Medicare Inpatient Rehabilitation Facility Prospective Payment System for FY 2023 and Updates to the IRF Quality Reporting Program [CMS-1767-P]
Summary of Proposed Rule

On April 6, 2022, the Centers for Medicare & Medicaid Services (CMS) published in the Federal Register (87 FR 20218) a proposed rule on the Medicare inpatient rehabilitation facility prospective payment system (IRF PPS) for federal fiscal year (FY) 2023. This rule proposes a permanent approach to smooth year-to-year changes in the IRF wage index by applying a cap on negative wage index changes greater than a 5 percent decrease from the prior year. It also codifies its longstanding IRF teaching status adjustment policy in regulation and updates its IRF teaching policy on IRF program closures and displaced residents. CMS also solicits comments on the methodology used to update the IRF facility level adjustments (i.e., rural, low-income, and teaching status) and whether to incorporate discharge to home health in the IRF transfer policy. The rule proposes one policy change to the IRF Quality Reporting Program (QRP) that would require quality data reporting for all IRF admissions regardless of payer. No changes are proposed to the measure set previously finalized for FY 2023. CMS also seeks comment on future measure concepts, adoption of a digital quality measure, and principles for measuring equity and healthcare quality disparities.

CMS estimates that the Medicare IRF PPS payments in FY 2023 will be about $170 million higher than in FY 2022.

The deadline for comments on the proposed rule is May 31, 2022.

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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 2022, 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] This included certain changes to the IRF PPS medical supervision requirements as well as modifying certain IRF coverage and classification requirements for freestanding IRF hospitals to relieve acute care hospital capacity concerns in certain states that are experiencing a surge during the PHE for COVID-19. 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.

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 2023, continuing the same methodologies used in past years, and now applied to FY 2021 IRF claims and FY 2020 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 0.9979.

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 99.3 percent of IRF cases are in CMGs for which the proposed FY 2023 weight differs from the FY 2022 weight by less than 5 percent (either increase or decrease).

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

CMS says that the proposed changes in the average length of stay values from FY 2022 to FY 2023 are small and do not show any trends in IRF length of stay patterns.

Column 7 of Table 14 in the impact section of the proposed rule (section IX below) shows the distributional effects of the changes in the CMGs by type of facility. Note that for this proposed rule, CMS has not posted the accompanying provider-specific files on the IRF PPS web page.

III. FY 2023 IRF PPS Payment Update

For FY 2023 payment, CMS proposes to 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. Market Basket Update and Productivity Adjustment

An update factor of 2.8 percent is proposed for the IRF PPS payment rates for FY 2023, composed of the following elements listed below.

Proposed FY 2023 IRF PPS Update Factor	
Market basket	3.2%
Total factor productivity (TFP)	-0.4%
Total	2.8%

The 3.2 percent FY 2023 market basket increase factor is based on IHS Global Insight's (IGI's) forecast from the fourth quarter of 2021, based on actual data through the third quarter. Similarly, the statutorily required productivity adjustment is based on IGI's fourth quarter 2021 forecast of the 10-year moving average (ending in 2023) of changes in annual economy-wide private nonfarm business total factor productivity.[2] The update factor for IRFs that fail to meet requirements for the IRF QRP is discussed in section VIII below and totals 0.8 percent. CMS will use more recent data, if available, for the final rule.

B. Labor-Related Share

CMS proposes a total labor-related share of 73.2 percent for FY 2023, a very minor change from the FY 2022 labor share of 72.9 percent. The 73.2 percent comes from the IGI fourth quarter 2021 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 IRF market basket. The relative importance reflects the different rates of price change for these cost categories between the base year (2016) and FY

[2] 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.

2023. Table 4 of the proposed rule compares the components of the FY 2022 and proposed FY 2023 labor shares.

C. 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 2023 CMS would use the FY 2023 pre-floor, pre-reclassification IPPS wage index. The FY 2023 pre-reclassification and pre-floor hospital wage index is based on FY 2019 cost report data. Any changes made to the IRF PPS wage index from the previous fiscal year are made in a budget neutral manner.

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[3] 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. For the same reasons, CMS is not making such a proposal for FY 2023.

CMS proposes a permanent approach to smooth year-to-year changes in providers' wage index In the past, CMS has established transition policies of limited duration to phase in significant changes to labor market areas. CMS notes that year-to-year fluctuations in an area's wage index can occur due to external factors beyond a provider's control, such as the COVID-19 PHE. It believes that a permanent policy will increase the predictability of IRF PPS payments for providers, and mitigate instability and significant negative impacts to providers resulting from changes to the wage index.

Specifically, CMS proposes to apply a 5-percent cap on any decrease to a provider's wage index in the prior year, regardless of the circumstances causing the decline. Under this policy, the IRF's wage index for FY 2023 would not be less than 95 percent of its final wage index for FY

[3] 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.

