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Medicare Inpatient Rehabilitation Facility Prospective Payment System for FY 2023 and Updates to the IRF Quality Reporting Program Final Rule Summary

On July 27, 2022, the Centers for Medicare & Medicaid Services (CMS) placed on public display a final rule on the Medicare inpatient rehabilitation facility prospective payment system (IRF PPS) for federal fiscal year (FY) 2023.

In addition to provisions that would update the IRF PPS payment rates and outlier threshold for FY 2023, this rule establishes a permanent cap policy 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. The rule adopts one policy change to the IRF Quality Reporting Program (QRP) that will require quality data reporting for all IRF admissions regardless of payer. In response to comments, CMS delays the start of reporting from FY 2023 to FY 2024. The final rule will be published in the August 1, 2022 issue of the *Federal Register.* **These regulations are effective on October 1, 2022, unless otherwise noted.**

CMS estimates that the Medicare IRF PPS payments in FY 2023 will be about $275 million higher than in FY 2022.

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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 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] These 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 finalized 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 (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 0.9979.

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

CMS says that the 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 final rule (section IX below) shows the distributional effects of the changes in the CMGs by type of facility.

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

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 3.9 percent is finalized for the IRF PPS payment rates for FY 2023, composed of the following elements listed below.

FY 2023 IRF PPS Update Factor	
Market basket	4.2%
Total factor productivity (TFP)	-0.3%
Total	3.9%

The 4.2 percent FY 2023 market basket increase factor is based on IHS Global Insight's (IGI's) forecast from the second quarter of 2022, based on actual data through the first quarter. Similarly, the statutorily required productivity adjustment is based on IGI's second quarter 2022 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 1.9 percent.

Based on more recent data available for the final rule, the overall update factor increased by 1.1 percentage points from the proposed rule (3.9 percent compared to 2.8 percent in the proposed rule).

Several commenters expressed concern that the proposed market basket update was inadequate relative to input price inflation experienced by IRFs. They suggest that the PHE, along with inflation, has significantly driven up operating costs and that these costs are not reflected in the market basket update. CMS notes that it is required by statute to update IRF PPS payments by the market basket update adjusted for productivity. CMS states that it used more recent data to update its final market basket update which incorporated and captures the revised outlook regarding the U.S. economy and expected price inflation. Based on IGI's second quarter 2022 forecast (with historical data through the first quarter of 2022), CMS projected a FY 2023 forecast of 4.2 percent and a productivity adjustment of 0.3 percentage points. It notes that this final market basket for IRFs is the highest market basket update implemented in a final rule since the beginning of the IRF PPS.

[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.

B. Labor-Related Share

CMS finalizes a total labor-related share of 72.9 percent for FY 2023, same as FY 2022. The 72.9 percent comes from the most recent forecast (IGI second quarter 2022) estimate of the sum of the relative importance of Wages and Salaries; Employee Benefits; Professional Fees: Labor-Related; Administrative and Facilities Support Services; Installation, Maintenance and Repair; All Other: Labor-related Services; and a portion (46 percent) of the Capital-Related cost weight from the IRF market basket. The relative importance reflects the different rates of price change for these cost categories between the base year (2016) and FY 2023. Table 4 of the final rule compares the components of the FY 2022 and 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 will 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 final 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 did not make such a proposal for FY 2023.

CMS proposed 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

[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.

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.

For FY 2023, CMS finalizes its proposal 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 will not be less than 95 percent of its final wage index for FY 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. A new IRF 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 it 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 final rule to be 1.0002. 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 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 FY 2023 index is the budget neutrality adjustment to be applied to the federal per diem base rate for FY 2023.

MedPAC expressed support for the 5-percent permanent cap on wage index decreases, but recommended that the 5-percent cap limit should apply to increases as well as decreases in the wage index. CMS states in its response that the purpose of its policy is to mitigate the significant negative impacts of certain wage index changes. CMS also believes it is appropriate for providers to receive the full benefit of their increased wage index value.

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

Table 5 of the final rule (reproduced below) shows the calculations used to determine the FY 2023 IRF standard payment amount. In addition, Table 6 of the final 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 final rule.

