFs that fail to meet requirements for the IRF QRP is discussed in section VI below and totals 1.0 percent. CMS will use more recent data, if available, for the final rule.

C. Labor-Related Share

CMS proposes a total labor-related share of 74.1 percent for FY 2024 is 1.2 percentage points higher than the FY 2023 labor share of 72.9 percent. The higher labor-related share is primarily

[5] Beginning with the November 18, 2021 release of productivity data, the U.S. Bureau of Labor Statistics (BLS) replaced the term multifactor productivity (MFP) with total factor productivity (TFP). This is a change in terminology only, not in data or methodology.

due to the incorporation of the 2021 Medicare cost report data, which increased the Compensation cost weight by approximately 0.8 percentage point compared to the 2016-based IRF market basket. The 74.1 percent comes from the IGI fourth quarter 2022 estimate of the sum of the relative importance of Wages and Salaries; Employee Benefits; Professional Fees: Labor-Related; Administrative and Facilities Support Services; Installation, Maintenance and Repair; All Other: Labor-related Services; and a portion (46 percent) of the Capital-Related cost weight from the proposed 2021-based IRF market basket. The relative importance reflects the different rates of price change for these cost categories between the proposed base year (2021) and FY 2024. Table 13 of the proposed rule compares the components of the FY 2023 and proposed FY 2024 labor shares.

D. Wage Adjustment

Under previously adopted policy, for the IRF PPS wage index CMS uses the Core Based Statistical Areas (CBSA) labor market area definitions and the pre-floor, pre-reclassification Inpatient Prospective Payment System (IPPS) hospital wage index for the current fiscal year. Thus, for FY 2024 CMS would use the FY 2024 pre-floor, pre-reclassification IPPS wage index. The FY 2024 pre-reclassification and pre-floor hospital wage index is based on FY 2020 cost report data. Based on the changes in the 2023 IRF PPS final rule, CMS applies a 5 percent cap on any decrease to a provider's wage index from its wage index in the prior year, regardless of the circumstances causing the decline.[6]

The CBSAs are established by the Office of Management and Budget (OMB). They are generally subject to major revisions every 10 years to reflect information from the decennial census, but OMB also issues minor revisions in the intervening years through OMB Bulletins. CMS has previously adopted OMB changes to CBSA delineations for purposes of the IRF PPS labor market areas. The history of these changes to the IRF wage index is discussed in the proposed rule. For purposes of the IRF wage index, OMB-designated Micropolitan Statistical Areas[7] are considered to be rural areas. The OMB Bulletins are available at https://www.whitehouse.gov/omb/information-for-agencies/bulletins/.

In the FY 2021 IRF PPS final rule (85 FR 48434 through 48440), CMS adopted the changes included in OMB Bulletin No. 18-04, issued on September 14, 2018. CMS also adopted a 1-year transition for FY 2021 under which CMS applied a 5 percent cap on any decrease in a hospital's wage index compared to its wage index in the prior fiscal year. CMS noted in the 2021 proposed rule that OMB issued OMB Bulletin No. 20-01 on March 6, 2020, but it was not issued in time for development of that proposed rule. CMS has determined that the changes in OMB Bulletin No. 20-01 did not impact the CBSA-based labor market delineations adopted in FY 2022 or 2023. For these reasons, CMS is not making such a proposal for FY 2024.

[6] New IRFs would be paid the wage index for the area in which it is geographically located for its first full or partial FY with no cap applied.
[7] OMB defines a Micropolitan Statistical Area as an area associated with at least one urban cluster that has a population of at least 10,000, but less than 50,000.

Changes to the IRF PPS wage index are made in a budget neutral manner; CMS estimates the budget neutrality adjustment for FY 2024 under the proposed rule to be 1.0032. To make this calculation, CMS estimates aggregate IRF PPS payments using the FY 2023 labor-related share and wage index values and then estimates aggregate payments using the proposed FY 2024 labor share and wage index values. The ratio of the amount based on the FY 2023 index to the amount estimated using the proposed FY 2024 index is the budget neutrality adjustment to be applied to the proposed federal per diem base rate for FY 2024.

E. Description of the IRF Standard Payment Conversion Factor and Payment Rates for FY 2024

Table 14 of the proposed rule (reproduced below) shows the calculations used to determine the proposed FY 2024 IRF standard payment amount. In addition, Table 15 of the proposed rule lists the FY 2024 payment rates for each CMG, and Table 16 provides a detailed hypothetical example of how the IRF FY 2024 federal prospective payment would be calculated for CMG 0104 (without comorbidities) for two different IRF facilities (one urban, teaching and one rural, non-teaching), using the applicable wage index values and facility-level adjustment factors under the proposed rule.

Table 14: Calculations to Determine the Proposed FY 2024 Standard Payment Conversion Factor

Explanation for Adjustment	Calculations
Standard Payment Conversion Factor for FY 2023	$17,878
Market Basket Increase Factor for FY 2024 (3.2 percent), reduced by 0.2 percentage point for the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act	x 1.030
Budget Neutrality Factor for the Updates to the Wage Index and Labor-Related Share	x 1.0032
Budget Neutrality Factor for the Revisions to the CMG Relative Weights	x 0.9999
Proposed FY 2024 Standard Payment Conversion Factor	= $18,471

IV. Update to Payments for High-Cost Outliers under the IRF PPS

Under the IRF PPS, if the estimated cost of a case (based on application of an IRF's overall cost-to-charge ratio (CCR) to Medicare allowable covered charges) is higher than the adjusted outlier threshold, CMS makes an outlier payment for the case equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold. From the beginning of the IRF PPS, CMS' intent has been to set the outlier threshold so that the estimated outlier payments would equal 3 percent of total estimated payments, and this policy is continued for FY 2024. CMS believes this level reduces financial risk to IRFs of caring for high-cost patients while still providing adequate payments for all other cases.

To update the IRF outlier threshold amount for FY 2024, CMS proposes to use FY 2022 claims data and the same methodology that has been used to set and update the outlier threshold since the FY 2002 IRF PPS final rule. CMS currently estimates that IRF outlier payments as a percentage of total estimated payments will be 2.3 percent of total IRF payments in FY 2023. To

maintain estimated outlier payments at the 3 percent level, CMS proposes to update the outlier threshold amount from $12,526 for FY 2023 to $9,690 for FY 2024.

