Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for FY 2025 and Updates to the IRF Quality Reporting Program
[CMS-1804-P]

Summary of Proposed Rule

On March 29, 2024, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* (89 FR 22246) a proposed rule on the Medicare inpatient rehabilitation facility prospective payment system (IRF PPS) for federal fiscal year (FY) 2025. In addition to provisions that would update the IRF PPS payment rates and outlier threshold for FY 2025, CMS also proposes to update the market area delineations used to adjust payments under the IRF PPS to reflect geographic differences in the cost of labor, and proposes a three-year phase-out of the payment adjustment to IRFs in rural areas that are defined as urban under the new labor market delineations. The rule also proposes four new and one modified patient assessment elements for use in the IRF Quality Reporting Program (QRP) effective in FY 2028, and the removal of an existing assessment item effective in FY 2027. Lastly, the proposed rule requests input that would inform future changes to the IRF QRP, as well as a future star rating system for IRFs.

CMS estimates that the Medicare IRF PPS payments in FY 2025 will be about $255 million higher than in FY 2024.

The deadline for comments on the proposed rule is May 28, 2024.

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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 2024, 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),[1] which created temporary waivers of policy and other flexibilities that expired with the declared end of the PHE on May 11, 2023. In addition, CMS discusses several IRF-related provisions of the Patient Protection and Affordable Care Act of 2010, particularly focusing on the IRF Quality Reporting Program (QRP) that the agency implemented in 2014.

II. Policy Changes and Updates to the IRF Prospective Payment Rates for FY 2025

For FY 2025 payment, CMS proposes to update the IRF PPS relative weights and length of stay values; 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 Inpatient Prospective Payment System (IPPS) hospital wage index data (including using new market area delineations and beginning a three-year phase-out of the current payment adjustment for rural IRFs). CMS also describes how the agency calculates the FY 2025 IRF conversion factor. Lastly the agency proposes to update the outlier threshold amount and the IRF cost-to-charge ratios for FY 2025.

A. Update 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 2025, continuing the same methodologies used in past years, and now applied using FY 2023 IRF claims and FY 2022 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 0.9973.

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. As proposed for FY 2025, 99.2 percent of IRF cases are in CMGs for which the

[1] These are referred to as the April 6, 2020 IFC (85 FR 19230) and the May 8, 2020 IFC (85 FR 27550).

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proposed FY 2025 weight differs from the FY 2024 weight by less than 5 percent (either increase or decrease).

CMS indicates that the proposed changes in the average length of stay values from FY 2024 to FY 2025 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 IV 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.[2]

B. Market Basket Update and Productivity Adjustment

An update factor of 2.8 percent is proposed for the IRF PPS payment rates for FY 2025, composed of the following elements listed below.

Proposed FY 2025 IRF PPS Update Factor	
IRF market basket	3.2%
Total factor productivity (TFP)	-0.4%
Total	**2.8%**

The 2.8 percent FY 2025 update 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 2023, based on actual data through the third quarter. Similarly, the statutorily required productivity adjustment is based on IGI's fourth quarter 2023 forecast of the 10-year moving average (ending in 2025) of changes in annual economy-wide private nonfarm business total factor productivity.[3] The update factor for IRFs that fail to meet requirements for the IRF QRP is discussed in section III below and totals 1.0 percent. CMS will use more recent data, if available, for the final rule.

C. Labor-Related Share and Wage Index Adjustment

Labor-related share

CMS proposes a total labor-related share of 74.2 percent for FY 2025, which is 0.1 percentage points higher than the FY 2024 labor share of 74.1 percent. The 74.2 percent comes from the IGI fourth quarter 2023 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 2025. Table 4 of the proposed rule compares the components of the FY 2024 and proposed FY 2025 labor shares.

[2] https://www.cms.gov/files/zip/fy-2025-irf-pps-data-files-proposed.zip

[3] 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.

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CMS invites comment on the proposed labor share for FY 2025.

