Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for FY 2024 and Updates to the IRF Quality Reporting Program
Summary of Final Rule

On July 27, 2023, the Centers for Medicare & Medicaid Services (CMS) issued a final 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 finalizes two new measures and is modifying another measure for the IRF Quality Reporting Program (QRP). This rule also finalizes its proposal to rebase and revise the IRF market basket to reflect more recent data on IRF cost structures. In addition, CMS finalizes 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 $355 million higher than in FY 2023.

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[1] It will be published in the Federal Register on August 2, 2023.

I. Introduction and Background

The final 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 expired 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 finalized for FY 2024, continuing the same methodologies used in past years, and now applied based on FY 2022 IRF claims and FY 2021 IRF cost report data (data updated from proposed rule to reflect a more complete set of claims for FY 2021 and additional cost report data for FY 2020). Changes to the CMG weights are made in a budget neutral manner; the budget neutrality factor is 1.0002.

Table 2 in the final rule displays the 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 FY 2024 weight differs from the FY 2023 weight by less than 5 percent (either increase or decrease).

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[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 expired at the end of May 11, 2023. Waivers and flexibilities authorized for the emergency period under 1135(g)(1) of the Social Security Act consequently also expired on that date.

CMS says that the 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 final 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 rebases and revises the IRF PPS market basket; applies the annual market basket update and productivity adjustment; updates the labor-related share of payment; and updates the wage index based on the most recent Inpatient Prospective Payment System (IPPS) hospital wage index data.

A. Rebasing and Revising of the IRF PPS Market Basket

Beginning with FY 2024, CMS finalizes its proposal 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 final 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 final 2021 to the current 2016-based market basket cost weights.

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

Table 7: IRF Market Basket Cost Weights, Comparison of 2016 to 2021 Based Weights		
Cost Category	**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**

CMS finalizes the operating and capital price proxies, as proposed. The price proxies are the same as used for the 2016-based market basket. Table 11 in the final rule details the operating and capital price proxies that it finalizes for the 2021-based IRF market basket.

Table 12, reproduced below, compares the percent change in the 2021-based and 2016-based IRF market baskets for FYs 2019 through FY 2026. While there are small differences for 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: The 2021-Based IRF Market Basket and 2016-Based IRF Market Basket Percent Changes, FY 2019 through FY 2026			
	Fiscal Year (FY)	**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	4.9	4.8
	FY 2024	3.6	3.6
	FY 2025	3.1	3.1
	FY 2026	2.9	2.9
	Average 2023-2026	3.6	3.6

Note that these market basket percent changes do not include any further adjustments as may be statutorily required.
Source: IHS Global Inc. 2nd quarter 2023 forecast.

Commenters were generally supportive of CMS' proposal to rebase and revise the IRF market basket from a 2016 base year to a 2021 base year. Several commenters, while supportive of rebasing the IRF market basket, recommended a later base year, such as 2022 or 2023 to more fully incorporate changes to IRF cost structures. CMS appreciates the support to rebase and revise the IRF market basket and notes that 2021 is the most complete year of cost report data available. It believes that it is more appropriate to update the base year cost weights to reflect the changes over this period (2016-2021) than delay the rebasing.

CMS received limited comments on its proposed methodology for developing the major cost weights of the 2021-based IRF market basket. A few commenters noted that their review of the market basket cost categories shows only modest increases, including with respect to labor and capital-related costs despite their members experiencing much more significant actual increases in expenditures compared to 2016. Some commenters were also particularly concerned with pharmaceuticals and capital-related costs. CMS explains that while costs for a particular category may have increased from 2016 to 2021, a change in the cost weight for a particular category would require that the costs for that category grew faster relative to other cost categories. Both pharmaceuticals and capital-related costs increased over this period but at a slower rate relative to other cost categories and thus their cost weights were lower in 2021 compared with 2016.