2022 and that for subsequent years, a provider's wage index would not be less than 95 percent of its wage index calculated in the prior FY. It believes that the impact to the wage index budget neutrality factor in future years would continue to be minimal as typical year-to-year variation has historically been within 5 percent. CMS also proposes for a new IRF that it would be paid the wage index for the area in which it is geographically located for the first full or partial FY with no cap applied, because a new IRF would not have a wage index in the prior year.

Changes to the IRF PPS wage index are made in a budget neutral manner; CMS estimates the budget neutrality adjustment for FY 2023 under the proposed rule to be 1.0007. To make this calculation, CMS estimates aggregate IRF PPS payments using the FY 2022 labor-related share and wage index values and then estimates aggregate payments using the proposed FY 2023 labor share and wage index values. The ratio of the amount based on the FY 2022 index to the amount estimated using the proposed FY 2023 index is the budget neutrality adjustment to be applied to the proposed federal per diem base rate for FY 2023.

D. Description of the IRF Standard Payment Conversion Factor and Payment Rates for FY 2023

Table 5 of the proposed rule (reproduced below) shows the calculations used to determine the proposed FY 2023 IRF standard payment amount. In addition, Table 6 of the proposed rule lists the FY 2023 payment rates for each CMG, and Table 7 provides a detailed hypothetical example of how the IRF FY 2023 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 5: Calculations to Determine the Proposed FY 2023 Standard Payment Conversion Factor	
Explanation for Adjustment	**Calculations**
Standard Payment Conversion Factor for FY 2022	$17,240
Market Basket Increase Factor for FY 2023 (3.2 percent), reduced by 0.4 percentage point 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 1.0007
Budget Neutrality Factor for the Revisions to the CMG Relative Weights	x 0.9979
Proposed FY 2023 Standard Payment Conversion Factor	= $17,698

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 2023.

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 2023, CMS proposes to use FY 2021 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 3.8 percent of total IRF payments in FY 2023. To maintain estimated outlier payments at the 3 percent level, CMS updates the outlier threshold amount from $9,491 for FY 2022 to $13,038 for FY 2023. It recognizes that the proposed outlier threshold amount for FY 2023 would result in a significant increase from the current outlier threshold amount for FY 2022 and plans to explore the underlying reasons for the large change in the proposed outlier amount. **CMS welcomes comments from stakeholders and any observations or information related to the increase in the proposed update to the outlier threshold amount for FY 2023.**

Updates are proposed to the national urban and rural CCRs for IRFs, as well as the national CCR ceiling for FY 2023, based on analysis of the most recent cost report data that are available (FY 2020). 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 2023; and other IRFs for which accurate data to calculate an overall CCR are not available. The national CCR ceiling for FY 2023 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 0.393 for urban IRFs and 0.463 for rural IRFs, and the national CCR ceiling is 1.40. That is, if an individual IRF's CCR were to exceed this ceiling of 1.40 for FY 2023, 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. Codification and Clarifications of IRF Teaching Status Adjustment Policy

A. Codification of Existing Teaching Status Adjustment Policies

CMS proposes to codify CMS' existing teaching status adjustment policy through proposed amendments to the regulation text and proposing to update and clarify the IRF teaching policy with respect to IRF hospital closures and displaced residents.

CMS notes that when the teaching status adjustment policy was finalized in the FY 2006 IRF PPS final rule (70 FR 47928 through 47932), the definition of this "factor" and explanations of how it is computed were not included in the regulations. Rather, the more detailed definition and the explanation of the teaching status payment adjustment provided in the FY 2006 IRF PPS

final rule, were published in the Medicare Claims Processing Manual (100-04, chapter 3, 140.2.5.4). CMS proposes that this be codified at 412.624(e)(4).

CMS also proposes to codify the IRF policy that was adopted in the FY 2012 IRF PPS final rule (76 FR 47846 through 47848) allowing an IRF to receive a temporary adjustment to its FTE cap to reflect residents added to its teaching program because of another IRFs closure or an IRFs medical residency training program closure. It proposes to codify CMS' existing IRF PPS' teaching hospital adjustment policies through proposed amendments to §412.602, except as specifically noted with respect to its proposed updated to the IRF teaching policy on IRF program closures and displaced residents (as discussed below).

B. Update to the IRF Teaching Policy on IRF Program Closures and Displaced Residents

CMS proposes to revise its teaching policy with regard to which residents can be considered "displaced" for the purpose of the receiving IRF's request to increase their IRF cap in the situation where an IRF announces publicly that it is closing, and/or that it is closing an IRF residency program. Specifically, it proposes to adopt the FY 2021 IPPS final rule definition of "displaced resident" as defined at §413.79(h)(1)(ii), for the purpose of calculating the IRF's teaching status adjustment. These changes include linking the status of displaced residents to when the program closure is publicly announced, but before the actual hospital or program closure. This will allow more residents to be classified as "displaced" and the IRF receiving these displaced residents to temporarily increase their FTE residence cap.