Market Areas
Under previously adopted policy, for the IRF PPS wage index CMS uses the Core Based Statistical Area (CBSA) labor market area definitions and the pre-floor, pre-reclassification IPPS hospital wage index for the current fiscal year. Thus, for FY 2025 CMS would use the FY 2025 pre-floor, pre-reclassification IPPS wage index. The FY 2025 pre-reclassification and pre-floor hospital wage index is based on FY 2020 cost report data. Based on the changes in the 2024 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.[4]

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[5] 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 purposes of adjusting FY 2025 IRF PPS payments to reflect geographic differences in labor costs, in this proposed rule CMS proposes to use the CBSA-based labor market delineations published in OMB Bulletin No. 23-01 on July 21, 2023. Under these revised delineations, 54 counties (and county equivalents) would transition from urban to rural status, and another 54 counties (and county equivalents) would transition from rural to urban status (Tables 5 and 6 of the proposed rule). Other changes resulting from the new OMB definitions include a number of counties that would move from one CBSA to a different one, and CBSAs that would have their name or number changed as a result of changes in their composition (Tables 7 and 8). Lastly, counties in Connecticut are redefined as county equivalent "Planning Regions" (Table 9).

[4] 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.
[5] 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.

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As a result of some counties transitioning from a rural designation to an urban one under the new OMB definitions, eight IRFs would lose their rural status for purposes of Medicare's 14.9 percent rural payment adjustment. CMS proposes to phase out the adjustment for these IRFs over a three-year period (FY 2025, FY 2026, and FY 2027).

Changes to the IRF PPS wage index are made in a budget-neutral manner; CMS estimates the budget neutrality adjustment for FY 2025 under the proposed rule to be 0.9928. To make this calculation, CMS estimates aggregate IRF PPS payments using the FY 2024 labor-related share and wage index values and then estimates aggregate payments using the proposed FY 2025 labor share and wage index values. The ratio of the amount based on the FY 2024 index to the amount estimated using the proposed FY 2025 index is the budget neutrality adjustment to be applied to the proposed federal per diem base rate for FY 2025.

CMS invites public comment on the FY 2025 proposed wage adjustment, the use of updated CBSA delineations, and the proposed phase-out of the rural payment adjustment for IRFs in counties previously designated as rural that now become urban under the new delineations.

D. Description of the IRF Standard Payment Conversion Factor and Payment Rates for FY 2025

Table 10 of the proposed rule (reproduced below) shows the calculations used to determine the proposed FY 2025 IRF standard payment amount. In addition, Table 11 of the proposed rule lists the FY 2025 payment rates for each CMG, and Table 12 provides a detailed hypothetical example of how the IRF FY 2025 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 10: Calculations to Determine the Proposed FY 2025 Standard Payment Conversion Factor

Explanation for Adjustment	Calculations
Standard Payment Conversion Factor for FY 2024	$18,541
Market Basket Increase Factor for FY 2025 (3.2 percent), reduced by 0.4 percentage points for the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act	x 1.028
Budget Neutrality Factor for the Updates to the Wage Index and Labor-Related Share	x 0.9928
Budget Neutrality Factor for the Revisions to the CMG Relative Weights	x 0.9973
Proposed FY 2025 Standard Payment Conversion Factor	= $18,872

CMS invites public comment on the proposed FY 2025 standard payment conversion factor.

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E. 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 2025. 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 2025, CMS proposes to use FY 2023 claims data and the same methodology that has been used to set and update the outlier threshold since FY 2002. CMS currently estimates that IRF outlier payments as a percentage of total estimated payments will be 3.2 percent of total IRF payments in FY 2024. To maintain estimated outlier payments at the 3 percent level, CMS proposes to update the outlier threshold amount from $10,423 for FY 2024 to $12,158 for FY 2025.

CMS invites public comment on the proposed update to the IRF outlier threshold for FY 2025.

F. Update to the cost-to-charge ratio ceiling, and urban/rural average CCRs

CMS proposes to update the national urban and rural CCRs for IRFs, as well as the national CCR ceiling for FY 2025, based on analysis of the most recent cost report data that are available (FY 2022). 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 2025; and other IRFs for which accurate data to calculate an overall CCR are not available. The national CCR ceiling for FY 2025 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 2025 are 0.406 for urban IRFs and 0.492 for rural IRFs, and the national CCR ceiling is 1.52. That is, if an individual IRF's CCR were to exceed this ceiling of 1.52 for FY 2025, 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).

CMS invites public comment on the proposed update to IRF CCR ceiling and the urban/rural averages for FY 2025.

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

Table 13 of this proposed rule (see below) lists the quality measures currently included in the IRF QRP.[6] CMS proposes, beginning with the FY 2028 IRF QRP, to:

- Collect through the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) four new standardized patient assessment data elements under the social determinants of health (SDOH) category (Living Situation, two items for Food, and one item for Utilities),
- Modify one existing item: The Transportation item within the SDOH category, and
- Delete one existing item: The Admission Class item.