Updates are proposed to the national urban and rural CCRs for IRFs, as well as the national CCR ceiling for FY 2024, based on analysis of the most recent cost report data that are available (FY 2021). CCRs are used in converting an IRF's Medicare allowable covered charges for a case to costs for purposes of determining appropriate outlier payment amounts. The national urban and rural CCRs are applied in the following situations: new IRFs that have not yet submitted their first Medicare cost report; IRFs with an overall CCR that is more than the national CCR ceiling for FY 2024; and other IRFs for which accurate data to calculate an overall CCR are not available. The national CCR ceiling for FY 2024 would continue to be set at 3 standard deviations above the mean CCR. If an individual IRF's CCR exceeds the ceiling, CMS replaces the IRF's CCR with the appropriate national average CCR (either urban or rural).

The proposed national average CCRs for FY 2023 are 0.398 for urban IRFs and 0.487 for rural IRFs, and the national CCR ceiling is 1.45. That is, if an individual IRF's CCR were to exceed this ceiling of 1.45 for FY 2024, CMS would replace the IRF's CCR with the appropriate proposed national average CCR (either rural or urban, depending on the geographic location of the IRF).

V. Proposed Modification to the Regulation for Excluded Inpatient Rehabilitation Facility Units Paid Under the IRF PPS

Current regulations at 42 CFR 412.25(c) specify when the status of an IRF unit may be changed from "not excluded from the IPPS" to "excluded from the IPPS" and be paid under the IRF PPS or vice versa. The same rules apply for units of inpatient psychiatric facilities (IPF) and exclusion from the IPPS to be paid under the IPF PPS system or vice versa.

- Status of change from not excluded to excluded from the IPPS: May only be done at the start of the cost reporting period. If a unit is added to a hospital after the start of a cost reporting period, it cannot be excluded from the IPPS before the start of a hospital's next cost reporting period.
- Status of change from excluded to not excluded from the IPPS: May be done at any time during a cost reporting period, subject to certain conditions:
    - The hospital must notify the MAC and the CMS Regional Office in writing at least 30 days before the date of the change, and must maintain the information needed to accurately determine costs that are or are not attributable to the excluded unit.
    - A status change from excluded to not excluded that is made during a cost reporting period must remain in effect for the rest of that cost reporting period.

CMS provides background for these policies, which were implemented before the establishment of the IRF PPS and the IPF PPS and were established to address the administrative complexity associated with cost-based reimbursement for excluded IRF and IPF units. Stakeholders have

observed that only permitting status changes from not excluded to excluded to be made before the start of a cost reporting period is no longer necessary, creates an unnecessary burden, and does not take into account challenges hospitals face completing construction projects to expand capacity before the start of a cost reporting period.

Noting that cost allocation is no longer used for payment purposes because IRF units are paid under the IRF PPS and IPF units are paid under the IPF PPS, CMS believes that the restriction that limits an IPF or IRF unit to being excluded from the IPPS only at the start of a cost reporting period is no longer necessary. Thus, it proposes to revise its regulations at §412.25(c)(1) to establish a uniform rule for status changes for IRF units which would permit the status of an IRF unit to be changed from not excluded to excluded (or excluded to not excluded) at any time during a cost reporting period. The hospital would be required to notify the MAC and the CMS Regional Office in writing of the change at least 30 days before the date of the change, and it would have to maintain the information needed to accurately determine costs that are or are not attributable to the IRF unit. Additionally, any change in the status of an IRF unit (i.e., from not excluded to excluded or vice versa) that is made during a cost reporting period must remain in effect for the rest of that cost reporting period.

CMS notes that the §412.25(c) applies to both IRFs and IPFs; it proposes the same change for IPFs in the IPF PPS proposed rule and would establish those rules for IPFs in a revised §412.25(c)(2). Discrete regulation text for IRF and IPF unit types is proposed in order to solicit comment on issues that might affect one hospital unit type and not the other. However, CMS may consider adopting one consolidated regulation text for both IRF and IPF units in either the IRF or IPF final rules for both unit types if it finalizes both of its proposals. CMS seeks comments on the proposals and also on whether it should finalize a consolidated provision that pertains to both IRF and IPF units.

VI. Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)

CMS proposes, beginning with the FY 2025 IRF QRP, to:

- Modify one existing measure: The COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) measure;
- Adopt one new measure: The Discharge Function Score measure; and
- Remove 3 existing measures:
    - The Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function measure (NQF #2631);
    - The IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients measure (NQF #2633); and
    - The IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients measure (NQF #2634).

CMS proposes, beginning with the FY 2026 IRF QRP, to adopt one new measure: The COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure.

CMS also seeks information on principles that CMS would use to select and maintain QRP quality measure in future years, provides an update on efforts to close the health equity gap, and proposes to begin public reporting of 4 measures.

CMS invites public comment on all of the proposals.

A. Background and Statutory Authority

The IRF QRP is authorized under section 1886(j)(7) of the Act. The program is applicable to freestanding IRFs and to inpatient rehabilitation units of hospitals or CAHs. By statute, a facility that does not submit data in accordance with the IRF QRP requirements for a rate year is subject to a 2.0 percentage point reduction in the update factor for that year. FY 2014 was the first IRF PPS rate year in which the IRF QRP affected payments.[8]

The IRF standardized patient assessment instrument (IRF-PAI) is used for data collection and reporting and includes standardized patient assessment data elements (SPADEs) that are interoperable and common across post-acute care (PAC) providers. Measures remain in the IRF QRP until they are removed, suspended, or replaced. Additional information about the program is available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting.

B. General Considerations Used for the Selection of Measures for the IRF QRP

CMS refers readers to 42 CFR §412.634(b)(2) for details on factors used to evaluate whether a measure should be removed from the IRF QRP and to the FY 2016 IRF PPS final rule (80 FR 47083 through 47084) for considerations CMS uses for selecting quality, resource use, and other measures.

The table below (Table 17 reproduced from the proposed rule with minor modifications) shows the current 18 measures for the FY 2024 IRF QRP, with the proposed changes noted in italics.

[8] A detailed legislative and regulatory history is available for download from the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS.