A few commenters expressed concern that CMS' use of the IHS Global Inc. (IGI) forecast for determining the market basket update does not capture the specialized nature of IRF costs. CMS notes that the IRF market basket measures price changes over time and would not reflect increases in costs associated with change in the volume or intensity of input goods and services

until the market basket is rebased. CMS relies on the impartial economic forecasts of the price proxies used in the market basket from IGI to reflect the expected price growth for each of the cost categories in the IRF market basket. It also notes that it has consistently used IGI economic price proxy forecasts in the market baskets since the implementation of the IRF PPS.

B. Market Basket Update and Productivity Adjustment

An update factor of 3.4 percent is finalized for the IRF PPS payment rates for FY 2024, composed of the following elements listed below.

FY 2024 IRF PPS Update Factor	
IRF market basket	3.6%
Total factor productivity (TFP)	-0.2%
Total	**3.4%**

The 3.6 percent FY 2024 market basket increase factor is based on IHS Global Insight's (IGI's) forecast from the second quarter of 2023, based on actual data through the first quarter. Similarly, the statutorily required productivity adjustment of 0.2 is based on IGI's second quarter 2023 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 1.4 percent.

Based on more recent data available for the final rule, the overall update factor increases by 0.4 percent from the proposed rule (3.4 percent compared to 3.0 percent in the proposed rule).

Many commenters expressed concern that the FY 2024 payment update does not adequately factor in the effects of many challenges faced by IRFs, such as the public health emergency, inflationary pressure, higher patient acuity, sequestration, increasing labor costs due to labor shortages, and other factors. Other commenters expressed concern about the continued application of the productivity adjustment to IRFs, while others requested that CMS consider making one-time adjustments to the market basket update or applying a forecast error adjustment. CMS responds that it is required by statute to update IRF PPS payments by the market basket update adjusted for productivity and uses the most recent data available for this update. It notes that there is currently no mechanism to adjust for market basket forecast error in the IRF payment update and that given uncertainty of future price trends the forecast error may not always benefit industry as the forecast errors can be both positive and negative.

[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.

C. Labor-Related Share

CMS finalizes a total labor-related share of 74.1 percent for FY 2024, which is 1.2 percentage points higher than the FY 2023 labor share of 72.9 percent. The higher labor-related share is primarily due to the incorporation of the 2021 Medicare cost report data, which increased the Compensation cost weight by approximately 0.8 percentage points compared to the 2016-based IRF market basket. The 74.1 percent comes from the IGI second 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 2021-based IRF market basket. The relative importance reflects the different rates of price change for these cost categories between the base year (2021) and FY 2024. Table 13 of the final rule compares the components of the FY 2023 and FY 2024 labor shares.

Of the comments received on this issue, several supported CMS' proposal to increase the labor-related share. One commenter disagreed with CMS' proposal to exclude from the labor-related share the proportion of non-medical professional services fees presumed to have been purchased outside of the hospital's labor market, such as certain accounting and auditing, legal, engineering, and management consulting services. CMS disagrees as many of these services are purchased from national firms not affected by the local labor market and reiterates that it only includes a cost category in the labor-related share if its labor intensive and varies with the local labor market.

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 IPPS hospital wage index for the current fiscal year. Thus, for FY 2024 CMS will 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 final rule. For purposes of the IRF wage index, OMB-designated Micropolitan Statistical Areas[7] are

[6] New IRFs would be paid the wage index for the area in which it is 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.

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 did not make any changes for FY 2024.

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 final rule to be 1.0028. 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 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 FY 2024 index is the budget neutrality adjustment to be applied to the federal per diem base rate for FY 2024.

Commenters continue to state support for the permanent 5-percent cap on wage index decreases. One commenter encouraged CMS to implement these caps in a non-budget neutral manner to mitigate volatility caused by wage index shifts. CMS replies that it is required by statute to implement updates to the wage index under the IRF PPS in a budget neutral manner. Others encouraged CMS to continue to reform the wage index policies by revising the IRF wage index to adopt Inpatient Prospective Payment System (IPPS) policies such as geographic reclassification, rural floor, low wage adjustment, and the Outpatient Prospective Payment System (OPPS) outmigration adjustments. CMS responds that it does not have an IRF-specific wage index and is unable to determine the degree, if any, to which these IPPS/OPPS policies under the IRF PPS would be appropriate.