Table 5: Calculations to Determine the 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 (4.2 percent), reduced by 0.3 percentage point for the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act	x 1.039
Budget Neutrality Factor for the Updates to the Wage Index and Labor-Related Share	x 1.0002
Budget Neutrality Factor for the Revisions to the CMG Relative Weights	x 0.9979
FY 2023 Standard Payment Conversion Factor	= $17,878

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 uses 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 3.6 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 $12,526 for FY 2023.

Updates are finalized 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 will 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 final national average CCRs for FY 2023 are 0.392 for urban IRFs and 0.466 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 national average CCR (either rural or urban, depending on the geographic location of the IRF).

Several commenters expressed concerns with the proposed outlier threshold amount and suggested that CMS consider making temporary changes due to the COVID-19 PHE. These

suggestions included blending multiple years of data or averaging the current 2022 threshold with the proposed threshold, using a charge inflation factor from prior years, and adjusting the CCRs used in the outlier calculation. In its response, CMS notes that the FY 2021 data reflect changes in IRF utilization related to the PHE and will therefore be more likely to reflect IRF utilization in FY 2023. It also believes that arbitrarily lowering the outlier threshold would fail to address that CMS estimates for FY 2022 it is overpaying by 0.6 percent the established outlier pool of 3 percent for the IRF PPS.

V. Codification and Clarifications of IRF Teaching Status Adjustment Policy

A. Codification of Existing Teaching Status Adjustment Policies

CMS finalized its proposal to codify CMS' existing teaching status adjustment policy through amendments to the regulation text and updates and clarifies 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 codifies this at §412.624(e)(4).

CMS also codifies 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 IRF's closure or an IRF's medical residency training program closure. It codifies CMS' existing IRF PPS' teaching hospital adjustment policies through amendments to §412.602, except as specifically noted with respect to its update to the IRF teaching policy on IRF program closures and displaced residents (as discussed below).

Most commenters were supportive of CMS codifying and consolidating the definition of the teaching status adjustment factor and how the adjustment is calculated in the regulation.

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

CMS finalizes its proposal 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 adopts 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 resident cap.

In addition, CMS changes 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 will 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 finalizes 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, to 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 finalizes 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 will be voluntary and made at the sole discretion of the originating IRF. It will also be the originating IRF's responsibility to determine how much of an available cap slot will 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.

Commenters were generally supportive of its proposal to amend §412.602 and §412.624(e)(4) to codify its longstanding polices regarding the teaching status adjustment. They also appreciated CMS clarifying the definition of a displaced resident for the purpose of reallocating the FTE to a new IRF, mitigating prior delayed transfer issues.

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

CMS currently adjusts 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 IRF is freestanding or hospital-based. Each of these factors is 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 final 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 sought comment from stakeholders on the methodology used to determine the facility-level adjustment factors and suggestions for possible updates and refinements to this methodology. It also welcomed ideas and suggestions as to what could be driving the changes observed in these adjustment factors from year-to-year. CMS did not respond to specific comments submitted in response to this solicitation but states it will take these into account in future development of payment policies.

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 policy change could have on patient access to appropriate post-acute care services?

CMS did not respond to specific comments submitted in response to this solicitation but states it will take these into account in future development of payment policies.

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

The IRF QRP 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. The IRF standardized patient assessment instrument (IRF-PAI) is used for quality data collection and reporting and includes standardized patient assessment data elements (SPADEs) that are interoperable and common across post-acute care (PAC) providers.

There were no changes proposed to the program's measure set for reporting for FY 2023, which is reproduced further below in this section. Additional information about the program is available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting.

A. All-Payer IRF QRP Reporting Requirement

1. Final Actions

CMS finalizes its proposal to require that an IRF-PAI be collected on each patient cared for in an IRF, regardless of payer, but delays implementation for a year. Facilities will be required to begin all-payer data collection on October 1, 2024 for IRF rate year FY 2026. Until now, facilities have been required to 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.

[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.

CMS also finalizes conforming changes regarding all-payer data collection and submission at §§ 412.604, 412.606, 412.610, 412.614, and 412.618 as proposed with modifications to reflect the 1-year delay in implementing all-payer reporting. The modifications appear at §§412.604(c), 412.606(a)(1), and 412.606(b)(1). CMS additionally finalizes without change at §412.610(f) to require IRFs to maintain IRF-PAIs completed on non-Medicare patients for a 5-year period. The existing 10-year record maintenance period continues to apply for IRF-PAIs completed on Medicare Part A and Part C patients.