IRF QRP Measure Set for FY 2024	
Short Name	**Measure Name & Data Source**
IRF-PAI	
Pressure Ulcer/Injury	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury
Application of Falls	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)
Application of Functional Assessment	Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631): *Proposed removal of this measure beginning for FY 2025*
Change in Self-Care	IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633): *Proposed removal of this measure beginning for FY 2025*
Change in Mobility	IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634): *Proposed removal of this measure beginning for FY 2025*
Discharge Self-Care Score	IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635)
Discharge Mobility Score	IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636)
DRR	Drug Regimen Review Conducted with Follow-Up for Identified Issues– PAC IRF QRP
TOH-Provider	Transfer of Health Information to the Provider-PAC Measure
TOH-Patient	Transfer of Health Information to the Patient-PAC Measure
DC Function	*Discharge Function Score measure: Proposed addition beginning for FY 2025*
Patient/Resident COVID-19 Vaccine	*COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure: Proposed addition beginning for FY 2026*
NHSN (National Healthcare Safety Network)	
CAUTI	NHSN Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138)
CDI	NHSN Facility-wide Inpatient Hospital-Onset Clostridium difficile Infection (CDI) Outcome Measure (NQF #1717)
HCP Influenza Vaccine	Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431)
HCP COVID-19 Vaccine	COVID-19 Vaccination Coverage among Healthcare Personnel: *Modified Measure proposed beginning for FY 2025*
Claims-based	
MSPB IRF	Medicare Spending per Beneficiary (MSPB)–PAC IRF QRP (NQF #3561)
DTC	Discharge to Community–PAC IRF QRP (NQF #3479)
PPR 30 day	Potentially Preventable 30-Day Post-Discharge Readmission Measure for IRF QRP
PPR Within Stay	Potentially Preventable Within Stay Readmission Measure for IRFs

C. Overview of IRF QRP Quality Measure Proposals

1. IRF QRP Quality Measure Proposals Beginning with the FY 2025 IRF QRP

a. Proposed Modification of the COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) Measure Beginning with the FY 2025 IRF QRP

Background: The COVID–19 Vaccination Coverage among Healthcare Personnel (HCP COVID-19 Vaccine) measure was adopted[9] into the IRF QRP measure set beginning with FY 2023, and requires each IRF to submit data on the number of healthcare personnel (HCP) eligible to work in the IRF for at least one day during the reporting period who have received a complete vaccination course against SARS-CoV-2 (excluding persons with contraindications to the COVID-19 vaccine). CMS describes that since adoption of the measure, the agency continues to believe vaccination is a critical component to effectively countering the spread of COVID-19, and that it is important to incentivize and track HCP vaccination in IRFs. However, CMS states it is important to update the specifications of the HCP COVID-19 Vaccine measure to reflect the most current guidance that specifies for HCP to receive primary series and booster vaccine doses in a timely manner.

Proposed modification: CMS proposes, beginning with the FY 2025 IRF QRP measure set, to modify the HCP COVID-19 Vaccine measure to:

- Replace the term "complete vaccination course" with the term "up to date" in the HCP vaccination definition; and
- Update the numerator to specify the time frames within which an HCP is considered up to date with recommended COVID-19 vaccines, including booster doses.

Pre-rulemaking: The current version of the HCP COVID-19 Vaccine ("Quarterly Reporting of COVID-19 Vaccination Coverage among Healthcare Personnel") measure received endorsement by NQF on July 26, 2022 (NQF #3636), but the measure so endorsed does not capture information about whether HCP are "up to date" with their COVID-19 vaccinations (as proposed in the CMS modifications to the measure). The CDC, the measure developer, is pursuing NQF endorsement for the modified version of the measure and is considering an expedited review process as the current version of the measure has already received endorsement.

CMS included an updated version of the HCP COVID-19 Vaccine measure on the Measures Under Consideration (MUC) List for December 1, 2022. Comments by interested parties were mixed and raised the concern about the difficulty of defining "up to date" for purposes of the measure. The Measure Applications Partnership (MAP) conditionally supported the rulemaking pending testing indicating the measure is reliable and valid, and pending endorsement by the NQF.

[9] FY 2022 IRF PPS final rule (86 FR 42385 through 42396).

CMS proposes to adopt the measure for FY 2025, consistent with the exception under section 1886(j)(7)(D)(i) of the Act and section 1899B(e)(2)(A) of the Act, having found no currently available, alternative measure that is comparable, NQF-endorsed, feasible, and practical.

Quality Measure Calculation and Specifications: The HCP COVID-19 Vaccine measure is a process measure (that is not risk-adjusted) developed by the CDC to track COVID-19 vaccination coverage among HCP in facilities such as IRFs.

- Denominator of Measure: The number of HCP eligible to work in the facility for at least one day during the reporting period, excluding persons with contraindications to COVID-19 vaccination that are described by the CDC. HCPs include employees of the facility, licensed independent practitioners, and adult students/trainees and volunteers. There are no proposed changes to the denominator of the current measure.
- Numerator of Modified Measure: The number of HCP in the denominator population who are considered up to date[10] with CDC-recommended COVID-19 vaccines.
- Data sources: IRFs currently report data for the current HCP COVID-19 Vaccine measure through the CDC's NHSN.
- Burden assessment: Since the data is collected through the CDC's NHSN, which IRFs already use to meet other IRF QRP requirements, and no changes are proposed to the form, manner, and timing of submission, there would be no increase in burden.
- Proposed compliance requirements and calculations*:*
    - For IRF QRP compliance in FY 2025, IRFs would collect the numerator and denominator for the modified measure for at least one self-selected week during each month of the reporting quarter, report individuals who are up to date beginning in quarter 4 of CY 2023, and submit the data to the NHSN Healthcare Personnel Safety (HPS) Component before the quarterly deadline.
    - If an IRF submits more than 1 week of data in a month, the CDC would use the most recent week's data to calculate the measure.
    - Each quarter, the CDC would calculate a single quarterly COVID-19 HCP vaccination coverage rate for each IRF, by taking the average of the data from the three weekly rates submitted by the IRF for that quarter.
    - Beginning with the FY 2026 IRF QRP, IRFs would be required to submit data for the entire calendar year.
    - Public reporting of the modified measure would begin by the September 2024 Care Compare refresh or as soon as technically feasible.