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

Table 14 of the final rule (reproduced below) shows the calculations used to determine the FY 2024 IRF standard payment amount. In addition, Table 15 of the final 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 final rule.

Table 14: Calculations to Determine the 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 (3.6 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 1.034
Budget Neutrality Factor for the Updates to the Wage Index and Labor-Related Share	x 1.0028
Budget Neutrality Factor for the Revisions to the CMG Relative Weights	x 1.0002
FY 2024 Standard Payment Conversion Factor	= $18,541

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 uses the 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 2.5 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 $12,526 for FY 2023 to $10,423 for FY 2024.

Updates are finalized 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 national average CCRs for FY 2023 are 0.402 for urban IRFs and 0.491 for rural IRFs, and the national CCR ceiling is 1.48. That is, if an individual IRF's CCR were to exceed this ceiling of 1.48 for FY 2024, CMS would replace the IRF's CCR with the appropriate national average CCR (either rural or urban, depending on the geographic location of the IRF).

V. 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.

These policies 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 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. 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 concludes that the restriction limiting 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, CMS finalizes its proposal to establish a uniform rule for status changes for IRF units (at §412.25(c)(1)) 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 must 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 must 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.

Noting that §412.25(c) applies to both IRFs and IPFs, CMS finalizes its proposal to make the same change for IPFs in the IPF PPS final rule in revised §412.25(c)(2). Based on stakeholder feedback, CMS adopts a consolidated regulation text that applies to both IRF and IPF units,

which is displayed in the IPF PPS final rule. CMS does not anticipate any financial impact for this modification to its regulations.

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

CMS finalizes its proposals to:

(1) Beginning with the FY 2025 IRF QRP:
- Modify the COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) measure;
- Adopt the Discharge Function Score measure; and
- Remove the following 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 (CBE #2631);
  - The IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients measure (CBE #2633); and
  - The IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients measure (CBE #2634).

(2) Beginning with the FY 2026 IRF QRP, adopt the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure.

(3) Begin public reporting of 4 measures.

The changes to the IRF QRP will result in an annual burden addition of $27.73 per IRF. The total change in annual burden hours for all IRFs will be an increase of 1,336 hours, with a total change in annual cost for all IRFs of $31,412.56.

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.

[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.

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 final rule with minor modifications) shows the current 18 measures for the FY 2024 IRF QRP, plus the changes finalized by the rule noted in italics.

IRF QRP Measure Set for FY 2024 with Finalized Changed for FYs 2025 and 2026	
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) (CBE #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 (CBE #2631): *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 (CBE #2633): *Removal of this measure beginning for FY 2025*
Change in Mobility	IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (CBE #2634): *Removal of this measure beginning for FY 2025*
Discharge Self-Care Score	IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (CBE #2635)
Discharge Mobility Score	IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (CBE #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: Addition beginning for FY 2025*
Patient/Resident COVID-19 Vaccine	*COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure: Addition beginning for FY 2026*
NHSN (National Healthcare Safety Network)	
CAUTI	NHSN Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure (CBE #0138)
CDI	NHSN Facility-wide Inpatient Hospital-Onset Clostridium difficile Infection (CDI) Outcome Measure (CBE #1717)
HCP Influenza Vaccine	Influenza Vaccination Coverage among Healthcare Personnel (CBE #0431)

IRF QRP Measure Set for FY 2024 with Finalized Changed for FYs 2025 and 2026	
Short Name	**Measure Name & Data Source**
HCP COVID-19 Vaccine	COVID-19 Vaccination Coverage among Healthcare Personnel: *Modified Measure beginning for FY 2025*
Claims-Based	
MSPB IRF	Medicare Spending Per Beneficiary (MSPB)–PAC IRF QRP (CBE #3561)
DTC	Discharge to Community–PAC IRF QRP (CBE #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 Measures

1. IRF QRP Quality Measures Beginning with the FY 2025 IRF QRP

a. *Modification of the COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) Measure*

CMS finalizes its proposal to modify the COVID-19 Vaccination Coverage Among HCP (HCP COVID-19 Vaccine) Measure beginning with the FY 2025 IRF QRP.