Lastly, CMS finalizes as proposed a regulation text change to correct an erroneous cross reference at §412.614(d)(2).

2. Operational Details

CMS states that the additional patient assessments will be included when determining whether a facility has met the data completion thresholds of the IRF QRP as is required for a facility to receive a full annual update. All-payer data from discharges between October 1, 2024 and December 31, 2024 will be added to the Medicare Part A and Part C data for discharges from January 1, 2024 through September 30, 2024 for the purpose of calculating data completeness rates for facilities for IRF rate year FY 2026. Completeness calculations for FY 2027 and subsequent years will be based entirely on all-payer data. CMS clarifies that all-payer data will not be used for IRF PPS rate-setting updates but used only in facility-level quality-related annual update factor calculations.

CMS notes that all-payer data collection will require use of a revised IRF-PAI. A draft version (with planned effective date October 1, 2022) is available for download at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-PAI-and-IRF-PAI-Manual.

3. Summary of Comments

CMS notes having received input from 61 commenters but does not state how many addressed the all-payer data collection proposal. Highlights are provided below from the preamble's fairly lengthy and detailed comment summary. No comments were received about the proposed changes to regulation text.

CMS indicates that some commenters fully supported the proposal for all-payer data collection, other than the implementation timeline. Many commenters supported the proposal in concept but objected to the timeline for adoption as too short. They also expressed operational concerns such as applicability of new SPADEs to other-than-Medicare patients, privacy safeguards and public reporting, and facility reporting burden.

CMS clarifies that IRFs will submit all-payer data in the same manner and using the same methods currently in use: IRF-PAI completion with submission through the agency's Internet Quality Improvement and Evaluation System (iQIES) and in accordance with the existing IRF-

PAI data submission deadlines (roughly 4 months after the end of a reporting quarter).[5] CMS further clarifies that the same IRF-PAI data completeness threshold will apply regardless of payer: 100 percent of required data is present for 95 percent of assessments submitted. Regarding reporting for "interrupted stays"—when a patient is discharged from an IRF and returns to that same IRF within 3 consecutive calendar days—CMS states that IRFs are expected to follow existing guidance for reporting interrupted stays regardless of payer.

Some commenters expected to encounter difficulties in completing certain newly required IRF-PAI SPADEs on pediatric patients beginning with FY 2023 (e.g., hearing, speech, and vision). CMS disagrees with commenters that the new items are inappropriate for pediatric patient reporting. The agency reviews several new measures in detail and provides rationales for the value these SPADEs add to the IRF QRP (e.g., better capture of medical complexity for all patients). CMS notes that the IRF-PAI guidance manual provides directions for providers about how to indicate when an item does not apply to a particular patient; doing so will cause the measure to be considered complete and countable toward the data completeness threshold.

Concerns were voiced about maintaining privacy of data submitted by IRFs about patients for whom Medicare is not their payer. CMS states that required IRF-PAI data collection is already covered under an existing System of Records Notices (SORN) number and will be treated by CMS as Protected Health Information as defined by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. Further, CMS notes that all-payer data submission is required only for those SPADEs necessary to calculate IRF QRP measure scores, not for all SPADEs. CMS describes in detail the security features of its data systems and processes. CMS emphasizes that the agency made no proposals about public reporting of any data submitted about patients for whom Medicare is not their payer and that any future public reporting proposals would be made only through notice-and-comment rulemaking.

Multiple commenters opposed the all-payer requirement because of the substantial new time and cost burdens that will be imposed on IRFs. CMS acknowledges that burden will increase but defends its burden estimates and views the burden as clearly outweighed by the benefits of all-payer data collection. CMS indicates that some burden reduction may accrue to facilities that no longer have to sort patients by payer for data collection purposes. CMS provides burden estimates related to all-payer quality data submission in sections XIII.B. and XIV.B. of the rule: 237 hours and $28,505 per IRF on average and 476,178 hours and $31,783,532 in aggregate for 1,115 facilities.

Commenters further objected to the added costs of all-payer data collection when IRF resources are already strained by costs associated with the COVID-19 PHE. Commenters also noted the widespread and significant staff shortages faced by IRFs that will be exacerbated when more staff time is needed to complete IRF-PAIs on all patients as well as to collect and submit the extra data. CMS notes that serious staff shortages have existed since well before the PHE's start.

[5] More information is available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Data-Submission-Deadlines.