[10] The definition of up to date is as of the first day of the quarter and can be found at https://www.cdc.gov/nhsn/pdfs/hps/covidvax/UpToDateGuidance-508.pdf. Further measure specification details can be found at https://www.cdc.gov/nhsn/nqf/index.html.

b. Proposed Adoption of Discharge Function Score Measure Beginning with the FY 2025 IRF QRP

Background: Section 1886(j)(7)(F)(i) of the Act requires CMS to develop and implement standardized quality measures from five quality measure domains, including the domain of functional status, cognitive function, and changes in function and cognitive function, across post-acute care settings. CMS emphasizes the need for a cross-setting functional outcome measure to align measure specifications across settings, including the use of a common set of standardized functional assessment data elements. CMS also describes the importance of implementing interventions that improve functional outcomes as a part of patient-centered care, and states that assessing functional status as a health outcome in IRFs can provide valuable information in determining treatment decisions throughout the care continuum.

Proposed measure: CMS proposes to adopt the Discharge Function Score (DC Function) measure beginning with the FY 2025 IRF QRP. The DC Function measure is an assessment-based outcome measure that evaluates functional status by calculating the percentage of IRF patients who meet or exceed an expected discharge function score.

The proposed measure would replace the topped-out Application of Functional Assessment/Care Plan cross-setting process measure proposed for removal. CMS describes that the proposed measure uses a set of cross-setting assessment items which would facilitate data collection, quality measurement, outcome comparison, and interoperable data exchange among PAC settings, whereas existing functional outcome measures do not use a set of cross-setting assessment items. CMS also explains that the proposed measure considers two dimensions of function (self-care and mobility activities) and accounts for missing data by using statistical imputation (i.e., recodes missing functional status data to the most likely value had the status been assessed). In contrast, the topped out measure treats patients with missing values the same as patients who were coded to the lowest functional status.

Measure testing: Validity was assessed for the measure performance,[11] the risk adjustment model,[12] face validity,[13] and statistical imputation models.[14]

Pre-Rulemaking: This measure went through the standard pre-rulemaking process. There were mixed comments ranging from support of the measure's reliability, validity, and feasibility to

[11] Validity testing of measure performance entailed determining Spearman's rank correlations between the proposed measure's performance for providers with 20 or more stays and the performance of other publicly reported IRF quality measures. Results indicated that the proposed DC Function measure captures the intended outcome as detailed in Table 18 of the Proposed Rule.
[12] Validity testing of the risk adjustment model showed the measure model has the predictive ability to distinguish patients with low expected functional capabilities from those with high expected functional capabilities.
[13] Cross-Setting Discharge Function TEPs and patient-family feedback showed strong support for the face validity and importance of the proposed measure as an indicator of quality of care.
[14] Validity testing of the measure's statistical imputation models indicated that the models demonstrate good discrimination and produce more precise and accurate estimates of function scores for items with missing scores when compared to the current imputation approach.

concern whether the measure is truly cross-setting. In accordance with the CMS pre-rulemaking process, the DC Function measure was included on the Measures Under Consideration (MUC) list for December 1, 2022. The measure is not NQF-endorsed, but CMS proposed to adopt the measure under the exception at section 1886(j)(7)(D)(ii) of the Act, which allows the Secretary to select non-NQF-endorsed measures when the Secretary is unable to identify a suitable NQF-endorsed measure that is available, feasible, and practical. CMS intends to submit the proposed measure to NQF for consideration of endorsement when feasible.

Measure Calculation and Specifications:
The proposed DC Function measure is an outcome measure that estimates the percentage of IRF patients who meet or exceed an expected discharge score during the reporting period.

- Numerator: The number of IRF stays with an observed discharge function score that is equal to or greater than the calculated expected discharge function score.
    - Observed discharge function score is the sum of individual function item values at discharge.
    - Calculated expected discharge function score is computed by risk-adjusting the observed discharge function score for each IRF stay.
    - The expected discharge function score is risk adjusted for patient characteristics such as admission function score, age, and clinical conditions.
- Denominator: The total number of IRF stays with an IRF-PAI record in the measure target period (four rolling quarters) that do not meet the measure exclusion criteria.[15]
- Burden assessment: Since the measure would be calculated using data from the IRF-PAI that are already reported to CMS for payment and quality reporting purposes, and the measure does not require collection of new data elements, there would be no additional burden.

c. Proposed Removal of the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function Beginning with the FY 2025 IRF QRP

Proposed Removal: CMS proposes to remove the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (Application of Functional Assessment/Care Plan) measure from the IRF QRP beginning with the FY 2025 IRF QRP. Public reporting of the Application of Functional Assessment/Care Plan measure would end by the September 2024 Care Compare refresh or as soon as technically feasible when public reporting of the proposed DC Function measure would begin (see section VIII.G.3. of the proposed rule). Beginning for the FY 2025 IRF QRP:

[15] For additional details regarding the numerator, denominator, risk adjustment, and exclusion criteria, refer to the Discharge Function Score for Inpatient Rehabilitation Facilities (IRFs) Technical Report. https://www.cms.gov/files/document/irf-discharge-function-score-technical-report-february-2023.pdf.

- IRFs would not be required to report a Self-Care Discharge Goal (GG0130, Column 2) or a Mobility Discharge Goals (GG0170, Column 2) on the IRF-PAI beginning with patients admitted on October 1, 2023.
- CMS would remove the items for Self-Care Discharge Goals (GG0130, Column 2) and Mobility Discharge Goals (GG0170, Column 2) with the next release of the IRF-PAI.

Basis for Removal: CMS explains that the proposed removal is based on the measure satisfying 2 of the 8 factors considered for removal of a measure.[16]

- Measure removal factor one: The measure performance among IRFs is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made. During the 2019-2021 period, the average performance rates on the measure was nearly 100 percent, indicating the measure has "topped out," and the measure no longer provides for any variation that would show distinction among IRFs.
- Measure removal factor six: There is an available measure that is more strongly associated with desired patient functional outcomes. CMS points to the proposed DC Function measure discussed in section VIII.C.1.b. of the proposed rule as a measure that better measures functional outcomes.

Burden Assessment: CMS predicts the removal of this measure would result in a decrease of 0.005 hours of clinical staff time to report data for each IRF-PAI at admission; an estimated decrease of 2,560 hours in burden at admission for all IRFs; and an estimated total decrease in cost by $195.65 per IRF annually (or $220,697.60 for all IRFs annually).

d. Proposed Removal of the IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients and Removal of the IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients Beginning With the FY 2025 IRF QRP

Proposed Removal: CMS proposes to remove the two measures of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (Change in Self-Care Score) and the IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (Change in Mobility Score) from the IRF QRP beginning with the FY 2025 IRF QRP.