In addition, CMS proposes to change another detail of the policy specific to the requirements for the receiving IRF. To apply for the temporary increase in the FTE resident cap, the receiving IRF would have to submit a letter to its Medicare Administrative Contractor (MAC) within 60 days after beginning to train the displaced interns and residents. As established in the FY 2012 IRF PPS final rule, this letter must identify the residents who have come from the closed IRF or closed residency program and caused the receiving IRF to exceed its cap, and must specify the length of time that the adjustment is needed. Furthermore, to maintain consistency with the IPPS IME policy, CMS proposes that the letter must also include:

(1) The name of each displaced resident;
(2) The last four digits of each displaced resident's social security number; this will reduce the amount of personally identifiable information (PII);
(3) The name of the IRF and the name of the residency program or programs in which each resident was training at previously; and
(4) The amount of the cap increase needed for each resident (based on how much the receiving IRF is in excess of its cap and the length of time for which the adjustments are needed).

CMS clarifies that the maximum number of FTE resident cap slots that could be transferred to all receiving IRFs is the number of FTE resident cap slots belonging to the IRF that has closed the resident training program, or that is closing. If the originating IRF is training residents in excess of its cap, then being a displaced resident does not guarantee that a cap slot will be transferred along with the resident. In this situation, CMS proposes that if there are more IRF displaced

residents than available cap slots, the slots may be apportioned according to the closing IRF's discretion. The decision to transfer a cap slot if one is available would be voluntary and made at the sole discretion of the originating IRF. It would also be the originating IRF's responsibility to determine how much of an available cap slot would go with a particular resident (if any). Displaced residents are factored into the receiving IRF's ratio of resident FTEs to the facility's average daily census.

CMS invites public comment on the proposed updates to the IRF teaching policy.

VI. Solicitation of Comments Regarding the Facility-Level Adjustment Factor Methodology

CMS currently adjust the prospective payment amount associated with a CMG to account for facility-level characteristics such as a facility's percentage of low-income patients (LIP), teaching status, and location in a rural area. It also adjusts whether the IFS is freestanding or hospital-based. Each of these factors are calculated based on a regression analysis. CMS has observed relatively large fluctuations in these factors from year-to-year and since 2015 it has maintained the same facility-level adjustment factors calculated in 2014. Table 9 in the proposed rule shows the variability in the LIP, teaching, and rural adjustment factors from 2014 to 2023. Table 10 (excerpt shown below) shows the distributional effects of the FY 2023 facility level adjustment factors

Excerpt from Table 10: Distributional Effects of the FY 2023 Facility Level Adjustment Factors

Facility Classification	Number of IRFs	Number of Cases	Rural Adjustment	LIP Adjustment	Teaching Adjustment
Total	1,115	380,165	0.0	0.0	0.0
Urban	970	357,324	0.2	0.0	0.2
Rural	145	22,841	-3.6	-0.2	-2.6
Teaching status					
Non-teaching	1,012	335,417	0.0	-0.2	-2.7
Resident to ADC less than 10%	59	32,213	0.2	0.9	9.0
Resident to ADC 10%-19%	34	11,327	0.2	0.7	23.8
Resident to ADC greater than 19%	10	1,208	0.2	1.6	102.1

CMS expresses concern about these patterns as it does not believe that the magnitude of the increases seen in these results are true reflections of the higher costs of teaching IRFs. In addition, it is concerned about the negative impacts these inordinate teaching status adjustments would have on rural IRFs given that these changes would be implemented in a budget neutral manner.

CMS seeks comment from stakeholders on the methodology used to determine the facility-level adjustment factors and suggestion for possible updates and refinements to this methodology. It also welcomes ideas and suggestions as to what could be driving the changes observed in these adjustment factors from year-to-year.

VII. Solicitation of Comments Regarding the IRF Transfer Payment Policy

The IRF transfer payment policy applies to IRF stays that are less than the average length of stay for the applicable CMG and tier and are transferred directly to another institutional site, including another IRF, an inpatient hospital, a nursing home that accepts payment under Medicare and Medicaid, or a long-term care hospital.

The IRF transfer payment policy currently does not apply to IRF stays that are less than the average length of stay for the applicable CMG and tier and are transferred to home health care. The HHS Office of Inspector General (OIG) recommended in 2021 that CMS expand the IRF transfer payment policy to apply to early discharges to home health. The OIG recommends that the IRF PPS should update its transfer payment policy, similar to the IPPS transfer payment policy, to include home health. It estimated that such a policy could have resulted in realized savings to Medicare of almost $1 billion over the 2017-2018 period.[4]

CMS notes that initially home health was not added to the IRF transfer policy due to a lack of home health claims data under the newly-established prospective payment system that CMS could analyze to determine the impact of this policy change. Given the OIG findings, CMS plans to analyze the home health claims data to determine the appropriateness of including home health in the IRF transfer policy to better understand these issues:

- Beyond the existing Medicare claims data, under what circumstances, and for what types of patients (in terms of clinical, demographic, and geographic characteristics) do IRFs currently transfer patients to home health?
- Should CMS consider a policy similar to the IPPS transfer payment policy?
- What impact, if any, do stakeholders believe this proposed policy change could have on patient access to appropriate post-acute care services?

