

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS–1804–P]

RIN 0938–AV31

Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2025 and Updates to the IRF Quality Reporting Program

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Proposed rule.

SUMMARY: This rule proposes updates to the prospective payment rates for inpatient rehabilitation facilities (IRFs) for Federal fiscal year (FY) 2025. As required by statute, this proposed rule includes the classification and weighting factors for the IRF prospective payment system's case-mix groups and a description of the methodologies and data used in computing the prospective payment rates for FY 2025. We are proposing updates to the Office of Management and Budget (OMB) market area delineations for the IRF prospective payment system (PPS) wage index and proposing to apply a 3-year phase-out of the rural adjustment. This rule also includes proposals for the IRF Quality Reporting Program (QRP).

DATES: To be assured consideration, comments must be received at one of the addresses provided below, by May 28, 2024.

ADDRESSES: In commenting, please refer to file code CMS–1804–P.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to <https://www.regulations.gov>. Follow the “Submit a comment” instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1804–P, P.O. Box 8016, Baltimore, MD 21244–8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1804–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT:

Patricia Taft, (410) 786–4561, for general information.

Kim Schwartz, (410) 786–2571, for information about the IRF payment policies, payment rates and coverage policies.

Ariel Cress, (410) 786–8571, for information about the IRF quality reporting program.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: <https://www.regulations.gov>. Follow the search instructions on that website to view public comments. CMS will not post on *Regulations.gov* public comments that make threats to individuals or institutions or suggest that the commenter will take actions to harm an individual. CMS continues to encourage individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

Plain Language Summary: In accordance with 5 U.S.C. 553(b)(4), a plain language summary of this rule may be found at <https://www.regulations.gov>.

I. Executive Summary

A. Purpose

This proposed rule updates the prospective payment rates for IRFs for FY 2025 (that is, for discharges occurring on or after October 1, 2024, and on or before September 30, 2025) as

required under section 1886(j)(3)(C) of the Social Security Act (the Act). As required by section 1886(j)(5) of the Act, this proposed rule includes the classification and weighting factors for the IRF PPS's case-mix groups (CMGs), a description of the methodologies and data used in computing the prospective payment rates for FY 2025, and revised OMB core-based statistical area delineations from the July 21, 2023, OMB Bulletin (No. 23–01) for the IRF PPS wage index. This proposed rule includes three proposals for the FY 2028 IRF QRP and two Requests for Information (RFIs).

This proposed rule proposes the collection of four new items as standardized patient assessment data elements and the modification of one item collected as a standardized patient assessment data element, in the IRF–Patient Assessment Instrument (IRF–PAI) beginning with the FY 2028 IRF QRP. This proposed rule also proposes to remove one assessment item from the IRF–PAI beginning October 1, 2026. In addition, this proposed rule requests information on quality measure concepts for the IRF QRP in future years and an IRF star rating system.

B. Summary of Major Provisions

In this proposed rule, we use the methods described in the FY 2024 IRF PPS final rule (88 FR 50956) to update the prospective payment rates for FY 2025 using updated FY 2023 IRF claims and the most recent available IRF cost report data, which is FY 2022 IRF cost report data. We are also proposing to use the revised OMB market area delineations from the July 21, 2023, OMB Bulletin (No. 23–01) for the IRF PPS wage index, and to apply a 3-year phase-out of the rural adjustment for those IRFs changing from rural to urban.

Beginning with the FY 2028 IRF QRP, we are proposing four new items as standardized patient assessment data elements to be collected and submitted using the IRF–PAI: one item for Living Situation, two items for Food, and one item for Utilities. Additionally, we are proposing to modify the current Transportation item, and to remove one item (Admission Class) from the IRF–PAI. Finally, we are seeking input from interested parties on future IRF QRP quality measure concepts and an IRF star rating system.

C. Summary of Impact

TABLE 1: Cost and Benefit

Provision Description	Transfers/Costs
FY 2025 IRF PPS payment rate update	The overall economic impact of this final rule is an estimated \$255 million in increased payments from the Federal Government to IRFs during FY 2025.
FY 2028 IRF QRP changes	The overall economic impact of this final rule is an estimated increase in cost to IRFs of \$392,113.40 beginning with the FY 2028 IRF QRP.

II. Background

A. Statutory Basis and Scope for IRF PPS Provisions

Section 1886(j) of the Act provides for the implementation of a per-discharge PPS for inpatient rehabilitation hospitals and inpatient rehabilitation units of a hospital (collectively, hereinafter referred to as IRFs). Payments under the IRF PPS encompass inpatient operating and capital costs of furnishing covered rehabilitation services (that is, routine, ancillary, and capital costs), but not direct graduate medical education costs, costs of approved nursing and allied health education activities, bad debts, and other services or items outside the scope of the IRF PPS. A complete discussion of the IRF PPS provisions appears in the original FY 2002 IRF PPS final rule (66 FR 41316) and the FY 2006 IRF PPS final rule (70 FR 47880) and we provided a general description of the IRF PPS for FYs 2007 through 2019 in the FY 2020 IRF PPS final rule (84 FR 39055 through 39057). A general description of the IRF PPS for FYs 2020 through 2024, along with detailed background information for various other aspects of the IRF PPS, is now available on the CMS website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS>.

Under the IRF PPS from FY 2002 through FY 2005, the prospective payment rates were computed across 100 distinct CMGs, as described in the FY 2002 IRF PPS final rule (66 FR 41316). We constructed 95 CMGs using rehabilitation impairment categories (RICs), functional status (both motor and cognitive), and age (in some cases, cognitive status and age may not be a factor in defining a CMG). In addition, we constructed five special CMGs to account for very short stays and for patients who expire in the IRF.

For each of the CMGs, we developed relative weighting factors to account for a patient's clinical characteristics and expected resource needs. Thus, the weighting factors accounted for the relative difference in resource use across

all CMGs. Within each CMG, we created tiers based on the estimated effects that certain comorbidities would have on resource use.

We established the Federal PPS rates using a standardized payment conversion factor (formerly referred to as the budget-neutral conversion factor). For a detailed discussion of the budget-neutral conversion factor, please refer to our FY 2004 IRF PPS final rule (68 FR 45684 through 45685). In the FY 2006 IRF PPS final rule (70 FR 47880), we discussed in detail the methodology for determining the standard payment conversion factor.

We applied the relative weighting factors to the standard payment conversion factor to compute the unadjusted prospective payment rates under the IRF PPS from FYs 2002 through 2005. Within the structure of the payment system, we then made adjustments to account for interrupted stays, transfers, short stays, and deaths. Finally, we applied the applicable adjustments to account for geographic variations in wages (wage index), the percentage of low-income patients, location in a rural area (if applicable), and outlier payments (if applicable) to the IRFs' unadjusted prospective payment rates.

For cost reporting periods that began on or after January 1, 2002, and before October 1, 2002, we determined the final prospective payment amounts using the transition methodology prescribed in section 1886(j)(1) of the Act. Under this provision, IRFs transitioning into the PPS were paid a blend of the Federal IRF PPS rate and the payment that the IRFs would have received had the IRF PPS not been implemented. This provision also allowed IRFs to elect to bypass this blended payment and immediately be paid 100 percent of the Federal IRF PPS rate. The transition methodology expired as of cost reporting periods beginning on or after October 1, 2002 (FY 2003), and payments for all IRFs now consist of 100 percent of the Federal IRF PPS rate.

Section 1886(j) of the Act confers broad statutory authority upon the

Secretary to propose refinements to the IRF PPS. In the FY 2006 IRF PPS final rule (70 FR 47880) and in correcting amendments to the FY 2006 IRF PPS final rule (70 FR 57166), we finalized a number of refinements to the IRF PPS case-mix classification system (the CMGs and the corresponding relative weights) and the case-level and facility-level adjustments. These refinements included the adoption of the Office of Management and Budget's (OMB's) Core-Based Statistical Area (CBSA) market definitions; modifications to the CMGs, tier comorbidities; and CMG relative weights, implementation of a new teaching status adjustment for IRFs; rebasing and revising the market basket used to update IRF payments, and updates to the rural, low-income percentage (LIP), and high-cost outlier adjustments. Beginning with the FY 2006 IRF PPS final rule (70 FR 47908 through 47917), the market basket used to update IRF payments was a market basket reflecting the operating and capital cost structures for freestanding IRFs, freestanding inpatient psychiatric facilities (IPFs), and long-term care hospitals (LTCHs). Any reference to the FY 2006 IRF PPS final rule in this final rule also includes the provisions effective in the correcting amendments. For a detailed discussion of the final key policy changes for FY 2006, please refer to the FY 2006 IRF PPS final rule.

In response to COVID-19 Public Health Emergency (PHE), we published two interim final rules with comment period affecting IRF payment and conditions for participation. The interim final rule with comment period (IFC) entitled "Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency," published on April 6, 2020 (85 FR 19230) (hereinafter referred to as the April 6, 2020 IFC), included certain changes to the IRF PPS medical supervision requirements at 42 CFR 412.622(a)(3)(iv) and 412.29(e) during the PHE for COVID-19. In addition, in the April 6, 2020 IFC, we removed the post-admission physician evaluation requirement at § 412.622(a)(4)(ii) for all

IRFs during the PHE for COVID–19. In the FY 2021 IRF PPS final rule, to ease documentation and administrative burden, we permanently removed the post-admission physician evaluation documentation requirement at § 412.622(a)(4)(ii) beginning in FY 2021.

A second IFC, entitled “Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program,” was published on May 8, 2020 (85 FR 27550) (hereinafter referred to as the May 8, 2020 IFC). Among other changes, the May 8, 2020 IFC included a waiver of the “3-hour rule” at § 412.622(a)(3)(ii) to reflect the waiver required by section 3711(a) of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) (Pub. L. 116–136, enacted on March 27, 2020). In the May 8, 2020 IFC, we also modified certain IRF coverage and classification requirements for freestanding IRF hospitals to relieve acute care hospital capacity concerns in States (or regions, as applicable) experiencing a surge during the PHE for COVID–19. In addition to the policies adopted in our IFCs, we responded to the PHE with numerous blanket waivers¹ and other flexibilities,² some of which are applicable to the IRF PPS. CMS finalized these policies in the Calendar Year 2023 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems final rule with comment period (87 FR 71748). Subsequently, on May 11, 2023, the U.S. Department of Health and Human Services (“HHS”) declared the expiration of the COVID–19 public health emergency. (See <https://www.hhs.gov/about/news/2023/02/09/fact-sheet-covid-19-public-health-emergency-transition-roadmap.html>.) As a result, the “3-hour rule” waiver at § 412.622(a)(3)(ii), and other IRF flexibilities were terminated.

The regulatory history previously included in each rule or notice issued under the IRF PPS, including a general description of the IRF PPS for FYs 2007 through 2024, is available on the CMS website at <https://www.cms.gov/>

¹ CMS, “COVID–19 Emergency Declaration Blanket Waivers for Health Care Providers,” (updated Feb. 19, 2021) (available at <https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf>).

² CMS, “COVID–19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing,” (updated March 5, 2021) (available at <https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf>).

Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS.

B. Provisions of the Affordable Care Act and the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Affecting the IRF PPS in FY 2012 and Beyond

The Patient Protection and Affordable Care Act (Pub. L. 111–148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), which amended and revised several provisions of the Patient Protection and Affordable Care Act, was enacted on March 30, 2010. In this proposed rule, we refer to the two statutes collectively as the “Affordable Care Act” or “ACA”.

The ACA included several provisions that affect the IRF PPS in FYs 2012 and beyond. In addition to what was previously discussed, section 3401(d) of the ACA also added section 1886(j)(3)(C)(ii)(I) of the Act (providing for a “productivity adjustment” for FY 2012 and each subsequent FY). The productivity adjustment for FY 2025 is discussed in section V.D. of this proposed rule. Section 1886(j)(3)(C)(ii)(II) of the Act provides that the application of the productivity adjustment to the market basket update may result in an update that is less than 0.0 for a FY and in payment rates for a FY being less than such payment rates for the preceding FY.

Section 3004(b) of the ACA and section 411(b) of the MACRA (Pub. L. 114–10, enacted on April 16, 2015) also addressed the IRF PPS. Section 3004(b) of ACA reassigned the previously designated section 1886(j)(7) of the Act to section 1886(j)(8) of the Act and inserted a new section 1886(j)(7) of the Act, which contains requirements for the Secretary to establish a QRP for IRFs. Under that program, data must be submitted in a form and manner and at a time specified by the Secretary. Beginning in FY 2014, section 1886(j)(7)(A)(i) of the Act requires the application of a 2-percentage point reduction to the market basket increase factor otherwise applicable to an IRF (after application of paragraphs (C)(iii) and (D) of section 1886(j)(3) of the Act) for a FY if the IRF does not comply with the requirements of the IRF QRP for that FY. Application of the 2-percentage point reduction may result in an update that is less than 0.0 for a FY and in payment rates for a FY being lower than payment rates for the preceding FY. Reporting-based reductions to the market basket increase factor are not cumulative; they only apply for the FY involved. Section 411(b) of the MACRA amended section 1886(j)(3)(C) of the Act

by adding paragraph (iii), which required us to apply for FY 2018, after the application of section 1886(j)(3)(C)(ii) of the Act, an increase factor of 1.0 percent to update the IRF prospective payment rates.

C. Operational Overview of the Current IRF PPS

As described in the FY 2002 IRF PPS final rule (66 FR 41316), upon the admission and discharge of a Medicare Part A fee-for-service (FFS) patient, the IRF is required to complete the appropriate sections of a Patient Assessment Instrument (PAI), designated as the IRF–PAI. In addition, beginning with IRF discharges occurring on or after October 1, 2009, the IRF is also required to complete the appropriate sections of the IRF–PAI upon the admission and discharge of each Medicare Advantage (MA) patient, as described in the FY 2010 IRF PPS final rule (74 FR 39762) and the FY 2010 IRF PPS correction notice (74 FR 50712). All required data must be electronically encoded into the IRF–PAI software product. Generally, the software product includes patient classification programming called the Grouper software. The Grouper software uses specific IRF–PAI data elements to classify (or group) patients into distinct CMGs and account for the existence of any relevant comorbidities.

The Grouper software produces a five-character CMG number. The first character is an alphabetic character that indicates the comorbidity tier. The last four characters are numeric characters that represent the distinct CMG number. A free download of the Grouper software is available on the CMS website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Software.html>. The Grouper software is also embedded in the internet Quality Improvement and Evaluation System (iQIES) User tool available in iQIES at <https://www.cms.gov/medicare/quality-safety-oversight-general-information/iqies>.