Background. The HCP COVID-19 Vaccine measure is a process measure developed by the CDC. It 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).

Modifications. CMS is updating the specifications of the measure to reflect the most current guidance that specifies for HCP to receive primary series and booster vaccine doses in a timely manner. The modifications are the following:

- 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.

Measure Calculation and Specifications.

- *Denominator*. 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.

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

- *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 will continue to report data for the 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 being made to the form, manner, and timing of submission, there will be no increase in burden.
- *Compliance requirements and calculations.*
    - For IRF QRP compliance in FY 2025, IRFs will 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 will use the most recent week's data to calculate the measure.
    - Each quarter, the CDC will 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 will be required to submit data for the entire calendar year.
    - Public reporting of the modified measure will begin by the September 2024 Care Compare refresh or as soon as technically feasible.

Comments and Responses. Several commenters supported the proposal, one of which said they continue to believe vaccination is critical as the most effective infection prevention to protect staff, patients, and visitors against severe illness, hospitalization, and death, and another of which encouraged CMS to continue to monitor the measure. CMS responded that it will continue to monitor all measures as part of routine monitoring.

Several commenters expressed concern that the measure did not undergo full reliability and validity testing and that it never went through a CBE endorsement process. CMS reminds commenters that the current version of the measure ("Quarterly Reporting of COVID-19 Vaccination Coverage among Healthcare Personnel") received endorsement by the CBE on July 26, 2022 (CBE #3636). The agency points out that the CBE endorsement speaks to the quality of the measure design, that the modified measure uses many of the same components as the current endorsed measure, and that the CDC, the measure developer, is seeking CBE

[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.

endorsement of the modified measure. It also reminds commenters that beta testing by the CDC of the modified measure showed that the collection of information on additional/booster dose coverage data was feasible with 63.9 percent of IRFs reporting such data to the NHSN for the first quarter of 2022, and that the measure score displayed significant differences in additional/booster vaccination coverage rates among IRFs.

Several commenters opposed the modifications, noting that the COVID-19 PHE ended on May 11, 2023, and that CMS has removed the staff vaccination requirement under the Hospital Conditions of Participation (COP). Concerns were raised that the measure is inconsistent with the requirements being lifted. Other concerns were raised that individuals choosing not to get vaccinated (or boosted) because of religious reasons are not excluded from the measure. CMS reiterates that it continues to believe in the importance of measuring vaccination status as a wellness and disease prevention mechanism to protect individuals and communities from the virus regardless of whether the COVID-19 PHE is in effect. It also distinguishes between the COP authority and vaccine requirements under §482.42(g) that were lifted, which required vaccination, and the IRF QRP, which does not require vaccination. The IRF QRP is a pay-for-reporting system, and the inclusion of the modified measure does not require an HCP to have received the additional/booster vaccine doses, but instead requires the IRF to report on the rate of HCP up-to-date vaccination.

Other commenters expressed concern about the definition of "up to date" constantly changing. Many commenters raised concern about administrative burden on the healthcare workforce. CMS states that generally the response to the virus necessitated an evolving approach, and that the updates to the measure aligns with that responsive approach to COVID-19. The agency also notes that the definition of up to date on *https://www.cdc.gov/nhsn/pdfs/hps/covidvax/UpToDateGuidance-508.pdf* will be updated quarterly to reflect any changes as the COVID-19 guidance evolves. If requirements change from one quarter to the next, providers will have the updated definition at the beginning of the quarter and have a minimum of 3 weeks to assess whether their HCP meet the definition before submitting the measure data during the self-selected week of a corresponding month. As far as burden, CMS notes IRFs have been reporting the current version since the initial submission period of October 1, 2021 through December 31, 2021, and the CDC provides frequent education to support IRFs. CMS clarifies that if the definition were to change from one quarter to the next, IRFs would not have to submit data retroactively.