CMS notes that it is not proposing to include home health care as part of the IRF transfer payment policy at this time, but hopes to use information from stakeholders in conjunction with its future analysis for potential rulemaking.

[4] Office of the Inspector General. December 7, 2021 Early Discharges From Inpatient Rehabilitation Facilities to Home Health Services [Report No. A-01-20-00501] https://oig.hhs.gov.

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

CMS proposes one policy change for the IRF QRP, expanding the quality data collection requirements. Beginning with program year FY 2025, IRFs would be required to report data on all admitted patients, regardless of payer. CMS does not propose any additions, revisions, replacements, or removal of measures from the previously finalized IRF QRP measure set for FY 2023 (listed in a table at the end of this summary section).

CMS also seeks input about the IRF QRP through a series of Requests for Information (RFIs) on the following topics:

- Three concepts for future quality measures;
- Adoption of a digital quality measure focused on infection control; and
- Principles for measuring equity and healthcare quality disparities.

CMS indicates that it will not respond specifically to comments received about any of these three RFIs through the FY 2023 IRF PPS final rule, but that all input from commenters will be considered in future policy making.

A. Background

The IRF QRP was established in accordance with section 1886(j) of the Act as amended by the Affordable Care Act (ACA, 2010). The program is applicable to freestanding IRFs and to inpatient rehabilitation units of hospitals or CAHs. By statute, a facility that does not meet IRF QRP participation 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.[5]

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. Proposed All-Payer IRF QRP Reporting Requirement

1. Details of the Proposal

CMS proposes to require that an IRF-PAI assessment be collected on each patient cared for in an IRF, regardless of payer. Currently, facilities must collect and submit data on patients for whom either Medicare Part A (Fee For Service—FFS) or Medicare Part C (Medicare Advantage—MA) is the payer. CMS further proposes that the new policy would begin with the

[5] 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 PPS FY 2025 rate year, meaning that facilities would need to start data collection for all patients regardless of payer on October 1, 2023.

The additional patient assessments would be included when determining whether a facility has met the data completion thresholds of the IRF QRP required to receive a full annual update. CMS notes that FY 2025 would be a transition year for which all-payer data for patients discharged between October 1 and December 1, 2023 would be combined with Medicare-only data collected January 1 through September 30, 2023, for the purposes of calculating a facility's FY 2025 data completion threshold performance.[6] Threshold performance calculations for FY 2026 and subsequent years would be based entirely on all-payer data.

> *IRF QRP Data Completion Thresholds*
> IRFs must meet or exceed two separate data completeness thresholds: 1) No less than 95 percent of IRF-PAI assessments submitted to CMS must have 100 percent completion of all required IRF-PAI data elements; and 2) Data required for measures that are collected and submitted through the National Health Safety Network (NHSN) of the Centers for Disease Control and Prevention (CDC) must be complete for 100 percent of submissions. A facility must meet or exceed both thresholds to avoid receiving a 2-percentage point reduction to their annual payment update for a given fiscal year.

CMS states that data from the additional assessments would not be used for purposes of updating the IRF PPS payment rates themselves, but used only in the annual update factor quality adjustment calculations. No changes are proposed to § 412.624(a)(1), which requires CMS to use the most recent Medicare data available in the methodology for calculating the Federal prospective payment rates.

2. Rationale for the Proposal

CMS shares that required reporting of all-payer IRP-PAI assessment data would:

- be responsive to stakeholder calls for increased data standardization across PAC settings, including from the NQF-convened Measure Applications Partnership (MAP);
- be consistent with similar requirements in the CMS quality programs for long-term acute care hospitals (LTCH QRP) and hospice providers (HQRP);
- provide a fuller, more accurate representation of IRF quality of care for use in beneficiary healthcare decision making, policy development, and health services research; and
- enhance identification of outcomes disparities across PAC settings and patient subsets.

CMS acknowledges the increased time and cost burden that is likely to accompany the requirement for expanded data collection and submission, but believes the burden may be partially offset by no longer having to reliably separate out Medicare patient data for reporting. Later in the preamble, CMS provides a burden estimate of approximately 437 hours and $28,500

[6] This is because IRF QRP data collection periods and submission deadlines are set using calendar-year quarters.

annually per facility (see section XI.B. of the rule for complete details). CMS also states its commitment to monitoring IRF QRP policy changes for unintended consequences and to protecting the privacy and security of protected health information entered into its data systems.