Once a Medicare Part A FFS patient is discharged, the IRF submits a Medicare claim as a Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Pub. L. 104–191, enacted on August 21, 1996) compliant electronic claim or, if the Administrative Simplification Compliance Act of 2002 (ASCA) (Pub. L. 107–105, enacted on December 27, 2002) permits, a paper claim (a UB–04 or a CMS–1450 as appropriate) using the five-character CMG number and sends it to the appropriate Medicare Administrative Contractor (MAC). In

addition, once a MA patient is discharged, in accordance with the Medicare Claims Processing Manual, chapter 3, section 20.3 (Pub. 100-04), hospitals (including IRFs) must submit to their MAC an informational-only bill (type of bill (TOB) 111) that includes Condition Code 04. This will ensure that the MA days are included in the hospital's Supplemental Security Income (SSI) ratio (used in calculating the IRF LIP adjustment) for FY 2007 and beyond. Claims submitted to Medicare must comply with both ASCA and HIPAA.

Section 3 of the ASCA amended section 1862(a) of the Act by adding paragraph (22), which requires the Medicare program, subject to section 1862(h) of the Act, to deny payment under Part A or Part B for any expenses for items or services for which a claim is submitted other than in an electronic form specified by the Secretary. Section 1862(h) of the Act, in turn, provides that the Secretary shall waive such denial in situations in which there is no method available for the submission of claims in an electronic form or the entity submitting the claim is a small provider. In addition, the Secretary also has the authority to waive such denial in such unusual cases as the Secretary finds appropriate. For more information, see the "Medicare Program; Electronic Submission of Medicare Claims" final rule (70 FR 71008). Our instructions for the limited number of Medicare claims submitted on paper are available at <https://www.cms.gov/manuals/downloads/clm104c25.pdf>.

Section 3 of the ASCA operates in the context of the administrative simplification provisions of HIPAA, which include, among others, the requirements for transaction standards and code sets codified in 45 CFR part 160 and part 162, subparts A and I through R (generally known as the Transactions Rule). The Transactions Rule requires covered entities, including covered healthcare providers, to conduct covered electronic transactions according to the applicable transaction standards. (See the CMS program claim memoranda at <https://www.cms.gov/ElectronicBillingEDITrans/> and listed in the addenda to the Medicare Intermediary Manual, Part 3, section 3600.)

The MAC processes the claim through its software system. This software system includes pricing programming called the "Pricer" software. The Pricer software uses the CMG number, along with other specific claim data elements and provider-specific data, to adjust the IRF's prospective payment for interrupted stays, transfers, short stays,

and deaths, and then applies the applicable adjustments to account for the IRF's wage index, percentage of low-income patients, rural location, and outlier payments. For discharges occurring on or after October 1, 2005, the IRF PPS payment also reflects the teaching status adjustment that became effective as of FY 2006, as discussed in the FY 2006 IRF PPS final rule (70 FR 47880).

III. Summary of Provisions of the Proposed Rule

In the FY 2025 IRF PPS proposed rule, we are proposing to update the IRF PPS for FY 2025 and the IRF QRP for FY 2028.

The proposed policy changes and updates to the IRF prospective payment rates for FY 2025 are as follows:

- Update the CMG relative weights and average length of stay values for FY 2025, in a budget neutral manner, as discussed in section IV.
- Update the IRF PPS payment rates for FY 2025 by the market basket increase factor, based upon the most current data available, with a productivity adjustment required by section 1886(j)(3)(C)(ii)(I) of the Act, as described in section V.
- Update the FY 2025 IRF PPS payment rates by the FY 2025 wage index, describe the proposed adoption of the revised OMB market area delineations, the phase-out of the rural adjustment for those IRFs changing from rural to urban, and the labor-related share in a budget-neutral manner, as discussed in section V.
- Describe the calculation of the IRF standard payment conversion factor for FY 2025, as discussed in section V.
- Update the outlier threshold amount for FY 2025, as discussed in section VI.
- Update the cost-to-charge ratio (CCR) ceiling and urban/rural average CCRs for FY 2025, as discussed in section VI.

We also propose updates to the IRF QRP beginning with the FY 2028 IRF QRP and request information in section VII. of this proposed rule as follows:

- Propose to adopt four items as standardized patient assessment data elements and modify one item collected as a standardized patient assessment data element in the IRF-PAI.
- Remove the Admission Class item from the IRF-PAI.
- Request information on IRF QRP quality measure and concepts.
- Request information on an IRF QRP star rating system.

IV. Proposed Update to the Case-Mix Group (CMG) Relative Weights and Average Length of Stay (ALOS) Values for FY 2025

As specified in § 412.620(b)(1), we calculate a relative weight for each CMG that is proportional to the resources needed for an average inpatient rehabilitation case in that CMG. For example, cases in a CMG with a relative weight of 2, on average, will cost twice as much as cases in a CMG with a relative weight of 1. Relative weights account for the variance in cost per discharge due to the variance in resource utilization among the payment groups, and their use helps to ensure that IRF PPS payments support beneficiary access to care, as well as provider efficiency.

In this proposed rule, we propose to update the CMG relative weights and ALOS values for FY 2025. Typically, we use the most recent available data to update the CMG relative weights and ALOS values. For FY 2025, we are proposing to use the FY 2023 IRF claims and FY 2022 IRF cost report data. These data are the most current and complete data available at this time. Currently, only a small portion of the FY 2023 IRF cost report data is available for analysis, but the majority of the FY 2023 IRF claims data are available for analysis. We are proposing that if more recent data become available after the publication of the proposed rule and before the publication of the final rule, we would use such data to determine the FY 2025 CMG relative weights and ALOS values in the final rule.

We are proposing to apply these data using the same methodologies that we have used to update the CMG relative weights and ALOS values each FY since we implemented an update to the methodology. The detailed cost to charge ratio (CCR) data from the cost reports of IRF provider units of primary acute care hospitals is used for this methodology, instead of CCR data from the associated primary care hospitals, to calculate IRFs' average costs per case, as discussed in the FY 2009 IRF PPS final rule (73 FR 46372). In calculating the CMG relative weights, we use a hospital-specific relative value method to estimate operating (routine and ancillary services) and capital costs of IRFs. The process to calculate the CMG relative weights for this proposed rule is as follows:

Step 1. We estimate the effects that comorbidities have on costs.

Step 2. We adjust the cost of each Medicare discharge (case) to reflect the effects found in Step 1.

Step 3. We use the adjusted costs from Step 2 to calculate CMG relative weights, using the hospital-specific relative value method.

Step 4. We normalize the FY 2025 CMG relative weights using a normalization factor that results in the average CMG relative weights in FY 2025 being the same as the average CMG relative weights in the FY 2024 IRF PPS final rule (88 FR 50956).

Consistent with the methodology that we have used to update the IRF classification system in each instance in the past, we are proposing to update the CMG relative weights for FY 2025 in such a way that total estimated aggregate payments to IRFs for FY 2025 are the same with or without the changes (that is, in a budget-neutral manner) by applying a budget neutrality

factor to the standard payment amount. To calculate the appropriate budget neutrality factor for use in updating the FY 2025 CMG relative weights, we use the following steps:

Step 1. Calculate the estimated total amount of IRF PPS payments for FY 2025 (with no changes to the CMG relative weights).

Step 2. Calculate the estimated total amount of IRF PPS payments for FY 2025 by applying the changes to the CMG relative weights (as discussed in this proposed rule).

Step 3. Divide the amount calculated in step 1 by the amount calculated in step 2 to determine the budget neutrality factor of 0.9973 that would maintain the same total estimated aggregate payments in FY 2025 with and without the changes to the proposed CMG relative weights.

Step 4. Apply the budget neutrality factor from step 3 to the FY 2025 IRF PPS standard payment amount after the application of the budget-neutral wage adjustment factor.

In section V. of this proposed rule, we discuss the use of the existing methodology to calculate the standard payment conversion factor for FY 2025.

In Table 2, “Relative Weights and Average Length of Stay Values for Case-Mix Groups,” we present the proposed CMGs, the comorbidity tiers, the corresponding relative weights, and the ALOS values for each CMG and tier for FY 2025. The ALOS for each CMG is used to determine when an IRF discharge meets the definition of a short-stay transfer, which results in a per diem case level adjustment.

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TABLE 2: Proposed Relative Weights and Average Length of Stay Values for the Case-Mix Groups

CMG	CMG Description (M=motor, A=age)	Relative Weight				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	No Comorbidity Tier	Tier 1	Tier 2	Tier 3	No Comorbidity Tier
0101	Stroke M ≥ 72.50	0.9768	0.8476	0.7762	0.7403	10	10	9	8
0102	Stroke M ≥ 63.50 and M < 72.50	1.2392	1.0752	0.9847	0.9392	11	11	11	10
0103	Stroke M ≥ 50.50 and M < 63.50	1.5975	1.3861	1.2694	1.2107	14	15	13	13
0104	Stroke M ≥ 41.50 and M < 50.50	2.0388	1.7690	1.6201	1.5452	17	16	16	16
0105	Stroke M < 41.50 and A ≥ 84.50	2.5472	2.2100	2.0240	1.9305	22	22	20	20
0106	Stroke M < 41.50 and A < 84.50	2.8963	2.5129	2.3014	2.1950	24	24	23	22
0201	Traumatic brain injury M ≥ 73.50	1.0197	0.8451	0.7679	0.7233	9	10	8	8
0202	Traumatic brain injury M ≥ 61.50 and M < 73.50	1.3225	1.0961	0.9959	0.9381	12	12	11	10
0203	Traumatic brain injury M ≥ 49.50 and M < 61.50	1.6521	1.3693	1.2441	1.1720	14	15	13	13
0204	Traumatic brain injury M ≥ 35.50 and M < 49.50	2.0483	1.6976	1.5425	1.4530	18	17	16	15
0205	Traumatic brain injury M < 35.50	2.6222	2.1732	1.9747	1.8601	29	22	19	18
0301	Non-traumatic brain injury M ≥ 65.50	1.1965	0.9588	0.8810	0.8309	10	10	9	9
0302	Non-traumatic brain injury M ≥ 52.50 and M < 65.50	1.5457	1.2387	1.1382	1.0734	13	12	12	11
0303	Non-traumatic brain injury M ≥ 42.50 and M < 52.50	1.8638	1.4936	1.3724	1.2942	15	15	14	14
0304	Non-traumatic brain injury M < 42.50 and A ≥ 78.50	2.1608	1.7316	1.5911	1.5005	20	17	16	15
0305	Non-traumatic brain injury M < 42.50 and A < 78.50	2.3777	1.9055	1.7508	1.6512	20	19	17	16
0401	Traumatic spinal cord injury M ≥ 56.50	1.2084	1.0874	1.0520	0.9558	13	11	11	11
0402	Traumatic spinal cord injury M ≥ 47.50 and M < 56.50	1.5448	1.3901	1.3448	1.2218	16	14	14	13
0403	Traumatic spinal cord injury M ≥ 41.50 and M < 47.50	1.9428	1.7482	1.6913	1.5367	18	17	17	17
0404	Traumatic spinal cord injury M < 31.50 and A < 61.50	2.9590	2.6627	2.5760	2.3404	22	29	23	23
0405	Traumatic spinal cord injury M ≥ 31.50 and M < 41.50	2.3976	2.1575	2.0873	1.8964	27	21	21	21
0406	Traumatic spinal cord injury M ≥ 24.50 and M < 31.50 and A ≥ 61.50	3.0626	2.7559	2.6663	2.4224	27	30	26	25
0407	Traumatic spinal cord injury M < 24.50 and A ≥ 61.50	4.1570	3.7408	3.6190	3.2880	42	39	33	36
0501	Non-traumatic spinal cord injury M ≥ 60.50	1.2759	0.9897	0.9351	0.8618	11	11	10	10
0502	Non-traumatic spinal cord injury M ≥ 53.50 and M < 60.50	1.5973	1.2390	1.1707	1.0789	15	12	12	12

CMG	CMG Description (M=motor, A=age)	Relative Weight				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	No Comorbidity Tier	Tier 1	Tier 2	Tier 3	No Comorbidity Tier
0503	Non-traumatic spinal cord injury M >=48.50 and M <53.50	1.8307	1.4200	1.3417	1.2365	15	14	14	13
0504	Non-traumatic spinal cord injury M >=39.50 and M <48.50	2.1769	1.6885	1.5954	1.4704	19	17	16	16
0505	Non-traumatic spinal cord injury M <39.50	3.0255	2.3467	2.2174	2.0436	26	23	22	20
0601	Neurological M >=64.50	1.3260	0.9955	0.9288	0.8380	10	10	9	9
0602	Neurological M >=52.50 and M <64.50	1.6823	1.2630	1.1784	1.0632	13	12	12	11
0603	Neurological M >=43.50 and M <52.50	1.9813	1.4874	1.3878	1.2522	15	14	13	13
0604	Neurological M <43.50	2.4852	1.8657	1.7408	1.5706	20	17	16	16
0701	Fracture of lower extremity M >=61.50	1.2565	0.9710	0.9201	0.8498	12	11	10	9
0702	Fracture of lower extremity M >=52.50 and M <61.50	1.5501	1.1978	1.1350	1.0483	13	13	12	11
0703	Fracture of lower extremity M >=41.50 and M <52.50	1.9073	1.4738	1.3966	1.2899	16	15	14	14
0704	Fracture of lower extremity M <41.50	2.3302	1.8006	1.7063	1.5759	19	18	17	16
0801	Replacement of lower-extremity joint M >=63.50	1.2136	0.9821	0.8906	0.8298	10	10	9	9
0802	Replacement of lower-extremity joint M >=57.50 and M <63.50	1.3773	1.1146	1.0107	0.9417	11	11	10	10
0803	Replacement of lower-extremity joint M >=51.50 and M <57.50	1.5280	1.2366	1.1213	1.0448	12	12	11	11
0804	Replacement of lower-extremity joint M >=42.50 and M <51.50	1.7135	1.3867	1.2575	1.1717	14	14	13	12
0805	Replacement of lower-extremity joint M <42.50	2.0539	1.6622	1.5073	1.4044	16	16	15	14
0901	Other orthopedic M >=63.50	1.1970	0.9619	0.8972	0.8211	10	10	9	9
0902	Other orthopedic M >=51.50 and M <63.50	1.4914	1.1985	1.1179	1.0231	12	12	12	11
0903	Other orthopedic M >=44.50 and M <51.50	1.7800	1.4304	1.3341	1.2210	14	14	13	13
0904	Other orthopedic M <44.5	2.1328	1.7140	1.5986	1.4631	17	17	16	15
1001	Amputation lower extremity M >=64.50	1.2060	0.9999	0.9126	0.8155	11	11	10	9
1002	Amputation lower extremity M >=55.50 and M <64.50	1.5303	1.2687	1.1579	1.0347	14	14	12	11
1003	Amputation lower extremity M >=47.50 and M <55.50	1.7958	1.4889	1.3588	1.2143	15	15	14	13
1004	Amputation lower extremity M <47.50	2.2977	1.9049	1.7385	1.5536	19	19	17	16
1101	Amputation non-lower extremity M >=58.50	1.2582	1.0190	1.0190	0.9934	10	11	12	11
1102	Amputation non-lower extremity M >=52.50 and M <58.50	1.6072	1.3017	1.3017	1.2689	13	14	14	13