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

CMS finalizes its proposal to adopt the Discharge Function Score (DC Function) measure as an assessment-based outcome 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 (PAC) settings. CMS describes that assessing functional status as a health

outcome in IRFs can provide valuable information in determining treatment decisions throughout the care continuum.

Measure Description. The DC Function measure evaluates functional status by calculating the percentage of IRF patients who meet or exceed an expected discharge function score. The measure will replace the topped-out Application of Functional Assessment/Care Plan cross-setting process measure (which is finalized for removal under section VIII.C.1.c. of the final rule). It uses a set of cross-setting assessment items which 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. The measure also 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, based on a patient's clinical characteristics and codes assigned on other standardized functional assessment data elements). In contrast, the topped-out measure treats patients with missing values the same as patients who were coded to the lowest functional status.

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

[11] 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.

[12] Validity testing of measure performance entailed determining Spearman's rank correlations between the measure's performance for providers with 20 or more stays and the performance of other publicly reported IRF quality measures. Results indicated that the DC Function measure captures the intended outcome as detailed in Table 18 of the Final Rule.

[13] 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.

[14] Cross-Setting Discharge Function TEPs and patient-family feedback showed strong support for the face validity and importance of the measure as an indicator of quality of care.

[15] 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.

the measure does not require collection of new data elements, there will be no additional burden.

Selected Comments and Responses. Several commenters did not support the adoption of the measure because it is not CBE-endorsed. CMS believes that since the measure fills gaps in the IRF QRP measurement set, is a cross-setting measure, and assesses both domains of function, it is important to adopt. It plans on submitting the measure for CBE endorsement as soon as feasible. Several commenters raised concern that the measure uses statistical imputation, which they believe overrides the clinical judgment of the clinicians. CMS clarifies that clinicians are still expected to use their clinical judgment and that statistical imputation is a component in measure calculation of reported data. It believes that by using each patient's available functional and clinical information to estimate the missing values, the measure improves on the imputation approach already implemented in the Change in Mobility Score, Change in Self-Care Score, Discharge in Mobility Score, and Discharge in Self-Care Score measures currently included in the IRF QRP. The agency explains that under the imputation approach for the DC Function measure it estimates a different recode value for each patient based on their clinical comorbidities, for codes on all other GG items (under functional abilities and goals), and for each setting. CMS further believes that the validity testing conducted showed that the DC Function measure reflected more accurate performance scores compared to the current simple imputation method used in the IRF QRP.

c. 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

CMS finalizes its proposal 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 measure will end by the September 2024 Care Compare refresh or as soon as technically feasible when public reporting of the DC Function measure begins. Beginning for the FY 2025 IRF QRP:

- IRFs will 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; and
- CMS will 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.

The measure's removal is based on the measure satisfying 2 of the 8 factors considered for removal of a measure.[16]

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

- 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 rate 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 (the DC Function measure) that is more strongly associated with desired patient functional outcomes.

Burden Assessment. CMS estimates 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 $194.79 per IRF annually (or $220,697.60 for all IRFs annually).

d. Removal of the IRF Functional Outcome Measures: Change in Self-Care Score for Medical Rehabilitation Patients and Change in Mobility Score for Medical Rehabilitation Patients

CMS finalizes its proposal to remove the following two IRF QRP Functional Outcome measures beginning with the FY 2025 IRF QRP: Change in Self-Care Score for Medical Rehabilitation Patients (Change in Self-Care Score) and the Change in Mobility Score for Medical Rehabilitation Patients (Change in Mobility Score). Public reporting of the measures will end by the September 2024 Care Compare refresh or as soon as technically feasible.

Background and Reason for Removal. 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 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.

The removal of the two measures is based on measure removal factor eight: the costs associated with each of the measures outweighs the benefits of each of the measure's uses in the IRF QRP program. CMS reasons that the 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, there is no additional estimated burden for IRFs.