Background: At the time the Change in Self-Care Score and Change in Mobility Score measures were adopted, CMS also adopted 2 other measures addressing the functional status, cognitive function, and changes in function and cognitive function domain. Those additional measures are the Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (Discharge Self-Care Score) and the Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (Discharge Mobility Score). By monitoring the measures since 2016 CMS concludes that the 2

[16] Section 412.634(b)(2) of title 42, CFR, specifies eight factors considered for measure removal from the IRF QRP.

self-care functional outcome measures and similarly the 2 mobility score measures provide almost identical information about this dimension of quality to IRFs and are therefore duplicative.

Basis for Removal: CMS reasons that removal of the Change in Self-Care Score measure and the Change in Mobility Score measure satisfy measure removal factor eight: the costs associated with each of the measures outweighs the benefits of the measures' uses in the IRF QRP program. CMS reasons that costs to IRFs associated with tracking similar or duplicative measures in the IRF QRP outweigh any benefit that might be associated with the measures, and the costs to CMS associated with program oversight of the measures outweigh the benefit of information obtained from the measures.

Burden Assessment: Since the data elements used to calculate the measures would still be collected by IRFs for other quality measures under the IRF QRP, CMS does not believe the proposal would change burden for IRFs.

2. IRF QRP Quality Measure Proposal Beginning with the FY 2026 IRF QRP

Background: CMS describes how COVID remains a major challenge to PAC facilities, including IRFs, and emphasizes that older persons are at a significantly higher risk of mortality and severe disease following infection. CMS details that studies have shown COVID vaccines provide strong protection against severe disease, hospitalization, and death in adults. The agency also describes that since the emergence of the Omicron variants and availability of boosters, multiple studies have shown protection is higher among individuals receiving booster doses (specifically the bivalent booster in the case of Omicron subvariants) than among those only receiving the primary series.

CMS also details significant gaps and disparities in vaccination rates between those receiving the primary vaccination series and the boosters. Variations are also present when examining vaccination rates by race, gender, and geographic location.

Proposed Measure: CMS is proposing to adopt the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date (Patient/Resident COVID-19 Vaccine) measure for the IRF QRP beginning with the FY 2026 IRF QRP. CMS explains the measure would:

- Increase the rate of COVID vaccination of patients in IRFs to prevent the spread of COVID within the IRF population;
- Support the goal of CMS' Meaningful Measure Initiative 2.0 to "Empower consumers to make good health care choices through patient-directed quality measures and public transparency objectives";
- Provide patients and caregivers with information for informed decision-making (since the measure would be reported on Care Compare) and facilitate patient care and coordination, such as at discharge from a hospital; and
- Allow for education of patients at time of discharge from the IRF as to why they should be vaccinated since vaccination status would be reported at discharge.

Pre-rulemaking: CMS conducted the usual pre-rulemaking process for stakeholder input, with comments generally positive in support of a measure addressing COVID-19 vaccination coverage among IRF patients, but concerns were raised, such as regarding the evolving recommendations related to boosters and the definition of "up to date." The proposed measure was included on 2022 Measures Under Consideration List for the IRF QRP.[17] The MAP workgroups were mostly supportive of the measure and recognized the importance of patients' COVID-19 vaccination, but concerns raised included provider actionability, lack of denominator exclusions, requirements for assessing patient vaccination status, evolving COVID19 vaccination recommendations, and data reporting frequency for this measure. CMS responded that the measure is to promote transparency of data for patients to make informed decisions regarding care and is not intended to be a measure of IRF action. However, the MAP PAC/LTC workgroup vote resulted in a "Do not support for rulemaking," with concerns being raised regarding the potential disruption to patient therapy due to vaccination and acuity of patients in the IRF setting, the measure not been fully tested, the shorter IRF length of stay, and the exclusion of medical contraindications from the denominator. The MAP Coordinating Committee recommended not to support the adoption of the measure, with 3 potential mitigation strategies:

- Reconsider exclusions for medical contraindications;
- Complete reliability and validity measure testing; and
- Seek NQF endorsement.

The measure is not NQF-endorsed, but CMS proposes despite MAP recommendation to adopt the measure under the exception at section 1886(j)(7)(D)(ii) of the Act, which allows the Secretary to select non-NQF-endorsed measures when the Secretary is unable to identify a suitable NQF-endorsed measure that is available, feasible, and practical. CMS proposes the measure adoption stating (1) exclusions for medical contraindications were not included because of the belief capturing the raw vaccination rate would be most helpful in patient and family/caregiver decision-making; (2) CMS plans to conduct reliability and validity measure testing once there is enough data; and (3) CMS intends to submit the proposed measure to NQF for consideration of endorsement when feasible.

Measure calculation and Specifications: The proposed Patient/Resident COVID-19 Vaccine measure is an assessment-based process measure that reports the percent of stays in which patients in an IRF are up to date on their COVID-19 vaccinations per the CDC's latest guidance. The measure has no exclusions and is not risk adjusted.

- Numerator: The total number of IRF stays in the denominator in which patients are up to date with their COVID-19 vaccination per CDC's latest guidance.
- Denominator: The total number of IRF stays discharged during the reporting period.
- Data Source: The IRF-PAI for IRF patients.

[17] Centers for Medicare & Medicaid Services. (2022). Overview of the List of Measures Under Consideration for December 1, 2022. https://mmshub.cms.gov/sites/default/files/2022-MUC-List-Overview.pdf.

- Burden Assessment: One data element would be added to the IRF-PAI at discharge, which CMS believes would result in an increase of 0.3 minutes of clinical staff time at discharge; estimating an increase of 3,896 hours in burden for all IRFs; and estimating the total cost of complying with the IRF QRP requirements would increase by $223.50 per IRF annually (or by $252,110.16 for all IRFs annually).[18]

D. Request for Information (RFI): Principles for Selecting and Prioritizing IRF QRP Quality Measures and Concepts under Consideration for Future Years

After discussing a framework of principles CMS could use to identify future IRF QRP measures, and discussing the identification of measurement gaps in the current IRF QRP and measures or measure concepts that could be used to fill such gaps, **CMS solicits public comment on**:

- The set of principles for selecting measures for the IRF QRP;
- The identified measurement gaps; and
- Measures that are available for immediate use, or that may be adapted or developed for use in the IRF QRP.