3. Associated Regulation Text Revisions

CMS proposes regulation text changes to align the current IRF-PAI data collection and submission requirements with the proposed expansion from Medicare-only to all-payer data (§§ 412.604, 412.606, 412.610, 412.614, and 412.618). Further proposed is a revision of the requirements at §412.610(f) for maintaining IRF-PAI records data on all Medicare patients treated by a facility; if finalized as proposed, record retention would be required for 5 years for Medicare Part A patients, 10 years for Medicare Part C patients, and 5 years for all other payers' patients.

C. Regulation Text Error Correction

CMS proposes a minor regulation text change to correct an erroneous cross reference. Currently §412.614(d)(2) *Transmission of patient assessment data. Medicare Part C (Medicare Advantage) data* incorrectly references §412.23(b)(2) *Excluded hospitals: Classifications. Rehabilitation hospitals.* The cross reference would be changed to §412.29(b)(1) *Classification criteria for payment under the inpatient rehabilitation facility prospective payment system.*

D. Request for Information (RFI): Future Quality Measure Concepts under Consideration

CMS seeks input on three concept areas in which one or more measures would be developed for future use in the IRF QRP.

1. Cross-setting Function – CMS is considering a functional measure for use across all PAC settings that would incorporate both of the domains of self-care and mobility.
2. Health Equity Measures – CMS expresses interest in structural measures that assess an organization's leadership in advancing health equity goals or assess progress towards achieving equity priorities.
3. COVID-19 Vaccination Coverage among PAC Patients – CMS invites comment on the value of a measure assessing whether IRF patients are current on their vaccinations.

E. Request for Information (RFI): IRF QRP Digital Quality Measures and Clostridioides difficile Infection Outcome Measure

CMS invites input into requiring electronic submission of quality data from IRFs via their electronic health records (EHRs) as part of the IRF QRP. Specifically, CMS poses questions related to the future inclusion of the *NHSN Healthcare-Associated Clostridioides difficile Infection Outcome Measure (HA-CDI)*[7] as the IRF QRP's first digital quality measure (dQM).

[7] The name of the bacterium that causes the illness being tracked by the CDI and HA-CDI measures was updated in 2016 from Clostridium difficile to Clostridioides difficile based on bacterial genome sequencing results.

- Would you support using EHRs to collect and submit data for IRF QRP measures?
- Would your EHR support exposing data via HL7 FHIR to locally installed software from CDC? For IRFs using certified EHR technology (CEHRT), how can existing certification criteria from the Office of the National Coordinator (ONC) for Health Information Technology (HIT) support reporting of dQM data? What updates, if any, to ONC's Certification Program would be needed to better support data capture and submission?
- Is a transition period between the current data submission method and an electronic submission method necessary? If so, how long; further, what specific factors are relevant in determining the length of any transition?
- Would vendors, including those that service IRFs, be interested in or willing to participate in pilots or voluntary electronic submission of quality data?
- Do IRFs anticipate challenges, other than the adoption of EHRs, to implementing the HA-CDI; if so, what are potential solutions for those challenges?

1. Background

In prior rulemaking, CMS expressed a commitment to transitioning its quality enterprise to dQMs by 2025. Data collection, submission, and other health information exchange related to the measures would occur primarily using application programming interfaces (APIs) that are based on the Health Level 7 Fast Healthcare Interoperability Resources standards (HL7 FHIR®).

The IRF-QRP currently requires reporting of NQF #1717 *NHSN Facility-wide Inpatient Hospital-Onset Clostridium difficile Infection Outcome Measure* (*CDI*). The CDI measure does not utilize EHR-derived data; instead, each IRF collects data and submits it on a monthly basis to CDC using the NHSN's online module for multidrug resistant organisms and C. difficile infections.[8] The HA-CDI dQM's associated software would include an embedded Measure Calculation Tool (MCT) that interfaces with a facility's EHR to extract data, calculate the measure, and submit the results. CMS reports, however, that the CDC is developing multiple submission options so that facilities with less advanced health IT systems (e.g., unable to support an MCT) could still transmit their HA-CDI data to CDC.

CMS notes that the HA-CDI measure better distinguishes C. difficile infection from colonization and allows easier identification of new C. difficile infections in patients already admitted to a facility when compared to the current CDI measure.

2. Measure Details

The HA-CDI dQM would track the development of new C. difficile infections among patients already admitted to an IRF, using algorithmic determinations based on EHR data.

Numerator. Patients with 1) a qualifying C. difficile-positive assay on an inpatient encounter on day 4 or later of an IRF admission and with no previously positive event in ≤ 14 days before the

[8] CDC processes the data and calculates the measure results, then transmits the results to CMS for IRF QRP scoring.