CMG	CMG Description (M=motor, A=age)	Relative Weight				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	No Comorbidity Tier	Tier 1	Tier 2	Tier 3	No Comorbidity Tier
1103	Amputation non-lower extremity M <52.50	2.0039	1.6230	1.6230	1.5821	17	14	17	14
1201	Osteoarthritis M >=61.50	1.3199	1.0100	0.9435	0.8649	11	10	9	10
1202	Osteoarthritis M >=49.50 and M <61.50	1.6025	1.2262	1.1456	1.0501	13	12	11	11
1203	Osteoarthritis M <49.50 and A >=74.50	2.0725	1.5859	1.4816	1.3580	16	17	15	14
1204	Osteoarthritis M <49.50 and A <74.50	2.1745	1.6639	1.5545	1.4249	17	15	16	13
1301	Rheumatoid other arthritis M >=62.50	1.1226	0.8989	0.8592	0.7969	10	9	10	8
1302	Rheumatoid other arthritis M >=51.50 and M <62.50	1.5415	1.2343	1.1798	1.0943	13	12	12	12
1303	Rheumatoid other arthritis M >=44.50 and M <51.50 and A >=64.50	1.7456	1.3977	1.3360	1.2392	15	13	13	13
1304	Rheumatoid other arthritis M <44.50 and A >=64.50	2.2136	1.7724	1.6942	1.5714	16	17	16	16
1305	Rheumatoid other arthritis M <51.50 and A <64.50	2.0921	1.6752	1.6012	1.4851	17	14	14	16
1401	Cardiac M >=68.50	1.1253	0.8889	0.8258	0.7601	10	9	9	8
1402	Cardiac M >=55.50 and M <68.50	1.4285	1.1284	1.0483	0.9649	12	12	11	10
1403	Cardiac M >=45.50 and M <55.50	1.7498	1.3822	1.2840	1.1820	14	14	13	12
1404	Cardiac M <45.50	2.1390	1.6897	1.5697	1.4449	18	16	15	14
1501	Pulmonary M >=68.50	1.2625	1.0315	0.9742	0.9097	12	10	9	9
1502	Pulmonary M >=56.50 and M <68.50	1.5969	1.3048	1.2323	1.1507	13	12	12	11
1503	Pulmonary M >=45.50 and M <56.50	1.8179	1.4853	1.4028	1.3099	16	14	13	12
1504	Pulmonary M <45.50	2.2486	1.8372	1.7351	1.6202	19	17	16	15
1601	Pain syndrome M >=65.50	1.2819	0.9705	0.8714	0.8110	9	10	9	9
1602	Pain syndrome M >=58.50 and M <65.50	1.4866	1.1254	1.0106	0.9405	11	11	10	10
1603	Pain syndrome M >=43.50 and M <58.50	1.8646	1.4116	1.2675	1.1796	13	13	13	12
1604	Pain syndrome M <43.50	2.3143	1.7520	1.5732	1.4641	14	15	16	14
1701	Major multiple trauma without brain or spinal cord injury M >=57.50	1.3312	1.0409	0.9627	0.8743	11	11	10	10
1702	Major multiple trauma without brain or spinal cord injury M >=50.50 and M <57.50	1.6546	1.2938	1.1965	1.0867	13	14	12	12
1703	Major multiple trauma without brain or spinal cord injury M >=41.50 and M <50.50	1.9665	1.5377	1.4221	1.2916	16	15	14	14
1704	Major multiple trauma without brain or spinal cord injury M >=36.50 and M <41.50	2.2253	1.7401	1.6093	1.4616	17	17	16	15
1705	Major multiple trauma without brain or spinal cord injury M <36.50	2.6098	2.0408	1.8874	1.7142	22	20	19	17

CMG	CMG Description (M=motor, A=age)	Relative Weight				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	No Comorbidity Tier	Tier 1	Tier 2	Tier 3	No Comorbidity Tier
1801	Major multiple trauma with brain or spinal cord injury M >=67.50	1.0552	0.8513	0.8025	0.7437	11	10	10	9
1802	Major multiple trauma with brain or spinal cord injury M >=55.50 and M <67.50	1.4134	1.1402	1.0748	0.9961	14	12	12	11
1803	Major multiple trauma with brain or spinal cord injury M >=45.50 and M <55.50	1.8216	1.4695	1.3852	1.2839	17	16	15	14
1804	Major multiple trauma with brain or spinal cord injury M >=40.50 and M <45.50	1.9918	1.6069	1.5147	1.4039	18	16	15	15
1805	Major multiple trauma with brain or spinal cord injury M >=30.50 and M <40.50	2.4129	1.9466	1.8349	1.7006	20	21	18	17
1806	Major multiple trauma with brain or spinal cord injury M <30.50	3.4116	2.7522	2.5944	2.4045	39	27	24	23
1901	Guillain-Barré M >=66.50	1.0348	0.7974	0.7436	0.7278	11	9	9	8
1902	Guillain-Barré M >=51.50 and M <66.50	1.6652	1.2833	1.1966	1.1713	17	14	13	13
1903	Guillain-Barré M >=38.50 and M <51.50	2.5018	1.9280	1.7977	1.7596	23	19	17	19
1904	Guillain-Barré M <38.50	3.6577	2.8188	2.6284	2.5727	32	30	25	25
2001	Miscellaneous M >=66.50	1.1777	0.9424	0.8810	0.8022	10	10	9	9
2002	Miscellaneous M >=55.50 and M <66.50	1.4691	1.1755	1.0989	1.0006	12	12	11	11
2003	Miscellaneous M >=46.50 and M <55.50	1.7588	1.4073	1.3156	1.1979	15	14	13	12
2004	Miscellaneous M <46.50 and A >=77.50	2.1025	1.6823	1.5727	1.4320	18	16	15	15
2005	Miscellaneous M <46.50 and A <77.50	2.2160	1.7731	1.6576	1.5093	19	18	16	15
2101	Burns M >=52.50	1.5169	1.1654	1.1654	0.9830	14	14	13	11
2102	Burns M <52.50	2.3089	1.7739	1.7739	1.4963	19	23	18	15
5001	Short-stay cases, length of stay is 3 days or fewer	0.0000	0.0000	0.0000	0.1715	0	0	0	2
5101	Expired, orthopedic, length of stay is 13 days or fewer	0.0000	0.0000	0.0000	0.7563	0	0	0	8
5102	Expired, orthopedic, length of stay is 14 days or more	0.0000	0.0000	0.0000	1.8223	0	0	0	16
5103	Expired, not orthopedic, length of stay is 15 days or fewer	0.0000	0.0000	0.0000	0.9160	0	0	0	9
5104	Expired, not orthopedic, length of stay is 16 days or more	0.0000	0.0000	0.0000	2.3794	0	0	0	23

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Generally, updates to the CMG relative weights result in some increases and some decreases to the CMG relative weight values. Table 2 shows how we estimate that the application of the proposed revisions for FY 2025 would

affect particular CMG relative weight values, which would affect the overall distribution of payments within CMGs and tiers. We note that, because we implement the CMG relative weight revisions in a budget-neutral manner (as previously described), total estimated

aggregate payments to IRFs for FY 2025 would not be affected as a result of the proposed CMG relative weight revisions. However, the proposed revisions would affect the distribution of payments within CMGs and tiers.

TABLE 3: Distributional Effects of the Proposed Changes to the CMG Relative Weights

Percentage Change in CMG Relative Weights	Number of Cases Affected	Percentage of Cases Affected
Increased by 15% or more	0	0.0%
Increased by between 5% and 15%	1,659	0.4%
Changed by less than 5%	401,353	99.2%
Decreased by between 5% and 15%	1,357	0.3%
Decreased by 15% or more	28	0.0%

As shown in Table 3, 99.2 percent of all IRF cases are in CMGs and tiers that would experience less than a 5 percent change (either increase or decrease) in the CMG relative weight value as a result of the proposed revisions for FY 2025. The proposed changes in the ALOS values for FY 2025, compared with the FY 2024 ALOS values, are small and do not show any particular trends in IRF length of stay patterns.

We invite public comment on our proposed updates to the CMG relative weights and ALOS values for FY 2025.

V. Proposed FY 2025 IRF PPS Payment Update

A. Background

Section 1886(j)(3)(C) of the Act requires the Secretary to establish an increase factor that reflects changes over time in the prices of an appropriate mix of goods and services for which payment is made under the IRF PPS. According to section 1886(j)(3)(A)(i) of the Act, the increase factor shall be used to update the IRF prospective payment rates for each FY. Section 1886(j)(3)(C)(ii)(I) of the Act requires the application of the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act. Thus, in this proposed rule, we are proposing to update the IRF PPS payments for FY 2025 by a market basket increase factor as required by section 1886(j)(3)(C) of the Act based upon the most current data available, with a productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act.

We have utilized various market baskets through the years in the IRF PPS. For a discussion of these market baskets, we refer readers to the FY 2016 IRF PPS final rule (80 FR 47046).

In FY 2016, we finalized the use of a 2012-based IRF market basket, using Medicare cost report data for both freestanding and hospital-based IRFs (80 FR 47049 through 47068). In FY 2020, we finalized a rebased and revised IRF market basket to reflect a 2016 base year. The FY 2020 IRF PPS final rule (84 FR 39071 through 39086) contains a complete discussion of the development

of the 2016-based IRF market basket. Beginning with FY 2024, we finalized a rebased and revised IRF market basket to reflect a 2021 base year. The FY 2024 IRF PPS final rule (88 FR 50966 through 50988) contains a complete discussion of the development of the 2021-based IRF market basket.

B. Proposed FY 2025 Market Basket Update and Productivity Adjustment

1. Proposed FY 2025 Market Basket Update

For FY 2025 (that is, beginning October 1, 2024, and ending September 30, 2025), we are proposing to update the IRF PPS payments by a market basket increase factor as required by section 1886(j)(3)(C) of the Act, with a productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act. For FY 2025, we are proposing to use the same methodology described in the FY 2024 IRF PPS final rule (88 FR 50982 through 50984).

Consistent with historical practice, we are proposing to estimate the market basket update for the IRF PPS for FY 2025 based on IHS Global Inc.'s (IGI's) forecast using the most recent available data. Based on IGI's fourth quarter 2023 forecast with historical data through the third quarter of 2023, the proposed 2021-based IRF market basket increase factor for FY 2025 is projected to be 3.2 percent. We are also proposing that if more recent data become available after the publication of the proposed rule and before the publication of the final rule (for example, a more recent estimate of the market basket update or productivity adjustment), we would use such data, if appropriate, to determine the FY 2025 market basket update in the final rule.

2. Proposed FY 2025 Productivity Adjustment

According to section 1886(j)(3)(C)(i) of the Act, the Secretary shall establish an increase factor based on an appropriate percentage increase in a market basket of goods and services. Section 1886(j)(3)(C)(ii) of the Act requires that, after establishing the increase factor for

a FY, the Secretary shall reduce such increase factor for FY 2012 and each subsequent FY, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act. Section 1886(b)(3)(B)(xi)(II) of the Act sets forth the definition of this productivity adjustment. The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide, private nonfarm business multifactor productivity (as projected by the Secretary for the 10-year period ending with the applicable FY, year, cost reporting period, or other annual period) (the "productivity adjustment"). The U.S. Department of Labor's Bureau of Labor Statistics (BLS) publishes the official measures of productivity for the U.S. economy. We note that previously the productivity measure referenced in section 1886(b)(3)(B)(xi)(II) of the Act, was referred to by BLS as private nonfarm business multifactor productivity. Beginning with the November 18, 2021, release of productivity data, BLS replaced the term multifactor productivity (MFP) with total factor productivity (TFP). BLS noted that this is a change in terminology only and will not affect the data or methodology. As a result of this change, the productivity measure referenced in section 1886(b)(3)(B)(xi)(II) is now published by BLS as private nonfarm business total factor productivity. However, as mentioned above, the data and methods are unchanged. Please see www.bls.gov for the BLS historical published TFP data. A complete description of IGI's TFP projection methodology is available on the CMS website at <https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-program-rates-statistics/market-basket-research-and-information>. In addition, in the FY 2022 IRF final rule (86 FR 42374), we noted that effective with FY 2022 and forward, CMS changed the name of this adjustment to refer to it as the productivity adjustment rather than the MFP adjustment.

Using IGI's fourth quarter 2023 forecast, the 10-year moving average

growth of TFP for FY 2025 is projected to be 0.4 percent. In accordance with section 1886(j)(3)(C) of the Act, we are proposing to base the FY 2025 market basket update, which is used to determine the applicable percentage increase for the IRF payments, on IGI's fourth quarter 2023 forecast of the 2021-based IRF market basket. We are proposing to then reduce the market basket percentage increase by the estimated productivity adjustment for FY 2025 of 0.4 percentage point (the 10-year moving average growth of TFP for the period ending FY 2025 based on IGI's fourth quarter 2023 forecast). Therefore, the proposed FY 2025 IRF update is equal to 2.8 percent (3.2 percent market basket percentage increase reduced by the 0.4 percentage point productivity adjustment). Furthermore, we are proposing that if more recent data become available after the publication of the proposed rule and before the publication of the final rule (for example, a more recent estimate of the market basket percentage increase and/or productivity adjustment), we would use such data, if appropriate, to determine the FY 2025 market basket percentage increase and productivity adjustment in the final rule.

For FY 2025, the Medicare Payment Advisory Commission (MedPAC) recommends that we reduce IRF PPS payment rates by 5 percent.³ As discussed, and in accordance with sections 1886(j)(3)(C) and 1886(j)(3)(D) of the Act, the Secretary is proposing to update the IRF PPS payment rates for FY 2025 by the proposed IRF market basket update of 2.8 percent. Section 1886(j)(3)(C) of the Act does not provide the Secretary with the authority to apply a different update factor to IRF PPS payment rates for FY 2025.