CMS states the agency will not be responding to specific comments submitted in response to this RFI in the FY 2024 IRF PPS final rule, but intend to use the comments to inform future policies.

1. Background

CMS describes the established National Quality Strategy (NQS) for supporting a high-value health care system promoting quality outcomes, safety, equity and accessibility for all individuals. CMS describes the "Universal Foundation"[19] of quality measures as a building-block approach to support these goals by streamlining quality measures across quality programs for adult and pediatric populations. The Universal Foundation is intended to reduce provider burden, identify disparities in care, prioritize development of interoperable digital quality measures, allow for cross-comparisons across programs, and help identify measurement gaps.

In furtherance of these goals, this RFI seeks to gather information on existing gaps in IRF QRP measures and solicit public comment, for purposes of filling such gaps.

2. Guiding Principles for Selecting and Prioritizing Measures

CMS identifies guiding principles for inclusion and maintenance of measures in the future IRF QRP measure set. These principles intend for the measures to be meaningful to beneficiaries and

[18] See table 20 of the Proposed Rule for costs associated with proposals associated with OMB control number 0938-0842 for the IRF QRP if adopted as proposed. The table shows the total resulting change in annual burden hours per IRF as an increase of 1.2; change in annual cost per IRF as an increase of $27.85; total change in annual burden hours for all IRFs as an increase of 1,336; and a total change in annual cost for all IRFs as $31,412.56.

[19] Jacobs DB, Schreiber M, Seshamani M, Tsai D, Fowler E, Fleisher LA. Aligning Quality Measures across CMS – The Universal Foundation. N Engl J Med. 2023 Mar 2; 338:776-779. doi: 10.1056/NEJMp2215539. PMID: 36724323.

caregivers, not impose undue burden on IRFs, align with PAC program goals, and be readily operationalized. The following 4 objectives are specified as follows:

- Actionability: IRF QRP measures should focus on structural elements, health care processes, and outcomes of care that have been demonstrated, such as through clinical evidence or other best practices, to be amenable to improvement and feasible for IRFs to implement.
- Comprehensiveness and Conciseness: IRF QRP measures should assess performance of all IRF core services using the smallest number of measures that comprehensively assess the value of care provided in IRF settings.
- Focus on Provider Response to Payment: IRF QRP measures should neither exacerbate nor induce (and, as able, should mitigate) unwanted responses to the payment systems.
- Compliance with Statutory Requirements: IRF QRP measures must comply with the governing statutory authorities and CMS' policy to align QRP measures with broader policy initiatives, such as the Meaningful Measures Framework.

3. Gaps in IRF QRP Measure Set and Potential New Measures

Using the above principles, CMS identified measurement gaps in the domains of cognitive function, behavioral and mental health, patient experience and patient satisfaction, and chronic conditions and pain management.

a. *Cognitive Function*: Section 1886(j)(7) of the Act requires IRFs to submit data on quality measures under section 1899B(c)(1) of the Act. CMS identifies cognitive function and changes in cognitive function as key dimensions of clinical care that are not currently represented in the IRF QRP. CMS describes that IRFs currently collect and report to CMS data on cognitive function using the Brief Interview for Mental Status (BIMS) and Confusion Assessment Method (CAM©), both of which are incorporated in the IRF-PAI as standardized patient assessment data elements, but neither of which have been developed into quality measures for the IRF QRP. CMS also identifies Patient-Reported Outcomes Measurement Information Set (PROMIS) Cognitive Function forms and the PROMIS Neuro-Quality of Life (Neuro-QoL) measures as alternative sources of information on cognitive functioning, from which quality measures may be construed.

   CMS is requesting comment on:

   - The availability of cognitive functioning measures outside of the IRF QRP that may be available for immediate use in the IRF QRP, or that may be adapted or developed for use in the IRF QRP, using instruments such as the BIMS, CAM, PROMIS Cognitive Function forms, and PROMIS Neuro-QoL;
   - The feasibility of measuring improvement in cognitive functioning during an IRF stay, which typically averages less than 15 days;
   - The cognitive skills that are more likely to improve during an IRF stay;
   - Conditions for which measures of maintenance (rather than improvement in cognitive functioning) are more practical; and

- The types of intervention that have been demonstrated to assist in improving or maintaining cognitive functioning.

b. *Behavioral and Mental Health*: CMS states that information on the availability and appropriateness of behavioral health measures in PAC settings is limited, and the 2021 National Impact Assessment of CMS Quality Measures Report identified PAC program measurement gaps in behavioral and mental health.

Looking at mental health quality measures used in other quality reporting programs, CMS identified the Home Health QRP measure, which assesses the extent to which patients have been screened for depression, but notes the measure doesn't assess performance in management of depression and related mental health concerns. CMS also identifies Consumer Assessment of Healthcare Providers and Systems (CAHPS) Experience of Care and Health Outcomes Survey (ECHO), the PROMIS suite of instruments, National Institutes of Health (NIH) Toolbox for the Assessment of Neurological and Behavioral Health Function, and the Screening, Brief Intervention, and Referral to Treatment (SBIRT) approach developed by SAMHSA as other instruments that may be adapted to assess management of mental health or SUDs in PAC settings.

CMS seeks feedback on:

- The specified measures and instruments and other measures or instruments that may be directly applied, adapted, or developed for use in the IRF QRP;
- The degree to which measures have been or will require validation and testing prior to application in the IRF QRP; and
- The availability of data, the manner in which data could be collected and reported to CMS, and the burden imposed on IRFs.

c. *Patient Experience and Patient Satisfaction*: Patient experience measures focus on how patients experienced aspects of care; patient satisfaction measures focus on if patient's expectations were met. These measures are often reported through instruments that use self-reported data, such as the CAHPS surveys, though CAHPS instruments have not been developed for use in IRFs.

CMS refers to the agency's development of the IRF Experience of Care Survey, which measures domains such as patient goal setting, communication with staff, respect and privacy received, ability to obtain assistance when needed, and cleanliness of facility. CMS also refers to the CoreQ: Short Stay Discharge (CoreQ: SS DC) measure developed for SNFs as a potential measure that could be adapted to the IRF setting.