IRF encounter; and 2) qualifying antimicrobial therapy newly started within the appropriate window (i.e., based on timing of stool specimen collection).
Denominator. Number of patients admitted to the IRF during the data collection period.
Exclusions. None (the measure's exclusion of patients from well-baby nurseries and neonatal intensive care units when the measure is used in other settings – e.g., acute care hospital – is not applicable to IRFs).
Data Sources. Microbiology, medication administration, patient location (e.g., type of nursing unit), patient encounter, and patient demographic data are extracted from the facility's EHR.

CMS states that the CDC would maintain both the CDI and HA-CDI measures concurrently for sufficient time until facilities gain enough experience with the HA-CDI measure to remove the CDI measure from the IRF QRP measure set.

3. Pre-rulemaking Process

In accordance with the CMS pre-rulemaking process, the HA-CDI measure was included on the 2021 Measures Under Consideration (MUC) list as MUC2021-098. CDC is the measure's steward. The measure was suggested for potential use in multiple CMS quality reporting programs, including the IRF QRP, SNF QRP, and LTCH QRP.

Also as part of pre-rulemaking, the HA-CDI measure was reviewed by several component workgroups of the NQF-convened Measure Applications Partnership (MAP). Overall, the MAP conditionally supported the measure for rulemaking, recommending first that the measure be submitted for NQF endorsement and that reliability and validity testing be completed. The MAP's Health Equity Advisory Group found the measure to have some potential to decrease health disparities.

F. Request for Information (RFI): Overarching Principles for Measuring Equity and Healthcare Quality Disparities Across CMS Quality Programs

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.

In this RFI, CMS describes key principles and approaches the agency will consider when addressing disparities through quality measure development and stratification. Topics for comment and supporting information provided are grouped by CMS around 5 key considerations and 2 potential measures. Highlights from the topics for comment and extensive supporting information provided by CMS are reviewed below; topics for comment appear in bold font. (See section V.A. of the preamble for the full set of topics and complete background material.)

- **Identification of Goals and Approaches for Measuring Healthcare Disparities and Using Measure Stratification Across CMS Quality Reporting Programs**
    - **Within- and between-provider disparity methods to present stratified IRF quality measure results.**
    - **Decomposition approaches to explain possible causes of measure performance disparities.**
    - **Alternative methods to identify disparities and the drivers of disparities.**

In discussing methodological approaches to reporting disparities, CMS notes that the "within-provider" method compares a measure's results between subgroups of patients treated by a single provider with or without a given demographic or social risk factor. The "between-provider" method compares performance across providers on measures for subgroups who all have the factor of interest (e.g., compare a single provider with a national benchmark). CMS views the two methods as complementary when reporting data stratified by the presence or absence of a demographic or social risk factor.[9]

Another approach, regression decomposition, can facilitate analysis when an identified performance disparity may have multiple contributing factors, allowing estimation of the relative contributions of the factors.[10] CMS walks through a decomposition analysis of hypothetical IRF data for the Medicare Spending Per Beneficiary Measure stratified by dual-eligible status, for the factors of health literacy level and Emergency Department service utilization (see section V.A.2.a. of the rule).

- **Guiding Principles for Selecting and Prioritizing Measures for Disparity Reporting**

    Measures to be prioritized could include:
    - **Existing, validated, reliable, clinical quality measures for which application of disparities methods and stratified reporting are feasible.**
    - **Measures related to treatment or outcomes for which some evidence of disparities has been shown.**

[9] 2020 Disparity Methods Updates and Specifications Report, prepared for CMS by the Yale Center for Outcomes Research and Evaluation. Available at https://qualitynet.cms.gov/inpatient/measures/disparity-methods/resources#tab3.

[10] CMS cites: Rahimi E, Hashemi Nazari S. A detailed explanation and graphical representation of the Blinder-Oaxaca decomposition method with its application in health inequalities. Emerg Themes Epidemiol. (2021)18:12. https://doi.org/10.1186/s12982-021-00100-9.

- **Measures for which predetermined standards for statistical reliability and representativeness (e.g., sample size) have been met prior to results reporting.**
- **Measures that offer meaningful, actionable, and valid feedback to providers.**

- **Principles for Social Risk Factor and Demographic Data Selection and Use**
  - **Patient-reported data are the gold standard;**
  - **Criteria for appropriate use of administrative data, area-based indicators (e.g., Area Deprivation Index) and imputed variables when patient-reported data are unavailable; and**
  - **Data collection and submission burden (time and costs) imposed on providers**

CMS notes the numerous and diverse demographic and social risk factor variables to be considered during disparities analysis (e.g., gender identity, social isolation). CMS reports early positive experience using Medicare Bayesian Improved Surname Geocoding (MBISG) to impute missing values for race and ethnicity from administrative data, surname, and residence.[11]

- **Identification of Meaningful Performance Differences**

  Methods for detecting meaningful differences could include:
  - **Statistical approaches for reliably grouping results (e.g., confidence intervals, clustering algorithm, cut points based on standard deviations);**
  - **Application of ranked ordering and percentiles to providers based on their disparity measure performances, for beneficiary use in decision making;**
  - **Categorizing different levels of provider performance by applying defined thresholds and fixed intervals to disparity measure results;**
  - **National or state-level benchmarking (e.g., mean, median); and**
  - **Criteria for when ranking performances is inappropriate (i.e., when only measure results can or should be reported without making comparisons)**

CMS states an intention to standardize its analytic approaches wherever possible. However, the agency also states that approaches must be tailored to contextual variations at the program level. Input on the benefits and limitations of the above list of methods is sought.