We invite public comment on our proposals for the FY 2025 market basket

percentage increase and productivity adjustment.

C. Proposed Labor-Related Share for FY 2025

Section 1886(j)(6) of the Act specifies that the Secretary is to adjust the proportion (as estimated by the Secretary from time to time) of IRFs' costs that are attributable to wages and wage-related costs, of the prospective payment rates computed under section 1886(j)(3) of the Act, for area differences in wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for such facilities. The labor-related share is determined by identifying the national average proportion of total costs that are related to, influenced by, or vary with the local labor market. We are proposing to continue to classify a cost category as labor-related if the costs are labor-intensive and vary with the local labor market.

Based on our definition of the labor-related share and the cost categories in the 2021-based IRF market basket, we are proposing to calculate the labor-related share for FY 2025 as the sum of the FY 2025 relative importance of Wages and Salaries, Employee Benefits, Professional Fees: Labor-Related, Administrative and Facilities Support Services, Installation, Maintenance, and Repair Services, All Other: Labor-Related Services, and a portion of the Capital-Related relative importance from the 2021-based IRF market basket. For more details regarding the methodology for determining specific cost categories for inclusion in the 2021-based IRF labor-related share, see the FY 2024 IRF PPS final rule (88 FR 50985 through 50988).

The relative importance reflects the different rates of price change for these cost categories between the base year

(2021) and FY 2025. We calculate the labor-related relative importance from the IRF market basket, and it approximates the labor-related portion of the total costs after taking into account historical and projected price changes between the base year and FY 2025. The price proxies that move the different cost categories in the market basket do not necessarily change at the same rate, and the relative importance captures these changes. Based on IGI's fourth quarter 2023 forecast of the 2021-based IRF market basket, the sum of the FY 2025 relative importance for Wages and Salaries, Employee Benefits, Professional Fees: Labor-Related, Administrative and Facilities Support Services, Installation Maintenance & Repair Services, and All Other: Labor-Related Services is 70.5 percent. We are proposing that the portion of Capital-Related costs that are influenced by the local labor market is 46 percent. Since the relative importance for Capital-Related costs is 8.1 percent of the 2021-based IRF market basket for FY 2025, we are proposing to take 46 percent of 8.1 percent to determine the labor-related share of Capital-Related costs for FY 2025 of 3.7 percent. Therefore, we are proposing a total labor-related share for FY 2025 of 74.2 percent (the sum of 70.5 percent for the proposed labor-related share of operating costs and 3.7 percent for the proposed labor-related share of Capital-Related costs). We are proposing that if more recent data become available after publication of the proposed rule and before the publication of the final rule (for example, a more recent estimate of the labor-related share), we would use such data, if appropriate, to determine the FY 2025 IRF labor-related share in the final rule.

Table 4 shows the current estimate of the proposed FY 2025 labor-related share and the FY 2024 final labor-related share using the 2021-based IRF market basket relative importance.

³ https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_ReportToCongress_SEC.pdf.

TABLE 4: FY 2025 Proposed IRF Labor-Related Share and FY 2024 IRF Labor-Related Share

	FY 2025 Proposed Labor-Related Share ¹	FY 2024 Final Labor Related Share ²
Wages and Salaries	49.3	49.0
Employee Benefits	11.7	11.8
Professional Fees: Labor-Related ³	5.5	5.5
Administrative and Facilities Support Services	0.7	0.7
Installation, Maintenance, and Repair Services	1.5	1.5
All Other: Labor-Related Services	1.8	1.8
Subtotal	70.5	70.3
Labor-related portion of Capital-Related (46%)	3.7	3.8
Total Labor-Related Share	74.2	74.1

¹ Based on the 2021-based IRF market basket relative importance, IGI 4th quarter 2023 forecast.

² Based on the 2021-based IRF market basket relative importance as published in the **Federal Register** (88 FR 50987).

³ Includes all contract advertising and marketing costs and a portion of accounting, architectural, engineering, legal, management consulting, and home office contract labor costs.

We invite public comments on the proposed labor-related share for FY 2025.

D. Wage Adjustment for FY 2025

1. Background

Section 1886(j)(6) of the Act requires the Secretary to adjust the proportion of rehabilitation facilities' costs attributable to wages and wage-related costs (as estimated by the Secretary from time to time) by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for those facilities. The Secretary is required to update the IRF PPS wage index on the basis of information available to the Secretary on the wages and wage-related costs to furnish rehabilitation services. Any adjustment or updates made under section 1886(j)(6) of the Act for a FY are made in a budget-neutral manner.

In the FY 2023 IRF PPS final rule (87 FR 47054 through 47056) we finalized a policy to apply 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. We amended IRF PPS regulations at § 412.624(e)(1)(ii) to reflect this permanent cap on wage index decreases. Additionally, we finalized a policy that a new IRF would be paid the wage index for the area in which it is geographically located for its first full or partial FY with no cap applied because a new IRF would not have a wage index in the prior FY. A full discussion of the adoption of this

policy is found in the FY 2023 IRF PPS final rule.

For FY 2025, we propose to maintain the policies and methodologies described in the FY 2024 IRF PPS final rule (88 FR 50956) related to the labor market area definitions and the wage index methodology for areas with wage data. Thus, we propose to use the core based statistical areas (CBSAs) labor market area definitions and the FY 2025 pre-reclassification and pre-floor hospital wage index data. In accordance with section 1886(d)(3)(E) of the Act, the FY 2025 pre-reclassification and pre-floor hospital wage index is based on data submitted for hospital cost reporting periods beginning on or after October 1, 2020, and before October 1, 2021 (that is, FY 2021 cost report data).

The labor market designations made by the OMB include some geographic areas where there are no hospitals and, thus, no hospital wage index data on which to base the calculation of the IRF PPS wage index. We propose to continue to use the same methodology discussed in the FY 2008 IRF PPS final rule (72 FR 44299) to address those geographic areas where there are no hospitals and, thus, no hospital wage index data on which to base the calculation for the FY 2025 IRF PPS wage index. For FY 2025, the only rural area without wage index data available is North Dakota. We have determined that the borders of 18 rural counties are local and contiguous with 8 urban counties. Therefore, under this methodology, the wage indexes for the counties of Burleigh/Morton/Oliver (CBSA 13900: 0.9020), Cass (CBSA 22020: 0.8763), Grand Forks (CBSA

24220: 0.7865), and McHenry/Renville/Ward (CBSA 33500: 0.7686) are averaged, resulting in an imputed rural wage index of 0.8334 for rural North Dakota for FY 2025. In past years for rural Puerto Rico, we did not apply this methodology due to the distinct economic circumstances there; due to the close proximity of almost all of Puerto Rico's various urban and non-urban areas, this methodology would produce a wage index for rural Puerto Rico that is higher than that in half of its urban areas. However, because rural Puerto Rico now has hospital wage index data on which to base an area wage adjustment, we will not apply this policy for FY 2025. For urban areas without specific hospital wage index data, we will continue using the average wage indexes of all urban areas within the State to serve as a reasonable proxy for the wage index of that urban CBSA as proposed and finalized in FY 2006 (70 FR 47927). For FY 2025, the only urban area without wage index data available is CBSA 25980, Hinesville-Fort Stewart, GA.

We invite public comment on our proposal regarding the Wage Adjustment for FY 2025.

2. Core-Based Statistical Areas (CBSAs) for the FY 2025 IRF Wage Index

The wage index used for the IRF PPS is calculated using the pre-reclassification and pre-floor inpatient PPS (IPPS) wage index data and is assigned to the IRF on the basis of the labor market area in which the IRF is geographically located. IRF labor market areas are delineated based on the CBSAs established by the OMB. The CBSA delineations (which were implemented

for the IRF PPS beginning with FY 2016) are based on revised OMB delineations issued on February 28, 2013, in OMB Bulletin No. 13–01. OMB Bulletin No. 13–01 established revised delineations for Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas in the United States and Puerto Rico based on the 2010 Census and provided guidance on the use of the delineations of these statistical areas using standards published in the June 28, 2010 **Federal Register** (75 FR 37246 through 37252). We refer readers to the FY 2016 IRF PPS final rule (80 FR 47068 through 47076) for a full discussion of our implementation of the OMB labor market area delineations beginning with the FY 2016 wage index.

Generally, OMB issues major revisions to statistical areas every 10 years, based on the results of the decennial census. Additionally, OMB occasionally issues updates and revisions to the statistical areas in between decennial censuses to reflect the recognition of new areas or the addition of counties to existing areas. In some instances, these updates merge formerly separate areas, transfer components of an area from one area to another or drop components from an area. On July 15, 2015, OMB issued OMB Bulletin No. 15–01, which provides minor updates to and supersedes OMB Bulletin No. 13–01 that was issued on February 28, 2013. The attachment to OMB Bulletin No. 15–01 provides detailed information on the update to statistical areas since February 28, 2013. The updates provided in OMB Bulletin No. 15–01 are based on the application of the 2010 Standards for Delineating Metropolitan and Micropolitan Statistical Areas to Census Bureau population estimates for July 1, 2012, and July 1, 2013.

In the FY 2018 IRF PPS final rule (82 FR 36250 through 36251), we adopted the updates set forth in OMB Bulletin No. 15–01 effective October 1, 2017, beginning with the FY 2018 IRF wage index. For a complete discussion of the adoption of the updates set forth in OMB Bulletin No. 15–01, we refer readers to the FY 2018 IRF PPS final rule. In the FY 2019 IRF PPS final rule (83 FR 38527), we continued to use the

OMB delineations that were adopted beginning with FY 2016 to calculate the area wage indexes, with updates set forth in OMB Bulletin No. 15–01 that we adopted beginning with the FY 2018 wage index.

On August 15, 2017, OMB issued OMB Bulletin No. 17–01, which provided updates to and superseded OMB Bulletin No. 15–01 that was issued on July 15, 2015. The attachments to OMB Bulletin No. 17–01 provide detailed information on the update to statistical areas since July 15, 2015, and are based on the application of the 2010 Standards for Delineating Metropolitan and Micropolitan Statistical Areas to Census Bureau population estimates for July 1, 2014, and July 1, 2015. In the FY 2020 IRF PPS final rule (84 FR 39090 through 39091), we adopted the updates set forth in OMB Bulletin No. 17–01 effective October 1, 2019, beginning with the FY 2020 IRF wage index.

On April 10, 2018, OMB issued OMB Bulletin No. 18–03, which superseded the August 15, 2017 OMB Bulletin No. 17–01, and on September 14, 2018, OMB issued OMB Bulletin No. 18–04, which superseded the April 10, 2018 OMB Bulletin No. 18–03. These bulletins established revised delineations for Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas, and provided guidance on the use of the delineations of these statistical areas. A copy of this bulletin may be obtained at <https://www.whitehouse.gov/wp-content/uploads/2018/09/Bulletin-18-04.pdf>.

To this end, as discussed in the FY 2021 IRF PPS proposed (85 FR 22075 through 22079) and final (85 FR 48434 through 48440) rules, we adopted the revised OMB delineations identified in OMB Bulletin No. 18–04 (available at <https://www.whitehouse.gov/wp-content/uploads/2018/09/Bulletin-18-04.pdf>) beginning October 1, 2020, including a 1-year transition for FY 2021 under which we applied a 5-percent cap on any decrease in an IRF's wage index compared to its wage index for the prior fiscal year (FY 2020). The updated OMB delineations more accurately reflect the contemporary urban and rural nature of areas across the country, and the use of such

delineations allows us to determine more accurately the appropriate wage index and rate tables to apply under the IRF PPS. OMB issued further revised CBSA delineations in OMB Bulletin No. 20–01, on March 6, 2020 (available on the web at <https://www.whitehouse.gov/wp-content/uploads/2020/03/Bulletin-20-01.pdf>). However, we determined that the changes in OMB Bulletin No. 20–01 do not impact the CBSA-based labor market area delineations adopted in FY 2021. Therefore, we did not propose to adopt the revised OMB delineations identified in OMB Bulletin No. 20–01 for FY 2022 through FY 2024.

On July 21, 2023, OMB issued OMB Bulletin No. 23–01 (available at <https://www.whitehouse.gov/wp-content/uploads/2023/07/OMB-Bulletin-23-01.pdf>) which updates and supersedes OMB Bulletin No. 20–01 based upon the 2020 Standards for Delineating Core Based Statistical Areas (“the 2020 Standards”) published by the Office of Management and Budget (OMB) on July 16, 2021 (86 FR 37770). OMB Bulletin No. 23–01 revised CBSA delineations which are comprised of counties and equivalent entities (for example, boroughs, a city and borough, and a municipality in Alaska, planning regions in Connecticut, parishes in Louisiana, municipios in Puerto Rico, and independent cities in Maryland, Missouri, Nevada, and Virginia). For FY 2025, we propose to adopt the revised OMB delineations identified in OMB Bulletin No. 23–01.

a. Urban Counties Becoming Rural

As previously discussed, we are proposing to implement the new OMB statistical area delineations (based upon the 2020 decennial Census data) beginning in FY 2025 for the IRF PPS wage index. Our analysis shows that a total of 54 counties (and county equivalents) that are currently considered part of an urban CBSA would be considered located in a rural area, for IRF PPS payment beginning in FY 2025, if we adopt the new OMB delineations. Table 5 lists the 54 urban counties that would be rural if we finalize our proposal to implement the new OMB delineations.