CMS seeks comment on:

- The feasibility and challenges of adapting, for use in the IRF QRP, existing patient experience and patient satisfaction measures and instruments, such as the CMS IRF Experience of Care Survey and the CoreQ: SS DC measure;

- The extent to which patient experience measures offer IRFs sufficient information to assist in quality improvement; and
- The challenges of collecting and reporting patient experience and patient satisfaction data.

d. *Chronic Conditions and Pain Management*: CMS describes that existing IRF QRP measures do not directly address aspects of care rendered to populations with chronic conditions (such as chronic respiratory conditions) nor address IRFs' management of patients' pain. CMS notes that beginning October 1, 2022, IRFs began collecting standardized patient assessment data elements under the IRF QRP, including items that assess pain interference with (1) daily activities, (2) sleep, and (3) participation in therapy.

CMS seeks comments on:

- Measures of chronic condition and pain management for patients that may be used to assess IRF performance; and
- The feasibility and challenges of measuring and reporting IRF performance on existing QRP measures, such as Discharge Self-Care Score and Discharge Mobility Score measures, for subgroups of patients defined by type of chronic condition.

4. Solicitation of Comments

CMS specifically solicits comments on the following questions:

- *Principles for identifying IRF QRP measures*: To what extent do you agree with the principles for selecting and prioritizing measures? Are there principles that you believe CMS should eliminate from the measure selection criteria? Are there principles that you believe CMS should add to the measure selection criteria?
- *Measurement Gaps*: CMS requests input on the identified measurement gaps, including in the areas of cognitive function, behavioral and mental health, patient experience and patient satisfaction, and chronic conditions and pain management. Specifically, are there gaps in the IRF QRP measures that have not been identified in this RFI?
- *Suitable Measures for Filling Gaps*: Are there measures that are either currently available for use or that could be adapted or developed for use in the IRF QRP program to assess performance in the areas of (1) cognitive functioning, (2) behavioral and mental health, (3) patient experience and patient satisfaction, (4) chronic conditions, (5) pain management, or (6) other areas not mentioned in this RFI?

E. Health Equity Update

1. Background

CMS notes that health inequity, manifested by significant disparities in healthcare outcomes, persists in the United States, particularly for individuals belonging to underserved communities. CMS describes health equity as "the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes."

The agency is committed to addressing persistent inequities through improving data collection to better measure and analyze disparities across its quality programs, policies, and measures. Already underway are confidential reporting to acute care hospitals about readmissions stratified by dual eligibility status and reporting of stratified Health Effectiveness Data Information Set (HEDIS) measure performance results to Medicare Advantage (MA) plans using several demographic and social risk factor variables.

CMS seeks to advance health equity and whole-person care as one of eight goals comprising the CMS National Quality Strategy (NQS). The NQS identifies a wide range of potential quality levers that can support the advancement of equity, including: (1) establishing a standardized approach for patient-reported data and stratification; (2) employing quality and value-based programs to address closing equity gaps; and (3) developing equity-focused data collections, regulations, oversight strategies, and quality improvement initiatives.

CMS solicited public comment in the FY 2023 IRF PPS proposed rule (87 FR 20247 through 20254) regarding principles for measuring equity and healthcare quality disparities across CMS quality programs and will take comments into account as they continue work in this area.

2. Anticipated Future State

CMS is considering including social determinants of health (SDOH) as part of new IRF QRP quality measures as a way to advance health equity in IRF QRP. Social determinants of health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. CMS is considering whether health equity measures adopted for other settings, such as hospitals, could be adopted in post-acute care settings. CMS describes the possibility of specifying a health equity measure using the same SDOH data items as is currently collected as standardized patient assessment data elements under the IRF. The agency also emphasizes the value in aligning SDOH items across all care settings, consistent with the Universal Foundation.

F. Form, Manner, and Timing of Data Submission under the IRF QRP

1. Background

No changes are proposed to existing IRF QRP data reporting policies.[20]

2. Proposed reporting schedule for IRF-PAI assessment data for discharge function score measure

For purposes of the FY 2025 IRF QRP, CMS proposes that IRFs would be required to report IRF-PAI assessment data for the Discharge Function Score (DC Function) measure (proposed for adoption in section VIII.C.1.b. of the proposed rule) beginning with patients discharged on October 1, 2023. Starting in CY 2024, IRFs would be required to submit data for the entire calendar year beginning with the FY 2026 IRF QRP. CMS states that there will be no burden associated with data collection since the DC Function measure is calculated based on data currently submitted in the IRF-PAI.

3. Proposed reporting schedule for the data submission of IRF-PAI assessment data for COVID-19 Vaccine: Percent of Patients/Residents Who are Up to Date Measure

For purposes of the FY 2026 IRF QRP, CMS proposes that IRFs would be required to report IRF-PAI assessment data related to the Patient/Resident COVID-19 Vaccine measure (proposed for adoption in section VIII.C.2.a. of the proposed rule) beginning with patients discharged on October 1, 2024. Starting in CY 2025, IRFs would be required to submit data for the entire calendar year beginning with the FY 2027 IRF QRP. CMS is also proposing to add a new item to the IRF-PAI discharge assessment to collect information on whether a patient is up to date with their COVID-19 vaccine at the time of discharge from the IRF.[21]

G. Policies Regarding Public Display of Measure Data for IRF QRP

1. Background

The Secretary must establish procedures for making the IRF QRP data available to the public after IRFs have the opportunity to review the data, in accordance with section 1886(j)(7)(E) of the Act.

[20] Regulatory text is available at §412.634(b)(1) for information regarding the current policies for reporting IRF QRP data.
[21] Draft of the new item is available in the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date. Draft Measure Specifications can be found at https://www.cms.gov/files/document/patient-resident-covid-vaccine-draft-specs.pdf.

2. Proposed Public Reporting of the Transfer of Health Information (TOH) the Provider – Post-Acute Care (PAC) Measure and TOH Information to the Patient – PAC Measure Beginning with the FY 2025 IRF QRP

These 2 assessment-based measures were adopted in the FY 2020 IRF final PPS rule, and data collection for the measures began with patients discharged on or after October 1, 2022. CMS proposes to publicly display four rolling quarters of the data received for these 2 measures, initially using data on discharges from January 1, 2023, through December 31, 2023. CMS would begin publicly displaying data for the measures beginning with September 2024 Care Compare refresh or as soon as technically feasible. CMS would not publicly report an IRF's performance on a measure if the IRF had fewer than 20 eligible cases in any four consecutive rolling quarters for that measure.