CMS ends by emphasizing the benefits that the agency believes will be realized from the finalized all-payer data submission requirement, including:

- Conducting data collection in accordance with the Improving Medicare Post-Acute Transformation Act (IMPACT Act, 2014);
- Facilitating comparison of health outcomes across post-acute care settings;
- Fuller understanding of the impact of the PHE on IRFs;
- Having a more representative quality database from which to monitor quality of care delivered by IRFs and to accurately assess resources consumed in delivering that care;
- Allowing CMS to make more precise, data-driven decisions about quality-based IRF payment adjustments; and
- Detecting care disparities among patient subpopulations treated within IRFs (e.g., between private payer and Medicare patients).

B. Table of IRF QRP Measures Adopted for the FY 2023 IRF QRP

(Table 11 reproduced from the rule)

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)

IRF QRP Measure Set for FY 2023	
Short Name	**Measure Name & Data Source** *(new or revised are in italics)*
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

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

In the proposed rule, CMS requested input on three concept areas in which one or more measures could be developed for future use in the IRF QRP. The agency briefly describes comments received about each and does not describe specific next steps.

- A functional measure for use across all PAC settings that would incorporate both of the domains of self-care and mobility
  - CMS states that a majority of commenters were supportive of this measure concept. Many requested additional details including measure specifications.
- Health equity structural measures that assess an organization's leadership in advancing health equity goals or assess progress towards achieving equity priorities
  - Commenters were noncommittal about this concept but they cautioned CMS about adding provider burden and encouraged use of existing data elements in these measures whenever possible.
- COVID-19 Vaccination Coverage among post-acute care patients (e.g., IRFs, skilled nursing facilities)
  - CMS states that some commenters supported this measure concept while others wished to see measure specifications and encouraged seeking NQF endorsement.

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

CMS requested input into requiring electronic submission of quality data from IRFs via their electronic health records (EHRs) and specifically about the future adoption of the CDC's National Health Safety Network's (NHSN) *Healthcare-Associated Clostridioides difficile Infection Outcome Measure (HA-CDI)* as the IRF QRP's first digital quality measure (dQM). IRFs currently report a less complex, chart-abstracted NHSN *C. difficile* infection measure to the CDC. (The detailed questions originally posed by CMS in the RFI are repeated in the rule in section XI.D.)

CMS briefly describes comments received, excerpted below, and does not discuss specific next steps.

- The digital measure appears to support more accurate diagnosis of *C. difficile* infection than the one currently reported by IRFs to CDC.
- Uptake of EHRs by IRFs has been limited and uneven nationwide due to cost constraints, and CMS should provide incentive payments to IRFs to adopt EHRs.
    - Several commenters indicated willingness to participate in an EHR pilot program in which the *C. difficile* dQM would be tested.
    - Others suggested trialing the dQM instead in acute care hospitals with well-established EHRs.
- A transition period would be helpful to IRFs in moving from the chart-abstracted measure to the dQM and commenters favored a 2-year period.
- Data integrity and cyberattack risk concerns were expressed.

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

In the proposed rule's RFI, CMS invited comments on key principles for consideration when addressing disparities through quality measure development and stratification. The agency does not respond directly to each comment but summarizes some of the input received. Specific next steps are not stated. Excerpts from the CMS summary comments are provided below under the topic areas from the proposed rule's RFI. (The topics and their associated questions posed by CMS in the proposed rule are repeated in full in section E.1. of the final rule.)

Hospital Commitment to Health Equity

CMS requested input about adopting a structural measure for the IRF QRP to assess engagement of hospital leadership in collecting health equity performance data. Attestation would be required in 5 domains: strategic plan for disparities reduction; demographic and social risk factor data collection; disparities analysis; quality improvement activities; and leadership involvement in reducing disparities. Most commenters did not support the structural measure for IRF QRP adoption. Objections raised included failure to provide actionable data, lack of evidence linking the measure to improved health outcomes, and duplication of ongoing efforts by IRFs to provide inclusive and culturally competent care.

Health Equity Summary Score (HESS)

CMS sought input about adapting the (HESS) for use in the IRF QRP. The HESS is a composite measure that 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.[6] Support was divided. Criticisms included technical challenges (e.g., small IRF sample sizes) and failure to provide actionable insights for facilities.