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TABLE 5: Counties That Would Transition from Urban to Rural Status

Federal Information Processing Standard (FIPS) County Code	County Name	State	Current CBSA	Current CBSA Name
01129	WASHINGTON	AL	33660	Mobile, AL
05025	CLEVELAND	AR	38220	Pine Bluff, AR
05047	FRANKLIN	AR	22900	Fort Smith, AR-OK
05069	JEFFERSON	AR	38220	Pine Bluff, AR
05079	LINCOLN	AR	38220	Pine Bluff, AR
09015	WINDHAM	CT	49340	Worcester, MA-CT
10005	SUSSEX	DE	41540	Salisbury, MD-DE
13171	LAMAR	GA	12060	Atlanta-Sandy Springs-Alpharetta, GA
16077	POWER	ID	38540	Pocatello, ID
17057	FULTON	IL	37900	Peoria, IL
17077	JACKSON	IL	16060	Carbondale-Marion, IL
17087	JOHNSON	IL	16060	Carbondale-Marion, IL
17183	VERMILION	IL	19180	Danville, IL
17199	WILLIAMSON	IL	16060	Carbondale-Marion, IL
18121	PARKE	IN	45460	Terre Haute, IN
18133	PUTNAM	IN	26900	Indianapolis-Carmel-Anderson, IN
18161	UNION	IN	17140	Cincinnati, OH-KY-IN
21091	HANCOCK	KY	36980	Owensboro, KY
21101	HENDERSON	KY	21780	Evansville, IN-KY
22045	IBERIA	LA	29180	Lafayette, LA
24001	ALLEGANY	MD	19060	Cumberland, MD-WV
24047	WORCESTER	MD	41540	Salisbury, MD-DE
25011	FRANKLIN	MA	44140	Springfield, MA
26155	SHIAWASSEE	MI	29620	Lansing-East Lansing, MI
27075	LAKE	MN	20260	Duluth, MN-WI
28031	COVINGTON	MS	25620	Hattiesburg, MS
31051	DIXON	NE	43580	Sioux City, IA-NE-SD
36123	YATES	NY	40380	Rochester, NY
37049	CRAVEN	NC	35100	New Bern, NC
37077	GRANVILLE	NC	20500	Durham-Chapel Hill, NC
37085	HARNETT	NC	22180	Fayetteville, NC
37087	HAYWOOD	NC	11700	Asheville, NC
37103	JONES	NC	35100	New Bern, NC
37137	PAMLICO	NC	35100	New Bern, NC
42037	COLUMBIA	PA	14100	Bloomsburg-Berwick, PA
42085	MERCER	PA	49660	Youngstown-Warren-Boardman, OH-PA
42089	MONROE	PA	20700	East Stroudsburg, PA
42093	MONTOUR	PA	14100	Bloomsburg-Berwick, PA
42103	PIKE	PA	35084	Newark, NJ-PA
45027	CLARENDON	SC	44940	Sumter, SC
48431	STERLING	TX	41660	San Angelo, TX
49003	BOX ELDER	UT	36260	Ogden-Clearfield, UT
51113	MADISON	VA	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV
51175	SOUTHAMPTON	VA	47260	Virginia Beach-Norfolk-Newport News, VA-NC

Federal Information Processing Standard (FIPS) County Code	County Name	State	Current CBSA	Current CBSA Name
51620	FRANKLIN CITY	VA	47260	Virginia Beach-Norfolk-Newport News, VA-NC
54035	JACKSON	WV	16620	Charleston, WV
54043	LINCOLN	WV	16620	Charleston, WV
54057	MINERAL	WV	19060	Cumberland, MD-WV
55069	LINCOLN	WI	48140	Wausau-Weston, WI
72001	ADJUNTAS	PR	38660	Ponce, PR
72055	GUANICA	PR	49500	Yauco, PR
72081	LARES	PR	10380	Aguadilla-Isabela, PR
72083	LAS MARIAS	PR	32420	Mayagüez, PR
72141	UTUADO	PR	10380	Aguadilla-Isabela, PR

We are proposing that the wage data for all hospitals located in the counties listed in Table 5 now be considered rural when their respective State's rural wage index value is calculated. This rural wage index value would be used under the IRF PPS.

b. Rural Counties Becoming Urban

Analysis of the new OMB delineations (based upon the 2020 decennial Census data) shows that a total of 54 counties (and county equivalents) that are currently located in

rural areas would be in urban areas if we finalize our proposal to implement the new OMB delineations. Table 6 lists the 54 rural counties that would be urban if we finalize this proposal.

TABLE 6: Counties That Would Transition from Rural to Urban Status

FIPS County Code	County	State	Proposed CBSA	Proposed CBSA Name
01087	MACON	AL	12220	Auburn-Opelika, AL
01127	WALKER	AL	13820	Birmingham, AL
12133	WASHINGTON	FL	37460	Panama City-Panama City Beach, FL
13187	LUMPKIN	GA	12054	Atlanta-Sandy Springs-Roswell, GA
15005	KALAWAO	HI	27980	Kahului-Wailuku, HI
17053	FORD	IL	16580	Champaign-Urbana, IL
17127	MASSAC	IL	37140	Paducah, KY-IL
18159	TIPTON	IN	26900	Indianapolis-Carmel-Greenwood, IN
18179	WELLS	IN	23060	Fort Wayne, IN
20021	CHEROKEE	KS	27900	Joplin, MO-KS
21007	BALLARD	KY	37140	Paducah, KY-IL
21039	CARLISLE	KY	37140	Paducah, KY-IL
21127	LAWRENCE	KY	26580	Huntington-Ashland, WV-KY-OH
21139	LIVINGSTON	KY	37140	Paducah, KY-IL
21145	MC CRACKEN	KY	37140	Paducah, KY-IL
21179	NELSON	KY	31140	Louisville/Jefferson County, KY-IN
22053	JEFFERSON DAVIS	LA	29340	Lake Charles, LA
22083	RICHLAND	LA	33740	Monroe, LA
26015	BARRY	MI	24340	Grand Rapids-Wyoming-Kentwood, MI
26019	BENZIE	MI	45900	Traverse City, MI
26055	GRAND TRAVERSE	MI	45900	Traverse City, MI
26079	KALKASKA	MI	45900	Traverse City, MI
26089	LEELANAU	MI	45900	Traverse City, MI
27133	ROCK	MN	43620	Sioux Falls, SD-MN
28009	BENTON	MS	32820	Memphis, TN-MS-AR
28123	SCOTT	MS	27140	Jackson, MS
30007	BROADWATER	MT	25740	Helena, MT
30031	GALLATIN	MT	14580	Bozeman, MT
30043	JEFFERSON	MT	25740	Helena, MT
30049	LEWIS AND CLARK	MT	25740	Helena, MT
30061	MINERAL	MT	33540	Missoula, MT
32019	LYON	NV	39900	Reno, NV
37125	MOORE	NC	38240	Pinehurst-Southern Pines, NC
38049	MCHENRY	ND	33500	Minot, ND
38075	RENVILLE	ND	33500	Minot, ND
38101	WARD	ND	33500	Minot, ND
39007	ASHTABULA	OH	17410	Cleveland, OH
39043	ERIE	OH	41780	Sandusky, OH
41013	CROOK	OR	13460	Bend, OR
41031	JEFFERSON	OR	13460	Bend, OR
42073	LAWRENCE	PA	38300	Pittsburgh, PA
45087	UNION	SC	43900	Spartanburg, SC
46033	CUSTER	SD	39660	Rapid City, SD
47081	HICKMAN	TN	34980	Nashville-Davidson--Murfreesboro--Franklin, TN
48007	ARANSAS	TX	18580	Corpus Christi, TX
48035	BOSQUE	TX	47380	Waco, TX
48079	COCHRAN	TX	31180	Lubbock, TX
48169	GARZA	TX	31180	Lubbock, TX

FIPS County Code	County	State	Proposed CBSA	Proposed CBSA Name
48219	HOCKLEY	TX	31180	Lubbock, TX
48323	MAVERICK	TX	20580	Eagle Pass, TX
48407	SAN JACINTO	TX	26420	Houston-Pasadena-The Woodlands, TX
51063	FLOYD	VA	13980	Blacksburg-Christiansburg-Radford, VA
51181	SURRY	VA	47260	Virginia Beach-Chesapeake-Norfolk, VA-NC
55123	VERNON	WI	29100	La Crosse-Onalaska, WI-MN

We are proposing that when calculating the area wage index, the wage data for hospitals located in these counties would be included in their new respective urban CBSAs.

c. Urban Counties Moving to a Different Urban CBSA

In addition to rural counties becoming urban and urban counties becoming rural, several urban counties would shift from one urban CBSA to another urban CBSA under our proposal to adopt the new OMB delineations. In other cases, if we adopt the new OMB delineations, counties would shift between existing

and new CBSAs, changing the constituent makeup of the CBSAs.

In one type of change, an entire CBSA would be subsumed by another CBSA. For example, CBSA 31460 (Madera, CA) currently is a single county (Madera, CA) CBSA. Madera County would be a part of CBSA 23420 (Fresno, CA) under the new OMB delineations.

In another type of change, some CBSAs have counties that would split off to become part of, or to form, entirely new labor market areas. For example, CBSA 29404 (Lake County-Kenosha County, IL-WI) currently is comprised of two counties (Lake County, IL and Kenosha County, WI). Under the new

OMB delineations, Kenosha County would split off and form the new CBSA 28450 (Kenosha, WI), while Lake County would remain in CBSA 29404.

Finally, in some cases, a CBSA would lose counties to another existing CBSA if we adopt the new OMB delineations. For example, Meade County, KY, would move from CBSA 21060 (Elizabethtown-Fort Knox, KY) to CBSA 31140 (Louisville/Jefferson County, KY-IN). CBSA 21060 would still exist in the new labor market delineations with fewer constituent counties. Table 7 lists the urban counties that would move from one urban CBSA to another urban CBSA under the new OMB delineations.

TABLE 7: Counties That Would Change to a Different CBSA

FIPS County Code	County Name	State	Current CBSA	Proposed CBSA
06039	MADERA	CA	31460	23420
11001	THE DISTRICT	DC	47894	47764
12053	HERNANDO	FL	45300	45294
12057	HILLSBOROUGH	FL	45300	45294
12101	PASCO	FL	45300	45294
12103	PINELLAS	FL	45300	41304
12119	SUMTER	FL	45540	48680
13013	BARROW	GA	12060	12054
13015	BARTOW	GA	12060	31924
13035	BUTTS	GA	12060	12054
13045	CARROLL	GA	12060	12054
13057	CHEROKEE	GA	12060	31924
13063	CLAYTON	GA	12060	12054
13067	COBB	GA	12060	31924
13077	COWETA	GA	12060	12054
13085	DAWSON	GA	12060	12054
13089	DE KALB	GA	12060	12054
13097	DOUGLAS	GA	12060	12054
13113	FAYETTE	GA	12060	12054
13117	FORSYTH	GA	12060	12054
13121	FULTON	GA	12060	12054
13135	GWINNETT	GA	12060	12054
13143	HARALSON	GA	12060	31924
13149	HEARD	GA	12060	12054
13151	HENRY	GA	12060	12054
13159	JASPER	GA	12060	12054
13199	MERIWETHER	GA	12060	12054
13211	MORGAN	GA	12060	12054
13217	NEWTON	GA	12060	12054
13223	PAULDING	GA	12060	31924
13227	PICKENS	GA	12060	12054
13231	PIKE	GA	12060	12054
13247	ROCKDALE	GA	12060	12054
13255	SPALDING	GA	12060	12054
13297	WALTON	GA	12060	12054
18073	JASPER	IN	23844	29414
18089	LAKE	IN	23844	29414
18111	NEWTON	IN	23844	29414
18127	PORTER	IN	23844	29414
21163	MEADE	KY	21060	31140
22103	ST. TAMMANY	LA	35380	43640
24009	CALVERT	MD	47894	30500

FIPS County Code	County Name	State	Current CBSA	Proposed CBSA
24017	CHARLES	MD	47894	47764
24033	PRINCE GEORGES	MD	47894	47764
24037	ST. MARYS	MD	15680	30500
25015	HAMPSHIRE	MA	44140	11200
34009	CAPE MAY	NJ	36140	12100
34023	MIDDLESEX	NJ	35154	29484
34025	MONMOUTH	NJ	35154	29484
34029	OCEAN	NJ	35154	29484
34035	SOMERSET	NJ	35154	29484
36027	DUTCHESS	NY	39100	28880
36071	ORANGE	NY	39100	28880
37019	BRUNSWICK	NC	34820	48900
39035	CUYAHOGA	OH	17460	17410
39055	GEAUGA	OH	17460	17410
39085	LAKE	OH	17460	17410
39093	LORAIN	OH	17460	17410
39103	MEDINA	OH	17460	17410
39123	OTTAWA	OH	45780	41780
47057	GRAINGER	TN	34100	28940
51013	ARLINGTON	VA	47894	11694
51043	CLARKE	VA	47894	11694
51047	CULPEPER	VA	47894	11694
51059	FAIRFAX	VA	47894	11694
51061	FAUQUIER	VA	47894	11694
51107	LOUDOUN	VA	47894	11694
51153	PRINCE WILLIAM	VA	47894	11694
51157	RAPPAHANNOCK	VA	47894	11694
51177	SPOTSYLVANIA	VA	47894	11694
51179	STAFFORD	VA	47894	11694
51187	WARREN	VA	47894	11694
51510	ALEXANDRIA CITY	VA	47894	11694
51600	FAIRFAX CITY	VA	47894	11694
51610	FALLS CHURCH CITY	VA	47894	11694
51630	FREDERICKSBURG CITY	VA	47894	11694
51683	MANASSAS CITY	VA	47894	11694
51685	MANASSAS PARK CITY	VA	47894	11694
53061	SNOHOMISH	WA	42644	21794
54037	JEFFERSON	WV	47894	11694
55059	KENOSHA	WI	29404	28450
72023	CABO ROJO	PR	41900	32420
72059	GUAYANILLA	PR	49500	38660
72079	LAJAS	PR	41900	32420
72111	PENUELAS	PR	49500	38660
72121	SABANA GRANDE	PR	41900	32420
72125	SAN GERMAN	PR	41900	32420
72153	YAUCO	PR	49500	38660

If providers located in these counties the new OMB delineations, there may move from one CBSA to another under

be impacts, both negative and positive, upon their specific wage index values.

In other cases, adopting the revised OMB delineations would involve a change only in CBSA name and/or number, while the CBSA continues to encompass the same constituent counties. For example, CBSA 19430 (Dayton-Kettering, OH) would

experience a change to its name and become CBSA 19430 (Dayton-Kettering-Beavercreek, OH), while all of its three constituent counties would remain the same. We consider these proposed changes (where only the CBSA name and/or number would change) to be

inconsequential changes with respect to the IRF PPS wage index. Table 8 sets forth a list of such CBSAs where there would be a change in CBSA name and/or number only if we adopt the revised OMB delineations.