The collection of these items does not represent changes to the measures that compose the IRF QRP for 2025.

CMS invites public comment on all of the IRF QRP proposals.

CMS also seeks information on three proposed measure concepts that would inform future iterations of the IRF QRP, as well as information that would facilitate the use of IRF QRP (and other) data to develop and implement a star rating system for inpatient rehabilitation facilities.

A. Background and Statutory Authority

The IRF QRP is authorized under section 1886(j)(7) of the Social Security Act (hereafter "the Act"). The program is applicable to freestanding IRFs and to inpatient rehabilitation units of hospitals or critical access hospitals (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.[7]

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.

Section 1899B(b)(vi) of the Act authorizes the Secretary to collect other categories of data through the IRF-PAI, and CMS has used that authority to collect elements related to social

[6] While the text at VII.B.1 indicates there are currently 18 measures in the IRF QRP, Table 13 only lists 17 measures. At the moment, we are unable to explain this discrepancy.
[7] 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.

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determinants of health (SDOH) beginning with the FY 2020 IRF PPS final rule. CMS has collected SDOH information in other post-acute care settings (*e.g.*, skilled nursing facilities and home health agencies) and periodically evaluates the utility of this information for use in risk adjustment or other aspects of payment.

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 13 reproduced from the proposed rule with minor modifications) shows the current measures for the FY 2025 IRF QRP.

Table 13. IRF QRP Measure Set for FY 2025

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)
Discharge Mobility Score	IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients
Discharge Self-Care Score	IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients
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: Added beginning in FY 2025*
Patient/Resident COVID-19 Vaccine	*COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure: Added beginning in FY 2026*
NHSN (National Healthcare Safety Network)	
CAUTI	NHSN Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure
CDI	NHSN Facility-wide Inpatient Hospital-Onset Clostridium difficile Infection (CDI) Outcome Measure
HCP Influenza Vaccine	Influenza Vaccination Coverage among Healthcare Personnel
HCP COVID-19 Vaccine	COVID-19 Vaccination Coverage among Healthcare Personnel: *Added beginning in FY 2025*
Claims-based	
MSPB IRF	Medicare Spending per Beneficiary (MSPB)–PAC IRF QRP
DTC	Discharge to Community–PAC IRF QRP
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

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C. Overview of IRF QRP Quality Measure Proposals

IRF QRP Quality Measure Proposals Beginning with the FY 2028 IRF QRP

In this rule, CMS proposes to add four new SDOH-related items to the IRF-PAI and to modify an existing item. CMS makes these proposals after considering responses to the Agency's Health Equity Update in the FY 2024 IRF PPS final rule. Under this proposal, IRFs would be required to report these new and modified items using the IRF-PAI beginning with patients admitted on October 1, 2026, for purposes of the FY 2028 IRF QRP. CMS is actively soliciting comment on the addition of each of the four new items and the modification of the existing Transportation item, discussed below.

Additionally, CMS proposes to remove the current Admission Class item from the IRF-PAI.

a. Proposed collection of Living Situation Item under the IRF-PAI beginning with the FY 2028 IRF QRP

Background: Healthy People 2030 asserts that economic stability is a key social determinant of health and that housing stability is an important component of economic stability.[8,9]

Proposed item:
CMS believes that information about an IRF patient's living situation is relevant to his/her discharge planning and proposes to add "Living Situation" as an IRF-PAI measure under the SDOH category beginning with the FY 2028 IRF QRP.

The proposed Living Situation item asks, "What is your living situation today?" The proposed response options are: (1) I have a steady place to live; (2) I have a place to live today, but I am worried about losing it in the future; (3) I do not have a steady place to live; (7) Patient declines to respond; and (8) Patient unable to respond.

Item origin: The proposed Living Situation item is based on the Living Situation item currently collected in the AHC HRSN Screening Tool[10] and was adapted from the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) tool.[11]

[8] https://health.gov/healthypeople/priority-areas/social-determinants-health
[9] Healthy People 2030 is a long-term, evidence-based effort led by the U.S. Department of Health and Human Services (HHS) that aims to identify nationwide health improvement priorities and improve the health of all Americans.
[10] More information about the AHC HRSN Screening Tool is available on the website at https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf.
[11] National Association of Community Health Centers and Partners, National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, Association OPC, Institute for Alternative Futures. "PRAPARE." 2017. https://prapare.org/the-prapare-screening-tool/.