Selected Comments and Responses. Several commenters support the removal of the measures since they are duplicative of other measures and their removal will reduce costs to IRFs and CMS. Several commenters did not support the removal of the measures because they believe the information on the amount of change patients experience, which is captured by these measures to be removed, is more important than capturing whether patients meet or exceed an expected amount of change (captured by the Discharge Self-Care Score and the Discharge Mobility Score measures). CMS acknowledges the trade-offs between maintaining the Change in Self-Care Score and Change in Mobility Score measures (being removed) versus the Discharge Self-Care Score and the Discharge Mobility Score measures (being retained). However, the agency points out that the majority of the technical expert panel (TEP) consulted by CMS agreed that the two measures being retained better capture a patient's relevant functional abilities, and the agency also believes the two measures being retained are more easily interpreted by many patients and their caregivers.

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

CMS finalizes its proposal 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.

Measure Description. The 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.
- 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 $222.52 per IRF annually (or by $252,110.16 for all IRFs annually).[17]

Background. CMS believes 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

[17] See Table 20 of the Final Rule for costs associated with proposals associated with OMB control number 0938-0842 for the IRF QRP.

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.

Selected Comments and Responses. A number of commenters did not support the proposal to adopt the measure. Some raised concerns that the measure is not fully tested for reliability and validity, as well as concerns about the feasibility for IRFs to collect and report the data. CMS responds that the measure was constructed based on prior use of similar items, such as the Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine included in the IRF QRP and LTCH QRP. Several commenters did not support adoption of the measure given the announcement of the end of the COVID-19 PHE. CMS emphasizes that regardless of the end of the COVID-19 PHE, the virus remains a public health priority, and it believes this measure promotes patient vaccination and education, which are important tools against the worst impacts of the virus.

Concern was also raised that the MAP did not recommend the measure for rulemaking. The MAP had recommended mitigation efforts, including exclusions for medical contraindications, conducting measure testing, and submitting the measure for CBE endorsement. CMS references section 1886(j)(7)(D)(ii) of the Act, which allows the Secretary to select non-CBE-endorsed measures when the Secretary is unable to identify a suitable CBE-endorsed measure that is available, feasible, and practical. CMS asserts that (i) the measure promotes transparency by providing patients and their caregivers with important information for informed decision-making, (ii) exclusions were not included because the focus groups with which it met provided feedback that capturing the raw vaccination rate would be most helpful in patient and family/caregiver decision-making, (iii) it plans to conduct reliability and validity measure testing once there is enough data, and (iv) it intends to submit the measure to the CBE when feasible.

A number of commenters raised concerns about the burden the measure would place on IRFs, including difficulty with data collection and keeping up with the definition of up to date. CMS responds that since gathering information about a patient's vaccination status is an important part of a plan of care, providers will likely already be collecting this information in the course of providing care. CMS acknowledges the definition of up to date may evolve, but notes changes are necessary given the nature of managing COVID-19. Providers will be able to use multiple sources of information available to obtain the vaccination data, including patient interviews, medical records, proxy response, and vaccination cards, and CMS will publish coding guidance and instructions.

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

In the proposed rule CMS invited comments on the following:

- A set of principles for selecting measures for the IRF QRP. CMS identified: (i) actionability, (ii) comprehensiveness and conciseness, (iii) focus on provider response to payment, and (iv) compliance with statutory requirements.
- The identification of measurement gaps, specifically in (i) cognitive function, (ii) behavioral and mental health, (iii) patient experience and patient satisfaction, and (iv) chronic conditions and pain management.
- Measures that are available for immediate use, or that may be adapted or developed for use, in the IRF QRP to address the identified measurement gaps.

CMS is not responding to specific comments in the final rule, but intends to use the input to inform future efforts.

1. Comments on Principles for Selecting and Prioritizing Measures

A few commenters supported the prioritization criteria identified in the RFI in the proposed rule, as well as those in the National Quality Strategy and the Universal Foundation. Several commenters requested CMS consider administrative burden associated with reporting measures, and to remove measures that are not tied to strategic quality improvement aims. Some of the other suggested criteria included: (i) whether the measure is endorsed by a CBE, (ii) the extent to which the measure focuses on a salient health care issue, (iii) the measure's technical specifications, (iv) reliability and validity, (v) implementation feasibility, and (vi) electronic availability of data.