TABLE 8: Urban CBSAs With Change to Name and/or Number

Current CBSA	Current CBSA Name	New CBSA	Proposed CBSA Name
10380	Aguadilla-Isabela, PR	10380	Aguadilla, PR
10540	Albany-Lebanon, OR	10540	Albany, OR
12060	Atlanta-Sandy Springs-Alpharetta, GA	12054	Atlanta-Sandy Springs-Roswell, GA
12060	Atlanta-Sandy Springs-Alpharetta, GA	31924	Marietta, GA
12420	Austin-Round Rock-Georgetown, TX	12420	Austin-Round Rock-San Marcos, TX
12540	Bakersfield, CA	12540	Bakersfield-Delano, CA
13820	Birmingham-Hoover, AL	13820	Birmingham, AL
13980	Blacksburg-Christiansburg, VA	13980	Blacksburg-Christiansburg-Radford, VA
14860	Bridgeport-Stamford-Norwalk, CT	14860	Bridgeport-Stamford-Danbury, CT
15260	Brunswick, GA	15260	Brunswick-St. Simons, GA
15680	California-Lexington Park, MD	30500	Lexington Park, MD
16540	Chambersburg-Waynesboro, PA	16540	Chambersburg, PA
16984	Chicago-Naperville-Evanston, IL	16984	Chicago-Naperville-Schaumburg, IL
17460	Cleveland-Elyria, OH	17410	Cleveland, OH
19430	Dayton-Kettering, OH	19430	Dayton-Kettering-Beavercreek, OH
19740	Denver-Aurora-Lakewood, CO	19740	Denver-Aurora-Centennial, CO
21060	Elizabethtown-Fort Knox, KY	21060	Elizabethtown, KY
21060	Elizabethtown-Fort Knox, KY	31140	Louisville/Jefferson County, KY-IN
21780	Evansville, IN-KY	21780	Evansville, IN
21820	Fairbanks, AK	21820	Fairbanks-College, AK
22660	Fort Collins, CO	22660	Fort Collins-Loveland, CO
23224	Frederick-Gaithersburg-Rockville, MD	23224	Frederick-Gaithersburg-Bethesda, MD
23844	Gary, IN	29414	Lake County-Porter County-Jasper County, IN
24340	Grand Rapids-Kentwood, MI	24340	Grand Rapids-Wyoming-Kentwood, MI
24860	Greenville-Anderson, SC	24860	Greenville-Anderson-Greer, SC

Current CBSA	Current CBSA Name	New CBSA	Proposed CBSA Name
25540	Hartford-East Hartford-Middletown, CT	25540	Hartford-West Hartford-East Hartford, CT
25940	Hilton Head Island-Bluffton, SC	25940	Hilton Head Island-Bluffton-Port Royal, SC
26380	Houma-Thibodaux, LA	26380	Houma-Bayou Cane-Thibodaux, LA
26420	Houston-The Woodlands-Sugar Land, TX	26420	Houston-Pasadena-The Woodlands, TX
26900	Indianapolis-Carmel-Anderson, IN	26900	Indianapolis-Carmel-Greenwood, IN
27900	Joplin, MO	27900	Joplin, MO-KS
27980	Kahului-Wailuku-Lahaina, HI	27980	Kahului-Wailuku, HI
29404	Lake County-Kenosha County, IL-WI	28450	Kenosha, WI
29404	Lake County-Kenosha County, IL-WI	29404	Lake County, IL
29820	Las Vegas-Henderson-Paradise, NV	29820	Las Vegas-Henderson-North Las Vegas, NV
31020	Longview, WA	31020	Longview-Kelso, WA
31460	Madera, CA	23420	Fresno, CA
34100	Morristown, TN	28940	Knoxville, TN
34740	Muskegon, MI	34740	Muskegon-Norton Shores, MI
34820	Myrtle Beach-Conway-North Myrtle Beach, SC-NC	34820	Myrtle Beach-Conway-North Myrtle Beach, SC
34820	Myrtle Beach-Conway-North Myrtle Beach, SC-NC	48900	Wilmington, NC
35084	Newark, NJ-PA	35084	Newark, NJ
35154	New Brunswick-Lakewood, NJ	29484	Lakewood-New Brunswick, NJ
35300	New Haven-Milford, CT	35300	New Haven, CT
35380	New Orleans-Metairie, LA	43640	Slidell-Mandeville-Covington, LA
35840	North Port-Sarasota-Bradenton, FL	35840	North Port-Bradenton-Sarasota, FL
35980	Norwich-New London, CT	35980	Norwich-New London-Willimantic, CT
36084	Oakland-Berkeley-Livermore, CA	36084	Oakland-Fremont-Berkeley, CA
36140	Ocean City, NJ	12100	Atlantic City-Hammonton, NJ
36260	Ogden-Clearfield, UT	36260	Ogden, UT
36540	Omaha-Council Bluffs, NE-IA	36540	Omaha, NE-IA
37460	Panama City, FL	37460	Panama City-Panama City Beach, FL
39100	Poughkeepsie-Newburgh-Middletown, NY	28880	Kiryas Joel-Poughkeepsie-Newburgh, NY
39340	Provo-Orem, UT	39340	Provo-Orem-Lehi, UT
39540	Racine, WI	39540	Racine-Mount Pleasant, WI
41540	Salisbury, MD-DE	41540	Salisbury, MD
41620	Salt Lake City, UT	41620	Salt Lake City-Murray, UT
41900	San Germán, PR	32420	Mayagüez, PR
42644	Seattle-Bellevue-Kent, WA	21794	Everett, WA
42680	Sebastian-Vero Beach, FL	42680	Sebastian-Vero Beach-West Vero Corridor, FL
42700	Sebring-Avon Park, FL	42700	Sebring, FL
43620	Sioux Falls, SD	43620	Sioux Falls, SD-MN
44140	Springfield, MA	11200	Amherst Town-Northampton, MA
44420	Staunton, VA	44420	Staunton-Stuarts Draft, VA
44700	Stockton, CA	44700	Stockton-Lodi, CA
45300	Tampa-St. Petersburg-Clearwater, FL	41304	St. Petersburg-Clearwater-Largo, FL
45300	Tampa-St. Petersburg-Clearwater, FL	45294	Tampa, FL
45540	The Villages, FL	48680	Wildwood-The Villages, FL
45780	Toledo, OH	41780	Sandusky, OH
47220	Vineland-Bridgeton, NJ	47220	Vineland, NJ
47260	Virginia Beach-Norfolk-Newport News, VA-NC	47260	Virginia Beach-Chesapeake-Norfolk, VA-NC

Current CBSA	Current CBSA Name	New CBSA	Proposed CBSA Name
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	11694	Arlington-Alexandria-Reston, VA-WV
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	30500	Lexington Park, MD
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	47764	Washington, DC-MD
48140	Wausau-Weston, WI	48140	Wausau, WI
48300	Wenatchee, WA	48300	Wenatchee-East Wenatchee, WA
48424	West Palm Beach-Boca Raton-Boynton Beach, FL	48424	West Palm Beach-Boca Raton-Delray Beach, FL
49340	Worcester, MA-CT	49340	Worcester, MA
49500	Yauco, PR	38660	Ponce, PR
49660	Youngstown-Warren-Boardman, OH-PA	49660	Youngstown-Warren, OH

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d. Change to County-Equivalents in the State of Connecticut

The June 6, 2022 Census Bureau Notice (87 FR 34235—34240), OMB Bulletin No. 23-01 replaced the 8 counties in Connecticut with 9 new

“Planning Regions.” Planning regions now serve as county-equivalents within the CBSA system. We are proposing to adopt the planning regions as county equivalents for wage index purposes. We believe it is necessary to adopt this migration from counties to planning

region county-equivalents in order to maintain consistency with OMB updates. We are providing the following crosswalk with the current and proposed FIPS county and county-equivalent codes and CBSA assignments.

TABLE 9: Connecticut Counties to Planning Regions

FIPS	Current County	Current CBSA	Proposed FIPS	Proposed Planning Region Area (County Equivalent)	Proposed CBSA
9003	Hartford	25540	9110	Capitol	25540
9015	Windham	49340	9150	Northeastern Connecticut	7
9005	Litchfield	7	9160	Northwest Hills	7
9001	Fairfield	14860	9190	Western Connecticut	14860
9011	New London	35980	9180	Southeastern Connecticut	35980
9013	Tolland	25540	9110	Capitol	25540
9009	New Haven	35300	9170	South Central Connecticut	35300
9007	Middlesex	25540	9130	Lower Connecticut River Valley	25540

3. Transition Policy for FY 2025 Wage Index Changes

Overall, we believe that implementing the new OMB delineations would result in wage index values being more representative of the actual costs of labor in a given area. We recognize that some providers (10 percent) would have a higher wage index due to our proposed implementation of the new labor market area delineations. However, we also recognize that more providers (16 percent) would experience decreases in wage index values as a result of our proposed implementation of the new labor market area delineations. Our analysis for the FY 2025 proposed rule indicates that 16 IRFs will experience a change in either rural or urban designations. Of these, 8

facilities designated as rural in FY 2024 would be designated as urban in FY 2025. Based upon the CBSA delineations, those rural IRFs that change from rural to urban would lose the 14.9 percent rural adjustment. To mitigate the financial impacts of this loss, we are proposing a transition for these facilities, as discussed further below.

CMS recognizes that IRFs in certain areas may experience reduced payments due to the proposed adoption of the revised OMB delineations and has finalized transition policies to mitigate negative financial impacts and provide stability to year-to-year wage index variations. In the FY 2021 final rule (85 FR 48434), CMS finalized a wage index transition policy to apply a 5 percent cap for IRFs that may experience

decreases in their final wage index from the prior fiscal year. In FY 2023, the 5 percent cap policy was made permanent. This 5 percent cap on reductions policy is discussed in further detail in FY 2023 final rule at 87 FR 47054 through 47056. It is CMS’s long held opinion that revised labor market delineations should be adopted as soon as is possible to maintain the integrity of the wage index system. We believe the 5- percent cap policy will sufficiently mitigate significant disruptive financial impacts on hospitals negatively affected by the proposed adoption of the revised OMB delineations. Besides the rural adjustment transition discussed immediately below, we do not believe any additional transition is necessary

considering that the current cap on wage index decreases, which was not in place when implementing prior decennial census updates in FY 2006 and FY 2015, ensures that an IRF's wage index would not be less than 95 percent of its final wage index for the prior year.

Consistent with the transition policy adopted in FY 2006 (70 FR 47923⁴ through 47927⁵), we considered the appropriateness of applying a 3-year phase-out of the rural adjustment for IRFs located in rural counties that would become urban under the new OMB delineations, given the potentially significant payment impacts for these facilities. We continue to believe, as discussed in the FY 2006 IRF final rule (70 FR 47880⁶), that the phase-out of the rural adjustment transition period for these facilities specifically is appropriate because, as a group, we expect these IRFs would experience a steeper and more abrupt reduction in their payments compared to other IRFs. Therefore, we are proposing a budget neutral three-year phase-out of the rural adjustment for existing FY 2024 rural IRFs that will become urban in FY 2025 and that experience a loss in payments due to changes from the new CBSA delineations. Accordingly, the incremental steps needed to reduce the impact of the loss of the FY 2024 rural adjustment of 14.9 percent will be phased out over FYs 2025, 2026 and 2027. This policy will allow rural IRFs which would be classified as urban in FY 2025 to receive two-thirds of the 2024 rural adjustment for FY 2025. For FY 2026, these IRFs will receive the full FY 2026 wage index and one-third of the FY 2024 rural adjustment. For FY 2027, these IRFs will receive the full FY 2027 wage index without a rural adjustment. We believe a three-year budget-neutral phase-out of the rural adjustment for IRFs that transition from rural to urban status under the new CBSA delineations would best accomplish the goals of mitigating the loss of the rural adjustment for existing FY 2024 rural IRFs. The purpose of the gradual phase-out of the rural adjustment for these facilities is to alleviate the significant payment implications for existing rural IRFs that may need time to adjust to the loss of their FY 2024 rural payment adjustment or that experience a reduction in payments solely because of this redesignation. As stated, this policy is specifically for rural IRFs that become

urban in FY 2025 and that experience a loss in payments due to changes from the new CBSA delineations. Thus, we are not implementing a transition policy for urban facilities that become rural in FY 2025 because these IRFs will receive the full rural adjustment of 14.9 percent beginning October 1, 2024.

We invite comments on our proposed implementation of revised labor market area delineations and on the proposed transition policy for rural IRFs that would be designated as urban under the new CBSA delineations. The proposed wage index applicable to FY 2025 is set forth in Table A available on the CMS website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRF-Rules-and-Related-Files.html>. Table A provides a crosswalk between the FY 2024 wage index for a provider using the current OMB delineations in effect in FY 2024 and the FY 2025 wage index using the proposed revised OMB delineations.

4. IRF Budget-Neutral Wage Adjustment Factor Methodology

To calculate the wage-adjusted facility payment for the proposed payment rates set forth in this proposed rule, we multiply the unadjusted Federal payment rate for IRFs by the FY 2025 labor-related share based on the 2021-based IRF market basket relative importance (74.2 percent) to determine the labor-related portion of the standard payment amount. (A full discussion of the calculation of the labor-related share appears in section VI.E. of this proposed rule.) We would then multiply the labor-related portion by the applicable IRF wage index. The wage index tables are available on the CMS website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRF-Rules-and-Related-Files.html>.

Adjustments or updates to the IRF wage index made under section 1886(j)(6) of the Act must be made in a budget-neutral manner. We calculate a budget-neutral wage adjustment factor as established in the FY 2004 IRF PPS final rule (68 FR 45689) and codified at § 412.624(e)(1), as described in the steps below. We use the listed steps to ensure that the FY 2025 IRF standard payment conversion factor reflects the update to the wage indexes (based on the FY 2021 hospital cost report data) and the update to the labor-related share, in a budget-neutral manner:

Step 1. Calculate the total amount of estimated IRF PPS payments using the labor-related share and the wage indexes from FY 2024 (as published in the FY 2024 IRF PPS final rule (88 FR 50956)).

Step 2. Calculate the total amount of estimated IRF PPS payments using the FY 2025 wage index values (based on updated hospital wage data and considering the permanent cap on wage index decreases policy) and the FY 2025 proposed labor-related share of 74.2 percent.

Step 3. Divide the amount calculated in step 1 by the amount calculated in step 2. The resulting quotient is the FY 2025 budget-neutral wage adjustment factor of 0.9928.

Step 4. Apply the budget neutrality factor from step 3 to the FY 2025 IRF PPS standard payment amount after the application of the increase factor to determine the FY 2025 standard payment conversion factor.

We discuss the calculation of the standard payment conversion factor for FY 2025 in section VI.G. of this proposed rule.

We invite public comment on our proposals regarding the Wage Adjustment for FY 2025.