- **Guiding Principles for Reporting Disparity Measures**
  - **Confidential reporting to providers for new programs and/or new measures;**
  - **Satisfying statutory requirements for public reporting;**
  - **Special considerations for resource-limited settings (e.g., rural, underserved) to avoid unintended disadvantaging of critical-access providers; and**
  - **Synchronous reporting of overall and stratified results for maximum value and impact.**

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11 Haas A., Elliott M.N., Dembosky J.W., et al. Imputation of race/ethnicity to enable measurement of HEDIS performance by race/ethnicity. *Health Serv Res*, 54(1):13-23. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6338295/pdf/HESR-54-13.pdf

CMS believes that varying approaches to results reporting may be useful for driving quality improvement in different contexts and settings. CMS emphasizes that overall improvement without resolution of disparities would be undesirable.

- **Potential Health Equity Measures for the IRF QRP: Desirable Characteristics**
  - **Actionable for providers;**
  - **Assist beneficiary decision making;**
  - **Adhere to high scientific acceptability standards (e.g., reliability); and**
  - **Avoid creating incentives to lower the quality of care.**

Health Equity Summary Score[12]
CMS seeks input about adapting the Health Equity Summary Score (HESS) for use in the IRF QRP. The HESS was developed by the CMS Office of Minority Health to assess care provided by MA plans to beneficiaries with social risk factors or high-risk demographics. It is a composite measure that includes multiple measures -- clinical and experience-of-care survey items[13] – and multiple at-risk groups.

Hospital Commitment to Health Equity
CMS seeks input about adopting a structural measure for the IRF QRP to assess engagement of hospital leadership in collecting health equity performance data. The measure – *Hospital Commitment to Health Equity* – combines attestations from 5 distinct domains of commitment: strategic plan for disparities reduction; demographic and social risk factor data collection; disparities analysis; quality improvement activities; and leadership involvement in reducing disparities. CMS began the pre-rulemaking process by including this measure on the 2021 MUC List. As such, it was reviewed by the MAP and received conditional support for rulemaking.[14] CMS also solicits comments on additional domains, facility-level information collection to facilitate health equity measure scoring, and other potential IRF QRP equity measures.

[12] Agniel D., Martino S.C., Burkhart Q, et al. Incentivizing excellent care to at-risk groups with a health equity summary score. J Gen Intern Med, 2021; 36(7):1847-1857. https://link.springer.com/content/pdf/10.1007/s11606-019-05473-x.pdf.
[13] Clinical measures are from HEDIS (maintained by the National Committee for Quality Assurance); survey items are from the Consumer Assessment of Healthcare Providers and Systems (CAHPS, maintained by the Agency for Healthcare Research and Quality).
[14] The MAP conditionally supported this measure, but prior to adoption in rulemaking recommended that: the measure be submitted for NQF endorsement; verification of the attestations should be required; and additional data be presented to evaluate its impact on quality of care (i.e., linking elements of the measure to clinical outcomes or process improvements). https://www.qualityforum.org/Publications/2022/03/MAP_2021-2022_Considerations_for_Implementing_Measures_Final_Report_-_Clinicians,_Hospitals,_and_PAC-LTC.aspx

G. Summary Table of IRF QRP Measures Adopted for the FY 2023 IRF QRP

(Table 11 reproduced from the rule with minor modifications)

IRF QRP Measure Set for FY 2023	
Short Name	**Measure Name & Data Source** *(new or revised are in italics)*
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)
Change in Self-Care	IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633)
Change in Mobility	IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634)
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
* Delayed compliance date implemented due to COVID-19 PHE (85 FR 27595); compliance date for collection and reporting revised to October 1, 2022 in Home Health PPS CY 2022 Final Rule (86 FR 62381-62386).	
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
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

IX. Regulatory Impact Analysis

CMS estimates that the proposed rule will increase Medicare payments to IRFs by $170 million in FY 2023 compared with FY 2022. This reflects the 2.8 percent increase from the update factor and the change in the outlier threshold, which will increase aggregate payments to IRFs by an estimated 2.0 percent. Table 14 in the proposed rule, reproduced below, shows the effects of these and other policy changes by type of IRF. The other policy changes shown in Table 14 involving the wage index and the permanent cap and changes to the CMG weights are all designed to be budget neutral and therefore have no effect on aggregate payments to IRFs. The $170 million figure excludes the effects of payment reductions to IRFs that fail to meet the IRF QRP requirements.