2. Comments on Gaps in IRF QRP Measure Set and Potential New Measures

Although several commenters agreed that there are measurement gaps, some raised concerns that any additional measures would increase administrative burden. While several other commenters supported including cognitive measures for future QRP measure sets, many did not support the use of the Confusion Assessment Method (CAM) or Brief Interview of Mental Status (BIMS) cognitive assessment as a source of data. The Functional Independence Measure and patient-reported outcome measures were suggested as ways to assess cognition. Commenters supported interest in measures that would address behavioral and mental health issues, but some raised concerns that such measures would not be appropriate for the IRF setting where it is unlikely for patients with severe behavioral or mental health impairments to participate in therapy. Some commenters supported the adoption of patient experience and patient satisfaction measures derived from patient surveys, with preference expressed for the IRF Experience of Care (EOC) survey over the CoreQ survey. Some of the other measurement gaps identified included (i) health equity, (ii) care for degenerative conditions, (iii) IRF workforce safety culture, engagement, and burnout, (iv) and measure of quality of life.

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.

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). It references its solicitation of comments in the FY 2023 IRF PPS proposed rule (87 FR 20247 through 20254) regarding principles for measuring equity and healthcare quality disparities across its quality programs, and notes that it will take comments into account as it continues 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 the 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 SPADES under the IRF QRP. The agency also emphasizes the value in aligning SDOH items across all care settings, consistent with the Universal Foundation.

3. Selected Comments and Response

A couple commenters supported the idea of measure stratification by certain SDOH. Some of the other comments included (i) the suggestion that receiving patient-level data for claims-based measures on a more frequent basis would better inform decisions, and (ii) the suggestion to collect and analyze data on disability status, veteran status, preferred language, health literacy, food security, transportation access, housing stability, social support, and access to care. CMS responds that it will take comments into consideration in its future work.

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

1. Reporting Schedule for IRF-PAI Assessment Data for Discharge Function Score Measure

CMS finalizes its proposal that IRFs be required to report IRF-PAI assessment data for the Discharge Function Score (DC Function) measure beginning with patients discharged on October 1, 2023, for purposes of the FY 2025 IRF QRP. Starting in CY 2024, IRFs will 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. No comments on the proposal were received by CMS.

2. 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

CMS finalizes its proposal that IRFs be required to report IRF-PAI assessment data related to the Patient/Resident COVID-19 Vaccine measure beginning with patients discharged on October 1, 2024, for purposes of the FY 2026 IRF QRP. Starting in CY 2025, IRFs will be required to submit data for the entire calendar year beginning with the FY 2027 IRF QRP. CMS is also finalizing its proposal 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.[18]

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.

2. Public Reporting of the Transfer of Health Information (TOH) to the Provider – Post-Acute Care (PAC) Measure and TOH Information to the Patient – PAC Measure

CMS finalizes its proposal to begin publicly displaying data for the TOH-Provider PAC measure and TOH-Patient PAC measure beginning with the September 2025 Care Compare refresh or as soon as technically feasible. These 2 assessment-based measures had been 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.

[18] 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.

As finalized, CMS will publicly display four rolling quarters of the data received for the measures, initially using data on discharges from January 1, 2023, through December 31, 2023. It will 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.

Selected Comments and Responses. Several commenters supported the proposal, saying that the information will provide helpful information to consumers.

3. Public Reporting of the Discharge Function Score (DC Function) Measure

CMS finalizes its proposal 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 will be provided to IRFs in June 2024, or as soon as feasible; thereafter, IRFs measure scores will be publicly displayed based on 4 quarters of data and updated quarterly. CMS will 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. Public Reporting of COVID-19 Vaccine: Percent of Patients/Residents Who are Up to Date Quality Measure

CMS finalizes its proposal to begin public display of data for this 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 will be distributed to IRFs in June 2025 for data collected in Q4 of 2024 and thereafter the data will be publicly displayed based on one quarter of data updated quarterly. An IRF's performance on the measure will not be publicly reported if the IRF had fewer than 20 eligible cases in the quarter.