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

To calculate the proposed standard payment conversion factor for FY 2025, as illustrated in Table 10, we begin by applying the proposed increase factor for FY 2025, as adjusted in accordance with sections 1886(j)(3)(C) of the Act, to the standard payment conversion factor for FY 2024 (\$18,541). Applying the proposed 2.8 payment update for FY 2025 to the standard payment conversion factor for FY 2024 of \$18,541 yields a standard payment amount of \$19,060. Then, we apply the proposed budget neutrality factor for the FY 2025 wage index (taking into account the policy placing a permanent cap on decreases in the wage index), and labor-related share of 0.9928, which results in a standard payment amount of \$18,923. We next apply the proposed budget neutrality factor for the CMG relative weights of 0.9973, which results in the proposed standard payment conversion factor of \$18,872 for FY 2025.

We invite public comment on the proposed FY 2025 standard payment conversion factor.

⁴ <https://www.federalregister.gov/citation/70-FR-47923>.

⁵ <https://www.federalregister.gov/citation/70-FR-47927>.

⁶ <https://www.federalregister.gov/citation/70-FR-47880>.

TABLE 10: Calculations to Determine the Proposed FY 2025 Standard Payment Conversion Factor

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

We then apply the proposed CMG relative weights described in section IV. of this proposed rule to the FY 2025 standard payment conversion factor

(\$18,872), to determine the unadjusted IRF prospective payment rates for FY 2025. The unadjusted prospective

payment rates for FY 2025 are shown in Table 11.

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TABLE 11: Proposed FY 2025 IRF PPS Payment Rates

CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidity
0101	\$18,434.17	\$15,995.91	\$14,648.45	\$13,970.94
0102	\$23,386.18	\$20,291.17	\$18,583.26	\$17,724.58
0103	\$30,148.02	\$26,158.48	\$23,956.12	\$22,848.33
0104	\$38,476.23	\$33,384.57	\$30,574.53	\$29,161.01
0105	\$48,070.76	\$41,707.12	\$38,196.93	\$36,432.40
0106	\$54,658.97	\$47,423.45	\$43,432.02	\$41,424.04
0201	\$19,243.78	\$15,948.73	\$14,491.81	\$13,650.12
0202	\$24,958.22	\$20,685.60	\$18,794.62	\$17,703.82
0203	\$31,178.43	\$25,841.43	\$23,478.66	\$22,117.98
0204	\$38,655.52	\$32,037.11	\$29,110.06	\$27,421.02
0205	\$49,486.16	\$41,012.63	\$37,266.54	\$35,103.81
0301	\$22,580.35	\$18,094.47	\$16,626.23	\$15,680.74
0302	\$29,170.45	\$23,376.75	\$21,480.11	\$20,257.20
0303	\$35,173.63	\$28,187.22	\$25,899.93	\$24,424.14
0304	\$40,778.62	\$32,678.76	\$30,027.24	\$28,317.44
0305	\$44,871.95	\$35,960.60	\$33,041.10	\$31,161.45
0401	\$22,804.92	\$20,521.41	\$19,853.34	\$18,037.86
0402	\$29,153.47	\$26,233.97	\$25,379.07	\$23,057.81
0403	\$36,664.52	\$32,992.03	\$31,918.21	\$29,000.60
0404	\$55,842.25	\$50,250.47	\$48,614.27	\$44,168.03
0405	\$45,247.51	\$40,716.34	\$39,391.53	\$35,788.86
0406	\$57,797.39	\$52,009.34	\$50,318.41	\$45,715.53
0407	\$78,450.90	\$70,596.38	\$68,297.77	\$62,051.14
0501	\$24,078.78	\$18,677.62	\$17,647.21	\$16,263.89
0502	\$30,144.25	\$23,382.41	\$22,093.45	\$20,361.00
0503	\$34,548.97	\$26,798.24	\$25,320.56	\$23,335.23
0504	\$41,082.46	\$31,865.37	\$30,108.39	\$27,749.39
0505	\$57,097.24	\$44,286.92	\$41,846.77	\$38,566.82
0601	\$25,024.27	\$18,787.08	\$17,528.31	\$15,814.74
0602	\$31,748.37	\$23,835.34	\$22,238.76	\$20,064.71
0603	\$37,391.09	\$28,070.21	\$26,190.56	\$23,631.52
0604	\$46,900.69	\$35,209.49	\$32,852.38	\$29,640.36
0701	\$23,712.67	\$18,324.71	\$17,364.13	\$16,037.43
0702	\$29,253.49	\$22,604.88	\$21,419.72	\$19,783.52
0703	\$35,994.57	\$27,813.55	\$26,356.64	\$24,342.99
0704	\$43,975.53	\$33,980.92	\$32,201.29	\$29,740.38
0801	\$22,903.06	\$18,534.19	\$16,807.40	\$15,659.99
0802	\$25,992.41	\$21,034.73	\$19,073.93	\$17,771.76
0803	\$28,836.42	\$23,337.12	\$21,161.17	\$19,717.47
0804	\$32,337.17	\$26,169.80	\$23,731.54	\$22,112.32
0805	\$38,761.20	\$31,369.04	\$28,445.77	\$26,503.84
0901	\$22,589.78	\$18,152.98	\$16,931.96	\$15,495.80
0902	\$28,145.70	\$22,618.09	\$21,097.01	\$19,307.94
0903	\$33,592.16	\$26,994.51	\$25,177.14	\$23,042.71
0904	\$40,250.20	\$32,346.61	\$30,168.78	\$27,611.62
1001	\$22,759.63	\$18,870.11	\$17,222.59	\$15,390.12
1002	\$28,879.82	\$23,942.91	\$21,851.89	\$19,526.86
1003	\$33,890.34	\$28,098.52	\$25,643.27	\$22,916.27
1004	\$43,362.19	\$35,949.27	\$32,808.97	\$29,319.54
1101	\$23,744.75	\$19,230.57	\$19,230.57	\$18,747.44
1102	\$30,331.08	\$24,565.68	\$24,565.68	\$23,946.68
1103	\$37,817.60	\$30,629.26	\$30,629.26	\$29,857.39
1201	\$24,909.15	\$19,060.72	\$17,805.73	\$16,322.39
1202	\$30,242.38	\$23,140.85	\$21,619.76	\$19,817.49
1203	\$39,112.22	\$29,929.10	\$27,960.76	\$25,628.18

CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidity
1204	\$41,037.16	\$31,401.12	\$29,336.52	\$26,890.71
1301	\$21,185.71	\$16,964.04	\$16,214.82	\$15,039.10
1302	\$29,091.19	\$23,293.71	\$22,265.19	\$20,651.63
1303	\$32,942.96	\$26,377.39	\$25,212.99	\$23,386.18
1304	\$41,775.06	\$33,448.73	\$31,972.94	\$29,655.46
1305	\$39,482.11	\$31,614.37	\$30,217.85	\$28,026.81
1401	\$21,236.66	\$16,775.32	\$15,584.50	\$14,344.61
1402	\$26,958.65	\$21,295.16	\$19,783.52	\$18,209.59
1403	\$33,022.23	\$26,084.88	\$24,231.65	\$22,306.70
1404	\$40,367.21	\$31,888.02	\$29,623.38	\$27,268.15
1501	\$23,825.90	\$19,466.47	\$18,385.10	\$17,167.86
1502	\$30,136.70	\$24,624.19	\$23,255.97	\$21,716.01
1503	\$34,307.41	\$28,030.58	\$26,473.64	\$24,720.43
1504	\$42,435.58	\$34,671.64	\$32,744.81	\$30,576.41
1601	\$24,192.02	\$18,315.28	\$16,445.06	\$15,305.19
1602	\$28,055.12	\$21,238.55	\$19,072.04	\$17,749.12
1603	\$35,188.73	\$26,639.72	\$23,920.26	\$22,261.41
1604	\$43,675.47	\$33,063.74	\$29,689.43	\$27,630.50
1701	\$25,122.41	\$19,643.86	\$18,168.07	\$16,499.79
1702	\$31,225.61	\$24,416.59	\$22,580.35	\$20,508.20
1703	\$37,111.79	\$29,019.47	\$26,837.87	\$24,375.08
1704	\$41,995.86	\$32,839.17	\$30,370.71	\$27,583.32
1705	\$49,252.15	\$38,513.98	\$35,619.01	\$32,350.38
1801	\$19,913.73	\$16,065.73	\$15,144.78	\$14,035.11
1802	\$26,673.68	\$21,517.85	\$20,283.63	\$18,798.40
1803	\$34,377.24	\$27,732.40	\$26,141.49	\$24,229.76
1804	\$37,589.25	\$30,325.42	\$28,585.42	\$26,494.40
1805	\$45,536.25	\$36,736.24	\$34,628.23	\$32,093.72
1806	\$64,383.72	\$51,939.52	\$48,961.52	\$45,377.72
1901	\$19,528.75	\$15,048.53	\$14,033.22	\$13,735.04
1902	\$31,425.65	\$24,218.44	\$22,582.24	\$22,104.77
1903	\$47,213.97	\$36,385.22	\$33,926.19	\$33,207.17
1904	\$69,028.11	\$53,196.39	\$49,603.16	\$48,551.99
2001	\$22,225.55	\$17,784.97	\$16,626.23	\$15,139.12
2002	\$27,724.86	\$22,184.04	\$20,738.44	\$18,883.32
2003	\$33,192.07	\$26,558.57	\$24,828.00	\$22,606.77
2004	\$39,678.38	\$31,748.37	\$29,679.99	\$27,024.70
2005	\$41,820.35	\$33,461.94	\$31,282.23	\$28,483.51
2101	\$28,626.94	\$21,993.43	\$21,993.43	\$18,551.18
2102	\$43,573.56	\$33,477.04	\$33,477.04	\$28,238.17
5001	\$-	\$-	\$-	\$3,236.55
5101	\$-	\$-	\$-	\$14,272.89
5102	\$-	\$-	\$-	\$34,390.45
5103	\$-	\$-	\$-	\$17,286.75
5104	\$-	\$-	\$-	\$44,904.04

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H. Example of the Methodology for Adjusting the Prospective Payment Rates

Table 12 illustrates the methodology for adjusting the proposed prospective payments (as described in section V. of this proposed rule). The following examples are based on two hypothetical Medicare beneficiaries, both classified

into CMG 0104 (without comorbidities). The unadjusted prospective payment rate for CMG 0104 (without comorbidities) appears in Table 11.

Example: One beneficiary is in Facility A, an IRF located in rural Spencer County, Indiana, and another beneficiary is in Facility B, an IRF located in urban Harrison County, Indiana. Facility A, a rural non-teaching hospital has a Disproportionate Share

Hospital (DSH) percentage of 5 percent (which would result in a LIP adjustment of 1.0156), a wage index of 0.8693, and a rural adjustment of 14.9 percent. Facility B, an urban teaching hospital, has a DSH percentage of 15 percent (which would result in a LIP adjustment of 1.0454 percent), a wage index of 0.9106, and a teaching status adjustment of 0.0784.

To calculate each IRF’s labor and non-labor portion of the proposed prospective payment, we begin by taking the proposed FY 2025 unadjusted prospective payment rate for CMG 0104 (without comorbidities) from Table 11. Then, we multiply the proposed labor-related share for FY 2025 (74.2 percent) described in section VI. of this proposed rule by the unadjusted prospective payment rate. To determine the non-labor portion of the proposed prospective payment rate, we subtract the labor portion of the Federal payment from the proposed unadjusted prospective payment.

To compute the wage-adjusted prospective payment, we multiply the

labor portion of the proposed Federal payment by the appropriate wage index located in the applicable wage index table. This table is available on the CMS website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRF-Rules-and-Related-Files.html>.

The resulting figure is the wage-adjusted labor amount. Next, we compute the wage-adjusted Federal payment by adding the wage-adjusted labor amount to the non-labor portion of the proposed Federal payment.

Adjusting the proposed wage-adjusted Federal payment by the facility-level adjustments involves several steps.

First, we take the wage-adjusted

prospective payment and multiply it by the appropriate rural and LIP adjustments (if applicable). Second, to determine the appropriate amount of additional payment for the teaching status adjustment (if applicable), we multiply the teaching status adjustment (0.0784, in this example) by the wage-adjusted and rural-adjusted amount (if applicable). Finally, we add the additional teaching status payments (if applicable) to the wage, rural, and LIP-adjusted prospective payment rates. Table 12 illustrates the components of the adjusted payment calculation.

TABLE 12: Example of Computing the Proposed FY 2025 IRF Prospective Payment

Steps		Rural Facility A (Spencer Co., IN)		Urban Facility B (Harrison Co., IN)	
1	Unadjusted Payment		\$29,161.01		\$29,161.01
2	Labor-Related Share	X	0.742	X	0.742
3	Labor Portion of Payment	=	\$21,637.47	=	\$21,637.47
4	CBSA-Based Wage Index	X	0.8693	X	0.9106
5	Wage-Adjusted Amount	=	\$18,809.45	=	\$19,703.08
6	Non-Labor Amount	+	\$7,523.54	+	\$7,523.54
7	Wage-Adjusted Payment	=	\$26,332.99	=	\$27,226.62
8	Rural Adjustment	X	1.149	X	1.000
9	Wage- and Rural-Adjusted Payment	=	\$30,256.61	=	\$27,226.62
10	LIP Adjustment	X	1.0156	X	1.0454
11	Wage-, Rural- and LIP-Adjusted Payment	=	\$30,728.61	=	\$28,462.71
12	Wage- and Rural-Adjusted Payment		\$30,256.61		\$27,226.62
13	Teaching Status Adjustment	X	0	X	0.0784
14	Teaching Status Adjustment Amount	=	\$0.00	=	\$2,134.57
15	Wage-, Rural-, and LIP-Adjusted Payment	+	\$30,728.61	+	\$28,462.71
16	Total Adjusted Payment	=	\$30,728.61	=	\$30,597.28

Thus, the proposed adjusted payment for Facility A would be \$30,728.61, and the proposed adjusted payment for Facility B would be \$30,597.28.

VI. Proposed Update to Payments for High-Cost Outliers Under the IRF PPS for FY 2025

A. Update to the Outlier Threshold Amount for FY 2025

Section 1886(j)(4) of the Act provides the Secretary with the authority to make payments in addition to the basic IRF prospective payments for cases incurring extraordinarily high costs. A case qualifies for an outlier payment if the estimated cost of the case exceeds the adjusted outlier threshold. We calculate the adjusted outlier threshold by adding the IRF PPS payment for the case (that is, the CMG payment adjusted by all of the relevant facility-level

adjustments) and the adjusted threshold amount (also adjusted by all of the relevant facility-level adjustments). Then, we calculate the estimated cost of a case by multiplying the IRF’s overall CCR by the Medicare allowable covered charge. If the estimated cost of the case is higher than the adjusted outlier threshold, we make an outlier payment for the case equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold.