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b. Proposed collection of two Food items under the IRF-PAI beginning with the FY 2028 IRF QRP

Background: CMS cites government and academic studies establishing the relationship between food/nutrition insecurity and other health outcomes ranging from obesity to mortality. The agency asserts that knowing more about an IRF patient's food and dietary insecurity can provide insight into their health complexity and thus help facilitate post-discharge coordination of care.

Proposed items:
CMS proposes to add two "Food" items as IRF-PAI measures under the SDOH category beginning with the FY 2028 IRF QRP.

The first proposed Food item states, "Within the past 12 months, you worried that your food would run out before you got money to buy more." The second proposed Food item states, "Within the past 12 months, the food you bought just didn't last and you didn't have money to get more." CMS proposes the same response options for both items: (1) Often true; (2) Sometimes true; (3) Never True; (7) Patient declines to respond; and (8) Patient unable to respond.

Item origin: These proposed items are based on the Food items currently collected in the AHC HRSN Screening Tool and were adapted from the USDA 18-item Household Food Security Survey (HFSS).[12]

c. Proposed collection of Utilities item under the IRF-PAI beginning with the FY 2028 IRF QRP

Background: CMS cites academic and U.S. Department of Energy studies that establish that energy (utility) insecurity disproportionately affects vulnerable populations (*e.g.*, low-income, and African American). Such energy insecurity may create environmental exposures that directly impact beneficiaries' health. CMS asserts that IRFs may be able to use information about their Medicare patients' utilities insecurity to connect them with community energy assistance programs.

Proposed item:
CMS proposes to add a "Utilities" item as an IRF-PAI measure under the SDOH category beginning with the FY 2028 IRF QRP. The proposed Utilities item asks, "In the past 12 months, has the electric, gas, oil, or water company threatened to shut off services in your home?" The proposed response options are: (1) Yes; (2) No; (3) Already shut off; (7) Patient declines to respond; and (8) Patient unable to respond.

[12] More information about the HFSS tool can be found at https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-u-s/survey-tools/.

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Item origin: This proposed item is based on the Utilities item currently collected in the AHC HRSN Screening Tool and was adapted from the Children's Sentinel Nutrition Assessment Program (C-SNAP) survey.[13]

d. Proposed Modification of the Transportation SDOH IRF-PAI item beginning with the FY 2028 IRF QRP

Background: CMS began collecting SDOH items via the IRF-PAI beginning October 1, 2022. One of these items (A1250) asks whether a lack of transportation has kept a patient from getting to and from medical appointments, meetings, work, or from getting things they need for daily living. CMS collects this information believing that access to transportation is essential to chronic disease management, and that identification of transportation needs can help improve health outcomes.

Currently, the Transportation item asks "Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?" The response options are: (A) Yes, it has kept me from medical appointments or from getting my medications; (B) Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need; (C) No; (X) Patient unable to respond; and (Y) Patient declines to respond.

Proposed modification: CMS proposes, beginning with the FY 2028 IRF QRP measure set, to modify the A1250 Transportation IRF-PAI item in two ways:

- First, it would bound the answers to the question with a 12-month lookback period (in contrast to the current six-to-twelve months); and
- Second it would simplify the solicited responses to (0) Yes, (1) No, (7) Patient declines to respond, and (8) Patient unable to respond.

Item origin: CMS notes that in its regular item and measure monitoring work, the agency recognized that changing the Transportation item in the IRF-PAI in these two ways would make it more consistent with the Transportation category used in other CMS programs.[14]

[13] CMS notes that this survey was developed as a clinical indicator of household energy security among pediatric caregivers. Cook, J.T., D.A. Frank., P.H. Casey, R. Rose-Jacobs, M.M. Black, M. Chilton, S. Ettinger de Cuba, *et al*. "A Brief Indicator of Household Energy Security: Associations with Food Security, Child Health, and Child Development in US Infants and Toddlers." *Pediatrics*, vol. 122, no. 4, 2008, pp. e874-e875. https://doi.org/10.1542/peds.2008-0286.

[14] Centers for Medicare & Medicaid Services, FY2024 Inpatient Psychiatric Prospective Payment System—Rate Update (88 FR 51107 through 51121), Centers for Medicate & Medicaid Services, FY2023 IPPS/LTCH PPS Final rule (87 FR 49202 through 49215).