Selected Comments and Responses. Several commenters questioned reporting only one quarter of data. CMS responds that public reporting on a rolling quarterly basis aligns with the existing HCP COVID-19 Vaccine measure, and this allows for the information to be updated quarterly with the most recent data, in contrast to averaging data over 12 months.

VII. Regulatory Impact Analysis

CMS estimates that the final rule will increase Medicare payments to IRFs by $355 million in FY 2024 compared with FY 2023. This reflects the 3.4 percent increase from the update factor and a 0.6 percent increase in estimated IRF outlier payments, which will increase aggregate payments to IRFs by an estimated 4.0 percent. Table 21 in the final 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

$355 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	1,133	385,653	0.6	0.0	0.0	4.0
Urban unit	648	137,080	1.0	0.0	0.0	4.5
Rural unit	135	16,844	0.9	-0.4	0.0	3.9
Urban hospital	338	226,579	0.2	0.0	0.0	3.7
Rural hospital	12	5,150	0.2	-0.8	0.1	2.8
Urban For-Profit	424	221,988	0.3	0.0	0.0	3.7
Rural For-Profit	35	8,209	0.4	-0.7	0.0	3.1
Urban Non-Profit	480	123,128	0.9	0.1	0.0	4.4
Rural Non-Profit	91	11,642	1.0	-0.3	0.0	4.0
Urban Government	82	18,543	1.0	0.0	0.0	4.5
Rural Government	21	2,143	0.6	-0.5	0.0	3.4
Urban	986	363,659	0.5	0.0	0.0	4.0
Rural	147	21,994	0.7	-0.5	0.0	3.6
Urban by region						
Urban New England	29	13,450	0.4	-0.2	0.0	3.6
Urban Middle Atlantic	118	40,542	0.7	0.5	0.0	4.7
Urban South Atlantic	170	81,632	0.5	0.1	0.0	4.0
Urban East North Central	164	43,093	0.6	-0.5	0.0	3.5
Urban East South Central	55	25,607	0.2	-0.1	0.0	3.5
Urban West North Central	77	21,080	0.6	0.1	0.0	4.1
Urban West South Central	201	87,094	0.3	0.3	0.0	4.0
Urban Mountain	77	27,560	0.5	-1.0	0.0	2.8
Urban Pacific	95	23,601	1.2	0.3	0.0	5.0
Rural by region						
Rural New England	5	1,054	0.8	-2.3	0.2	2.0
Rural Middle Atlantic	10	1,048	1.1	-0.5	0.0	4.1
Rural South Atlantic	15	3,957	0.3	0.2	0.0	3.9
Rural East North Central	24	2,939	0.6	-0.6	0.0	3.4

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 East South Central	21	3,453	0.3	-0.6	0.0	3.0
Rural West North Central	20	2,374	1.2	-0.5	-0.1	4.0
Rural West South Central	43	6,423	0.8	-0.5	0.0	3.7
Rural Mountain	6	461	1.7	-0.1	0.0	4.9
Rural Pacific	3	285	3.1	-0.3	0.0	6.2
Teaching status						
Non-teaching	1,030	341,160	0.5	-0.1	0.0	3.9
Resident to ADC less than 10%	58	32,410	0.7	0.3	0.0	4.4
Resident to ADC 10%-19%	33	10,675	1.1	0.6	0.0	5.2
Resident to ADC greater than 19%	12	1,408	1.4	0.7	-0.1	5.5
Disproportionate share patient percentage (DSH PP)						
DSH PP = 0%	49	6,136	0.7	0.5	0.0	4.6
DSH PP <5%	137	60,402	0.4	0.4	0.0	4.1
DSH PP 5%-10%	233	92,942	0.4	0.0	0.0	3.9
DSH PP 10%-20%	415	150,180	0.6	-0.1	0.0	3.8

[1] This column includes the impact of the updates in columns (4), (5), and (6), and of the IRF market basket update for FY 2024 of 3.6 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.