Identification of Goals and Approaches for Measuring Healthcare Disparities and Using Measure Stratification Across CMS Quality Reporting Programs

[6] 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.

Commenters generally supported combining within- and between-provider disparity methods to present stratified IRF QRP results and emphasized the importance of risk adjustment (e.g., through peer grouping) and confidential reporting. Two of 3 commenters supported the use of performance disparity decomposition techniques, although noted methodological complexity beyond the capabilities of most IRFs. One opposed the Blinder-Oaxaca methodology suggested by CMS for this purpose.[7]

Principles for Social Risk Factor and Demographic Data Selection and Use
Commenters supported collection of a broad range of social risk and demographic variables and emphasized the relevance for the IRF QRP of collecting disability-related variables.

Guiding Principles for Selecting and Prioritizing Measures for Disparity Reporting
Identification of Meaningful Performance Differences
Commenters recommended that prioritizing measures should precede the selection of methods for use in identifying meaningful performance differences. Peer grouping received support for use to identify differences while rank ordering and percentile assignment did not. CMS was encouraged to set high reliability standards, using techniques such as setting case minimums.

Guiding Principles for Reporting Disparity Measures
Commenters supported confidential reporting to facilities and to promptly begin sharing with facilities stratified results for existing measures.

IX. Regulatory Impact Analysis

CMS estimates that the final rule will increase Medicare payments to IRFs by $275 million in FY 2023 compared with FY 2022. This reflects the 3.9 percent increase from the update factor (+ $330 million) and the change in the outlier threshold (-$55 million). This results in a net increase of $275 million in payments to IRFs or an estimated 3.2 percent. Table 14 in the final rule, reproduced below, shows the effects of these and other policy changes by type of IRF. The other policy changes shown in Table 14 (excerpt reproduced below) involving the wage index, 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 $275 million figure excludes the effects of payment reductions to IRFs that fail to meet the IRF QRP requirements.

[7] Regression decomposition may allow estimation of relative contributions of multiple demographic and social risk variables when disparities have multifactorial origins. Cited by CMS was 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.

Excerpt of 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	Permanent Wage Index Decreases Cap	CMG Weights	Total Percent Change [1]
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Total	1,118	381,561	-0.6	0.0	0.0	0.0	3.2
Urban unit	654	144,567	-1.1	0.0	0.0	-0.2	2.6
Rural unit	134	17,810	-0.9	0.0	0.0	-0.1	2.9
Urban hospital	318	213,991	-0.3	0.0	0.0	0.1	3.7
Rural hospital	12	5,193	-0.2	-0.1	0.0	0.1	3.7
Urban For-Profit	399	207,219	-0.3	0.0	0.0	0.1	3.7
Rural For-Profit	35	8,074	-0.3	0.0	0.0	0.1	3.7
Urban Non-Profit	487	132,031	-1.0	0.0	0.0	-0.1	2.7
Rural Non-Profit	90	12,472	-0.9	-0.1	0.0	-0.1	2.7
Urban Government	86	19,308	-1.3	-0.1	0.0	-0.2	2.3
Rural Government	21	2,457	-0.8	-0.1	0.0	-0.1	2.9
Urban	972	358,558	-0.6	0.0	0.0	0.0	3.2
Rural	146	23,003	-0.7	-0.1	0.0	0.0	3.1
Teaching status							
Non-teaching	1,015	336,600	-0.6	0.0	0.0	0.0	3.3
Resident to ADC less than 10%	58	32,033	-0.7	0.1	0.0	-0.1	3.2
Resident to ADC 10%-19%	36	11,929	-1.3	0.1	0.0	-0.3	2.4
Resident to ADC > 19%	9	999	-1.2	0.6	0.0	-0.1	3.3
Disproportionate share patient percentage (DSH PP)							
DSH PP = 0%	51	6,477	-0.6	-0.2	0.0	0.0	3.0
DSH PP <5%	135	54,839	-0.7	-0.1	0.0	0.1	3.2
DSH PP 5%-10%	250	99,408	-0.4	0.0	0.0	0.1	3.5
DSH PP 10%-20%	392	144,541	-0.6	0.0	0.0	0.0	3.3
DSH PP greater than 20%	290	76,296	-0.9	0.0	0.0	-0.1	2.8

[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 (4.2 percent), reduced by 0.3 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 results in more accurate payments as well as maintaining the targeted 3 percent outlier pool.