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e. Proposed deletion of the Admission Class IRF-PAI item beginning October 1, 2026

Background: CMS requires IRFs to complete and submit the IRF-PAI for all Medicare patients pursuant to the FY 2002 IRF PPS final rule, and expanded this requirement to all patients, irrespective of payer, beginning October 1, 2024.

Currently, the Admission Class item requires IRFs to report whether the admission is for i) initial rehabilitation, iii) readmission, iv) unplanned discharge, or v) continuing rehabilitation.

Proposed removal: CMS proposes to remove the Admission Class item in its entirety effective October 1, 2026, having determined in the course of the agency's standard review processes that the information collected through the Admission Class item is not used in the IRF QRP or any other Medicare purpose (payment, survey, or care planning).

D. Request for Information (RFI): IRF QRP Measure Concepts Under Consideration for Future Years

CMS seeks stakeholder input on three concepts currently under consideration for use in the QRP in future years: vaccination composite, pain management, and depression.[15] CMS initially solicited information in its 2024 IRF proposed rule on principles and priorities for the IRF QRP, and subsequently on December 15, 2023, convened a technical expert panel (TEP) to identify measurement concepts that could fill gaps in measures identified in responses to the 2024 RFI. The TEP gave priority to those items that would help further the alignment of IRF quality measures with the "Universal Foundation" quality measures used in other CMS programs.[16]

CMS states the agency will not be responding to specific comments submitted in response to this RFI in the FY 2025 IRF PPS final rule but intends to use the comments to inform future policies.

E. Request for Information (RFI): Future IRF Star Rating System

CMS notes that pursuant to Section 1886(j)(7)(E) of the Social Security Act the agency collects information submitted under the auspices of the IRF QRP and makes this information publicly available through the CMS Care Compare Website.[17] CMS notes that many other provider sectors (*e.g.*, hospitals, nursing homes, dialysis facilities) compile detailed quality of care information for these providers into "star ratings." Star ratings allow patients and their advocates to quickly identify differences in the quality of care among different providers of a type that a beneficiary may need in the course of their care or treatment of condition or illness.

[15] In the regulation text, CMS calls out Table 13 as the display of these concepts, but we believe the call out should be to Table 14.
[16] Centers for Medicare & Medicaid Services. Aligning Quality Measures Across CMS—the Universal Foundation. November 17, 2023. https://www.cms.gov/aligning-quality-measures-across-cms-universal-foundation
[17] https://www.medicare.gov/care-compare/.

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CMS seeks input on the development of a five-star methodology that would allow patients and their caregivers to meaningfully but quickly compare differences in the quality of care provided by IRFs. This initial solicitation is described as the first of multiple opportunities for IRFs and other stakeholders to provide input into the development of a five-star ratings system for IRFs. Here, CMS specifically seeks input related to two questions:

> 1. Are there specific criteria CMS should use to select measures for an IRF star rating system?
> 2. How should CMS present IRF star ratings information in a way that it is most useful to consumers?

The agency indicates that it will not be responding to specific comments in response to this RFI in the FY 2025 IRF PPS final rule, but rather intends to use this input to inform its future star rating development efforts. CMS intends to consider how a rating system would determine an IRF's star rating, the methods used for such calculations, and an anticipated timeline for implementation. CMS indicates that it will consider comments in response to this RFI for future rulemaking.

IV. Regulatory Impact Analysis

CMS estimates that the proposed rule will increase Medicare payments to IRFs by $255 million in FY 2025 compared with FY 2024. This reflects the 3.2 percent increase from the update factor, a -0.4 percent productivity adjustment, and a -0.2 percent decrease in estimated IRF outlier payments, which will increase aggregate payments to IRFs by an estimated 2.5 percent. Table 17 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 $255 million figure excludes the effects of payment reductions to IRFs that fail to meet the IRF QRP requirements.