TABLE 14: IRF Impact Table for FY 2023 (Columns 4 through 8 in percentage)

Facility Classification	Number of IRFs	Number of Cases	Outlier	Wage Index FY23	Proposed Permanent Wage Index Decreases Cap	CMG Weights	Total Percent Change[1]
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Total	1,115	380,165	-0.8	0.0	0.0	0.0	2.0
Urban unit	653	143,947	-1.4	0.0	0.0	-0.1	1.2
Rural unit	133	17,660	-1.0	-0.1	0.0	-0.1	1.5
Urban hospital	317	213,377	-0.3	0.0	0.0	0.1	2.6
Rural hospital	12	5,181	-0.3	-0.2	0.0	0.2	2.5
Urban For-Profit	396	206,158	-0.3	0.0	0.0	0.1	2.6
Rural For-Profit	35	8,048	-0.4	-0.1	0.0	0.1	2.4
Urban Non-Profit	489	132,251	-1.3	0.0	0.0	-0.1	1.4
Rural Non-Profit	88	12,252	-1.1	-0.2	0.0	-0.1	1.4
Urban Government	85	18,915	-1.6	-0.1	0.0	-0.2	0.9
Rural Government	22	2,541	-0.9	-0.2	0.0	-0.1	1.6
Urban	970	357,324	-0.8	0.0	0.0	0.0	2.0
Rural	145	22,841	-0.8	-0.2	0.0	0.0	1.8
Urban by region							
Urban New England	29	13,576	-0.5	-1.1	0.0	-0.1	1.1

Facility Classification	Number of IRFs	Number of Cases	Outlier	Wage Index FY23	Proposed Permanent Wage Index Decreases Cap	CMG Weights	Total Percent Change[1]
Urban Middle Atlantic	121	41,622	-1.2	0.2	0.0	0.0	1.8
Urban South Atlantic	158	75,753	-0.6	-0.2	0.0	0.0	1.9
Urban East North Central	158	44,520	-0.8	-0.1	0.0	-0.1	1.8
Urban East South Central	55	25,224	-0.2	-0.3	0.0	0.0	2.3
Urban West North Central	76	21,675	-0.7	-0.5	0.0	-0.1	1.4
Urban West South Central	197	83,013	-0.5	0.2	0.0	0.2	2.7
Urban Mountain	79	27,597	-0.6	0.3	0.0	0.0	2.5
Urban Pacific	97	24,344	-1.7	0.5	0.0	-0.2	1.3
Rural by region							
Rural New England	5	1,116	-0.9	1.2	0.0	-0.2	2.9
Rural Middle Atlantic	10	926	-1.1	-0.3	0.0	0.0	1.3
Rural South Atlantic	16	4,000	-0.2	-0.7	0.0	0.1	1.9
Rural East North Central	23	3,379	-0.8	-0.8	0.0	-0.1	1.0
Rural East South Central	20	3,626	-0.5	-0.4	0.0	-0.1	1.7
Rural West North Central	20	2,579	-1.4	0.1	0.0	0.0	1.5
Rural West South Central	42	6,514	-0.8	0.4	0.0	0.1	2.4
Rural Mountain	6	379	-1.2	-0.5	0.1	0.1	1.2
Rural Pacific	3	322	-3.9	-0.3	0.0	-0.3	-1.8
Teaching status							
Non-teaching	1,012	335,417	-0.7	0.0	0.0	0.0	2.1
Resident to ADC less than 10%	59	32,213	-1.0	0.0	0.0	-0.1	1.7
Resident to ADC 10%-19%	34	11,327	-1.6	0.1	0.0	-0.2	1.0
Resident to ADC greater than 19%	10	1,208	-1.1	0.5	0.0	-0.1	2.1

Facility Classification	Number of IRFs	Number of Cases	Outlier	Wage Index FY23	Proposed Permanent Wage Index Decreases Cap	CMG Weights	Total Percent Change[1]
Disproportionate share patient percentage (DSH PP)							
DSH PP = 0%	64	11,557	-1.5	0.2	0.0	0.0	1.5
DSH PP <5%	127	49,049	-0.6	-0.2	0.0	0.1	2.0
DSH PP 5%-10%	260	105,962	-0.6	0.1	0.0	0.1	2.4
DSH PP 10%-20%	388	140,935	-0.7	0.0	0.0	0.0	2.0
DSH PP greater than 20%	276	72,662	-1.2	0.1	0.0	-0.1	1.6

[1]This column includes the impact of the updates in columns (4), (5), (6), and (7) above, and of the IRF market basket increase factor for FY 2023 (2.3 percent), reduced by 0.4 percentage point for the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act

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 2023. CMS argues, however, that adjusting these amounts based on the most recent 2021 claims data would result in more accurate payments as well as maintaining the targeted 3 percent outlier pool.