3. Proposed Public Reporting of the Discharge Function Score (DC Function) Measure Beginning with the FY 2025 IRF QRP

CMS proposes to begin public display of data for the DC Function measure beginning with the September 2024 refresh of Care Compare or as soon as technically feasible, and will use data collected from January 1, 2023, through December 31, 2023. Provider preview reports would be provided to IRFs in June 2024, or as soon as feasible; thereafter, IRFs measure scores would be publicly displayed based on 4 quarters of data and updated quarterly. CMS would not publicly report an IRF's performance on a measure if the IRF had fewer than 20 eligible cases in any quarter for that measure.

4. Proposed Public Reporting of COVID-19 Vaccine: Percent of Patients/Residents Who are Up to Date Quality Measure Beginning with the FY 2026 IRF QRP

CMS proposes to begin public display of data for the measure with the September 2025 refresh of Care Compare or as soon as technically feasible, and will use data collected from quarter 4 of 2024. Provider preview reports would be distributed to IRFs in June 2025 for data collected in Q4 of 2024 and thereafter the data would be publicly displayed based on one quarter of data updated quarterly. An IRF's performance on the measure would not be publicly reported if the IRF had fewer than 20 eligible cases in the quarter.

VII. Regulatory Impact Analysis

CMS estimates that the proposed rule will increase Medicare payments to IRFs by $335 million in FY 2024 compared with FY 2023. This reflects the 3.0 percent increase from the update factor and a 0.7 percent increase in estimated IRF outlier payments, which will increase aggregate payments to IRFs by an estimated 3.7 percent. Table 21 in the proposed rule, reproduced below, shows the effects of these and other policy changes by type of IRF. The other policy changes involving the wage index and labor-related shares and changes to the CMG weights are all designed to be budget neutral and therefore have no effect on aggregate payments to IRFs. The

$335 million figure excludes the effects of payment reductions to IRFs that fail to meet the IRF QRP requirements.

CMS states that it considered alternative policies to maintain the existing CMG relative weights and average length of stay values and/or maintaining the existing outlier threshold amount for FY 2024. CMS argues, however, that adjusting these amounts based on the most recent data is appropriate to ensure that these values are as reflective as possible of recent changes in IRF utilization and case-mix.

Table 21: IRF Impact Table for FY 2024 (Columns 4 through 7 in percentage)

Facility Classification	Number of IRFs	Number of Cases	Outlier	FY 2024 Wage Index and Labor-Related Share	CMG Weights	Total Percent Change[1]
(1)	(2)	(3)	(4)	(5)	(6)	(7)
Total	1,128	383,601	0.7	0.0	0.0	3.7
Urban unit	645	136,108	1.3	0.1	-0.0	4.4
Rural unit	134	16,705	1.0	-0.4	-0.1	3.5
Urban hospital	337	225,650	0.3	0.0	0.0	3.4
Rural hospital	12	5,138	0.2	-1.0	0.1	2.3
Urban For-Profit	420	220,853	0.4	0.0	0.0	3.4
Rural For-Profit	35	8,113	0.6	-0.9	0.0	2.7
Urban Non-Profit	480	122,596	1.2	0.1	0.0	4.4
Rural Non-Profit	90	11,608	1.0	-0.4	0.0	3.6
Urban Government	82	18,309	1.3	0.1	0.0	4.4
Rural Government	21	2,122	0.7	-0.6	-0.1	3.1
Urban	982	361,758	0.7	0.0	0.0	3.8
Rural	146	21,843	0.8	-0.6	0.0	3.2
Urban by region						
Urban New England	29	13,377	0.5	-0.3	0.0	3.2
Urban Middle Atlantic	118	40,264	0.8	0.6	0.1	4.6
Urban South Atlantic	170	81,239	0.6	0.0	0.0	3.6
Urban East North Central	164	42,894	0.8	-0.4	0.0	3.4
Urban East South Central	55	25,490	0.2	-0.2	0.0	3.1
Urban West North Central	76	20,887	0.8	-0.1	-0.1	3.7
Urban West South Central	198	86,706	0.5	0.2	0.0	3.8
Urban Mountain	77	27,445	0.6	-0.7	-0.1	2.8
Urban Pacific	95	23,456	1.7	0.3	0.0	5.0
Rural by region						
Rural New England	5	1,051	0.6	-2.5	0.3	1.3
Rural Middle Atlantic	10	1,028	0.8	-0.7	0.0	3.1

Facility Classification	Number of IRFs	Number of Cases	Outlier	FY 2024 Wage Index and Labor-Related Share	CMG Weights	Total Percent Change[1]
(1)	(2)	(3)	(4)	(5)	(6)	(7)
Rural South Atlantic	15	3,946	0.4	-0.1	0.0	3.4
Rural East North Central	24	2,913	0.7	-0.5	0.0	3.1
Rural East South Central	20	3,418	0.3	-0.8	-0.1	2.5
Rural West North Central	20	2,357	1.5	-0.5	-0.1	3.9
Rural West South Central	43	6,387	1.0	-0.4	0.0	3.5
Rural Mountain	6	463	2.3	-0.1	-0.1	5.1
Rural Pacific	3	280	2.3	-0.4	-0.1	4.8
Teaching status						
Non-teaching	1,027	340,427	0.7	-0.1	0.0	3.6
Resident to ADC less than 10%	56	31,139	0.9	0.4	0.0	4.3
Resident to ADC 10%-19%	34	10,744	1.5	0.6	0.1	5.3
Resident to ADC greater than 19%	11	1,291	1.8	1.0	-0.1	5.8
Disproportionate share patient percentage (DSH PP)						
DSH PP = 0%	59	10,028	0.9	0.4	0.0	4.4
DSH PP <5%	132	57,035	0.6	0.1	0.0	3.7
DSH PP 5%-10%	243	95,773	0.5	0.1	0.0	3.6
DSH PP 10%-20%	395	142,995	0.7	-0.1	0.0	3.7
DSH PP greater than 20%	299	77,770	1.0	0.0	0.0	4.0

[1] This column includes the impact of the updates in columns (4), (5), and (6) above, and of the proposed IRF market basket update for FY 2024 of 3.2 percent, reduced by 0.2 percentage point for the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act. Note, the products of these impacts may be different from the percentage changes shown here due to rounding effects.