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Table 17: IRF Impact Table for FY 2025 (Columns 4 through 7 in percentage)

Facility Classification	Number of IRFs	Number of Cases	Outlier	FY 2025 Wage Index (5% cap), FY 2024 CBSA delineations, and Labor-related share	FY 2025 Wage Index (5% cap), FY 2025 CBSA delineations, and Labor-related share	CMG Weights	Total Percent Change[1]
(1)	(2)	(3)	(4)	(5a)	(5b)	(6)	(7)
Total	1,154	413,171	-0.2	0.0	0.0	0.0	2.5
Urban unit	651	141,326	-0.5	-0.5	0.0	0.0	1.8
Rural unit	130	17,792	-0.4	1.8	0.3	0.0	4.6
Urban hospital	360	247,531	-0.1	0.1	0.0	0.0	2.8
Rural hospital	13	6,522	0.0	1.5	0.5	-0.1	4.7
Urban For-Profit	459	45,730	-0.1	0.1	-0.1	0.0	2.7
Rural For-Profit	35	9,689	-0.1	0.9	0.4	0.0	4.0
Urban Non-Profit	475	125,194	-0.4	-0.4	0.0	0.0	2.0
Rural Non-Profit	89	12,682	-0.5	2.3	0.3	0.0	5.1
Urban Government	77	17,933	-0.5	0.2	0.0	0.0	2.5
Rural Government	19	1,943	-0.4	1.4	0.4	0.1	4.3
Urban	1,011	388,857	-0.2	-0.1	0.0	0.0	2.4
Rural	143	24,314	-0.3	1.7	0.3	0.0	4.6
Urban by region							
Urban New England	30	14,274	-0.2	-1.6	0.1	0.1	1.1
Urban Middle Atlantic	116	41,445	-0.3	-0.8	0.0	0.0	1.7
Urban South Atlantic	180	90,206	-0.3	0.3	-0.2	0.0	2.7
Urban East North Central	164	46,765	-0.3	-0.4	0.1	0.0	2.2
Urban East South Central	56	27,196	-0.1	1.3	0.0	0.0	4.0
Urban West North Central	78	23,171	-0.3	-0.1	0.0	0.0	2.4
Urban West South Central	210	89,840	-0.1	0.4	0.0	0.0	3.1
Urban Mountain	79	31,110	-0.2	0.3	0.0	0.0	2.9
Urban Pacific	98	24,850	-0.5	-1.6	-0.1	0.0	0.6
Rural by region							
Rural New England	5	1,108	-0.4	0.0	0.0	-0.1	2.3
Rural Middle Atlantic	11	1,472	-0.4	8.8	-1.0	0.0	10.4
Rural South Atlantic	17	5,819	-0.2	2.2	1.6	0.0	6.5
Rural East North Central	22	2,871	-0.3	1.1	-0.2	0.0	3.7
Rural East South Central	19	3,300	-0.3	1.1	-0.2	0.0	3.5
Rural West North Central	18	2,250	-0.5	1.4	0.0	0.1	3.8

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Facility Classification	Number of IRFs	Number of Cases	Outlier	FY 2025 Wage Index (5% cap), FY 2024 CBSA delineations, and Labor-related share	FY 2025 Wage Index (5% cap), FY 2025 CBSA delineations, and Labor-related share	CMG Weights	Total Percent Change[1]
(1)	(2)	(3)	(4)	(5a)	(5b)	(6)	(7)
Rural West South Central	43	6,763	-0.3	0.7	0.2	0.1	3.5
Rural Mountain	6	423	-0.7	2.5	0.2	0.1	4.9
Rural Pacific	2	308	-1.3	-0.7	0.0	0.1	0.8
Teaching status							
Non-teaching	1,051	365,667	-0.2	0.1	0.0	0.0	2.7
Resident to ADC less than 10%	55	34,285	-0.3	-0.4	0.1	0.0	2.2
Resident to ADC 10%-19%	37	11,749	-0.5	-1.8	0.0	0.1	0.6
Resident to ADC greater than 19%	11	1,470	-0.5	-1.6	0.0	-0.1	0.6
Disproportionate share patient percentage (DSH PP)							
DSH PP = 0%	72	14,302	-0.5	0.7	0.4	0.0	3.3
DSH PP <5%	130	64,148	-0.1	0.3	0.0	0.0	3.0
DSH PP 5%-10%	229	98,988	-0.2	0.4	-0.1	0.0	2.9
DSH PP 10%-20%	418	152,107	-0.3	-0.3	0.0	0.0	2.2
DSH PP greater than 20%	305	83,626	-0.3	-0.2	0.1	0.0	2.3

[1] This column includes the impact of the updates in columns (4), (5a), (5b), and (6) above, and of the proposed IRF market basket update for FY 2025 of 3.2 percent, reduced by 0.4 percentage points for the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act. Note that the products of these impacts may be different from the percentage changes shown here due to rounding effects.

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