In the FY 2002 IRF PPS final rule (66 FR 41362 through 41363), we discussed our rationale for setting the outlier threshold amount for the IRF PPS so that estimated outlier payments would equal 3 percent of total estimated payments. For the FY 2002 IRF PPS final rule, we analyzed various outlier policies using 3, 4, and 5 percent of the total estimated payments, and we concluded that an outlier policy set at

3 percent of total estimated payments would optimize the extent to which we could reduce the financial risk to IRFs of caring for high-cost patients, while still providing for adequate payments for all other (non-high cost outlier) cases.

Subsequently, we updated the IRF outlier threshold amount in the FYs 2006 through 2024 IRF PPS final rules and the FY 2011 and FY 2013 notices (70 FR 47880, 71 FR 48354, 72 FR 44284, 73 FR 46370, 74 FR 39762, 75 FR 42836, 76 FR 47836, 76 FR 59256, 77 FR 44618, 78 FR 47860, 79 FR 45872, 80 FR 47036, 81 FR 52056, 82 FR 36238, 83 FR 38514, 84 FR 39054, 85 FR 48444, 86 FR 42362, 87 FR 47038, and 88 FR 50956 respectively) to maintain estimated outlier payments at 3 percent of total estimated payments. We also stated in the FY 2009 final rule (73 FR 46370 at 46385) that we would continue to

analyze the estimated outlier payments for subsequent years and adjust the outlier threshold amount as appropriate to maintain the 3 percent target.

To update the IRF outlier threshold amount for FY 2025, we propose to use FY 2023 claims data and the same methodology that we used to set the initial outlier threshold amount in the FY 2002 IRF PPS final rule (66 FR 41362 through 41363), which is also the same methodology that we used to update the outlier threshold amounts for FYs 2006 through 2024. The outlier threshold is calculated by simulating aggregate payments and using an iterative process to determine a threshold that results in outlier payments being equal to 3 percent of total payments under the simulation. To determine the outlier threshold for FY 2025, we estimated the amount of FY 2025 IRF PPS aggregate and outlier payments using the most recent claims available (FY 2023) and the proposed FY 2025 standard payment conversion factor, labor-related share, and wage indexes, incorporating any applicable budget-neutrality adjustment factors. The outlier threshold is adjusted either up or down in this simulation until the estimated outlier payments equal 3 percent of the estimated aggregate payments. Based on an analysis of the preliminary data used for the proposed rule, we estimated that IRF outlier payments as a percentage of total estimated payments would be approximately 3.2 percent in FY 2024. Therefore, we propose to update the outlier threshold amount from \$10,423 for FY 2024 to \$12,158 for FY 2025 to maintain estimated outlier payments at approximately 3 percent of total estimated aggregate IRF payments for FY 2025.

We note that, as we typically do, we will update our data between the FY 2025 IRF PPS proposed and final rules to ensure that we use the most recent available data in calculating IRF PPS payments.

We invite public comment on the proposed update to the IRF outlier threshold for FY 2025.

B. Proposed Update to the IRF Cost-to-Charge Ratio Ceiling and Urban/Rural Averages for FY 2025

CCRs are used to adjust charges from Medicare claims to costs and are computed annually from facility-specific data obtained from MCRs. IRF specific CCRs are used in the development of the CMG relative weights and the calculation of outlier payments under the IRF PPS. In accordance with the methodology stated in the FY 2004 IRF PPS final rule (68 FR45692 through 45694), we propose to

apply a ceiling to IRFs' CCRs. Using the methodology described in that final rule, we propose to update the national urban and rural CCRs for IRFs, as well as the national CCR ceiling for FY 2025, based on analysis of the most recent data available. We apply the national urban and rural CCRs in the following situations:

- New IRFs that have not yet submitted their first MCR.
- IRFs whose overall CCR is in excess of the national CCR ceiling for FY 2025, as discussed below in this section.
- Other IRFs for which accurate data to calculate an overall CCR are not available.

Specifically, for FY 2025, we propose to estimate a national average CCR of 0.492 for rural IRFs, which we calculated by taking an average of the CCRs for all rural IRFs using their most recently submitted cost report data. Similarly, we propose to estimate a national average CCR of 0.406 for urban IRFs, which we calculated by taking an average of the CCRs for all urban IRFs using their most recently submitted cost report data. We apply weights to both of these averages using the IRFs' estimated costs, meaning that the CCRs of IRFs with higher total costs factor more heavily into the averages than the CCRs of IRFs with lower total costs. For this proposed rule, we have used the most recent available cost report data (FY 2022). This includes all IRFs whose cost reporting periods begin on or after October 1, 2021, and before October 1, 2022. If, for any IRF, the FY 2022 cost report was missing or had an "as submitted" status, we used data from a previous FY's (that is, FY 2004 through FY 2021) settled cost report for that IRF. We do not use cost report data from before FY 2004 for any IRF because changes in IRF utilization since FY 2004 resulting from the 60 percent rule and IRF medical review activities suggest that these older data do not adequately reflect the current cost of care. Using updated FY 2022 cost report data for this proposed rule, we estimate a national average CCR of 0.492 for rural IRFs, and a national average CCR of 0.406 for urban IRFs.

In accordance with past practice, we propose to set the national CCR ceiling at 3 standard deviations above the mean CCR. Using this method, we proposed a national CCR ceiling of 1.52 for FY 2025. This means that, if an individual IRF's CCR were to exceed this ceiling of 1.52 for FY 2025, we will replace the IRF's CCR with the appropriate proposed national average CCR (either rural or urban, depending on the geographic location of the IRF). We

calculated the proposed national CCR ceiling by:

Step 1. Taking the national average CCR (weighted by each IRF's total costs, as previously discussed) of all IRFs for which we have sufficient cost report data (both rural and urban IRFs combined).

Step 2. Estimating the standard deviation of the national average CCR computed in step 1.

Step 3. Multiplying the standard deviation of the national average CCR computed in step 2 by a factor of 3 to compute a statistically significant reliable ceiling.

Step 4. Adding the result from step 3 to the national average CCR of all IRFs for which we have sufficient cost report data, from step 1.

We also propose that if more recent data become available after the publication of this proposed rule and before the publication of the final rule, we would use such data to determine the FY 2025 national average rural and urban CCRs and the national CCR ceiling in the final rule. Using the FY 2022 cost report data for this proposed rule, we estimate a national average CCR ceiling of 1.52, using the same methodology.

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

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

A. Background and Statutory Authority

The Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP) is authorized by section 1886(j)(7) of the Act, and it applies to freestanding IRFs, as well as inpatient rehabilitation units of hospitals or Critical Access Hospitals (CAHs) paid by Medicare under the IRF PPS. Section 1886(j)(7)(A)(i) of the Act requires the Secretary to reduce by 2 percentage points the annual increase factor for discharges occurring during a FY for any IRF that does not submit data in accordance with the IRF QRP requirements set forth in subparagraphs (C) and (F) of section 1886(j)(7) of the Act. We have codified our program requirements in our regulations at § 412.634.

We are proposing to require IRFs to report four new items to the IRF-Patient Assessment Instrument (PAI) and modify one item on the IRF-PAI as described in section VII.C. of this proposed rule. We are also proposing to remove an item from the IRF-PAI as described in section VII.F.3. Finally, we are seeking information on future measure concepts for the IRF QRP and on an IRF star rating system.

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

For a detailed discussion of the considerations we use for the selection of IRF QRP quality, resource use, or other measures, we refer readers to the

FY 2016 IRF PPS final rule (80 FR 47083 through 47084).

1. Quality Measures Currently Adopted for the IRF QRP

The IRF QRP currently has 18 adopted measures, which are listed in

Table 13. For a discussion of the factors used to evaluate whether a measure should be removed from the IRF QRP, we refer readers to § 412.634(b)(2).

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TABLE 13: Quality Measures Currently Adopted for the IRF QRP

Short Name	Measure Name & Data Source
Inpatient Rehabilitation Facility – Patient Assessment Instrument (IRF-PAI) Assessment-Based Measures	
Pressure Ulcer/Injury	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury
Application of Falls	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)
Discharge Mobility Score	IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients
Discharge Self-Care Score	IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients
DRR	Drug Regimen Review Conducted With Follow-Up for Identified Issues–Post Acute Care (PAC) Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP)
TOH-Provider	Transfer of Health Information to the Provider–Post-Acute Care (PAC)
TOH-Patient	Transfer of Health Information to the Patient–Post-Acute Care (PAC)
DC Function	
Patient/Resident COVID-19 Vaccine	COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date
National Healthcare Safety Network	
CAUTI	National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection Outcome Measure
CDI	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset <i>Clostridium difficile</i> Infection (CDI) Outcome Measure
HCP Influenza Vaccine	Influenza Vaccination Coverage among Healthcare Personnel
HCP COVID-19 Vaccine	COVID-19 Vaccination Coverage among Healthcare Personnel (HCP)
Claims-Based	
MSPB IRF	Medicare Spending Per Beneficiary (MSPB)–Post Acute Care (PAC) IRF QRP
DTC	Discharge to Community–PAC IRF QRP
PPR 30 day	Potentially Preventable 30-Day Post-Discharge Readmission Measure for IRF QRP
PPR Within Stay	Potentially Preventable Within Stay Readmission Measure for IRFs

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We are not proposing to adopt any new measures for the IRF QRP.

C. Proposal To Collect Four New Items as Standardized Patient Assessment Data Elements and Modify One Item Collected as a Standardized Patient Assessment Data Element Beginning With the FY 2028 IRF QRP

In this proposed rule, we are proposing to require IRFs to report the following four new items⁷ to be collected as standardized patient assessment data elements in the IRF-PAI under the social determinants of health (SDOH) category under the IRF QRP: one item for Living Situation; two items for Food; and one item for Utilities. We are also proposing to modify one of the current items collected as standardized patient assessment data under the SDOH category (the Transportation item), as described in section VII.C.5. of this proposed rule.

1. Definition of Standardized Patient Assessment Data

Section 1886(j)(7)(F)(ii) of the Act requires IRFs to submit standardized patient assessment data required under section 1899B(b)(1) of the Act. Section 1899B(b)(1)(A) of the Act requires post-acute care (PAC) providers to submit standardized patient assessment data under applicable reporting provisions (which, for IRFs, is the IRF QRP) with respect to the admission and discharge of an individual (and more frequently as the Secretary deems appropriate) using a standardized patient assessment instrument. Section 1899B(a)(1)(C) of the Act requires, in part, the Secretary to modify the PAC assessment instruments in order for PAC providers, including IRFs, to submit standardized patient assessment data under the Medicare program. IRFs are currently required to report standardized patient assessment data through the patient assessment instrument, referred to as the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI). Section 1899B(b)(1)(B) of the Act describes standardized patient assessment data as data required for at least the quality measures described in section 1899B(c)(1) of the Act and that is with respect to the following categories: (1) functional status, such as mobility and self-care at admission to a PAC provider and before discharge from a PAC provider; (2) cognitive function, such as ability to express ideas and to understand, and mental status, such as

⁷ Items may also be referred to as “data elements.”

depression and dementia; (3) special services, treatments, and interventions, such as need for ventilator use, dialysis, chemotherapy, central line placement, and total parenteral nutrition; (4) medical conditions and comorbidities, such as diabetes, congestive heart failure, and pressure ulcers; (5) impairments, such as incontinence and an impaired ability to hear, see, or swallow, and (6) other categories deemed necessary and appropriate by the Secretary.

2. Social Determinants of Health Collected as Standardized Patient Assessment Data Elements

Section 1899B(b)(1)(B)(vi) of the Act authorizes the Secretary to collect standardized patient assessment data elements with respect to other categories deemed necessary and appropriate. Accordingly, we finalized the creation of the SDOH category of standardized patient assessment data elements in the FY 2020 IRF PPS final rule (84 FR 39149 through 39161), and defined SDOH as the socioeconomic, cultural, and environmental circumstances in which individuals live that impact their health.⁸ According to the World Health Organization, research shows that the SDOH can be more important than health care or lifestyle choices in influencing health, accounting for between 30–55% of health outcomes.⁹ This is a part of a growing body of research that highlights the importance of SDOH on health outcomes. Subsequent to the FY 2020 IRF PPS final rule, we expanded our definition of SDOH: SDOH 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.^{10 11 12} This update will align our definition of

⁸ Office of the Assistant Secretary for Planning and Evaluation (ASPE). Second Report to Congress on Social Risk and Medicare’s Value-Based Purchasing Programs. June 28, 2020. Available at: <https://aspe.hhs.gov/reports/second-report-congress-social-risk-medicare-value-based-purchasing-programs>.

⁹ World Health Organization. Social determinants of health. Available at: https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1.

¹⁰ Using Z Codes: The Social Determinants of Health (SDOH). Data Journey to Better Outcomes. <https://www.cms.gov/files/document/zcodes-infographic.pdf>.

¹¹ Improving the Collection of Social Determinants of Health (SDOH) Data with ICD-10-CM Z Codes. <https://www.cms.gov/files/document/cms-2023-omh-z-code-resource.pdf>.

¹² CMS.gov. Measures Management System (MMS). CMS Focus on Health Equity. Health Equity Terminology and Quality Measures. <https://mmshub.cms.gov/about-quality/quality-at-CMS/goals/cms-focus-on-health-equity/health-equity-terminology>.

SDOH with the definition used by HHS agencies, including OASH, the Centers for Disease Control and Prevention (CDC), and the White House Office of Science and Technology Policy.^{13 14} We currently collect seven items in this SDOH category of standardized patient assessment data elements: ethnicity, race, preferred language, interpreter services, health literacy, transportation, and social isolation (84 FR 39149 through 39161).¹⁵

In accordance with our authority under section 1899B(b)(1)(B)(vi) of the Act, we similarly finalized the creation of the SDOH category of standardized patient assessment data elements for Skilled Nursing Facilities (SNFs) in the FY 2020 SNF PPS final rule (84 FR 38805 through 38817), for Long-Term Care Hospitals (LTCHs) in the FY 2020 Inpatient Prospective Payment System (IPPS)/LTCH PPS final rule (84 FR 42577 through 42588), and for Home Health Agencies (HHAs) in the Calendar Year (CY) 2020 HH PPS final rule (84 FR 60597 through 60608). We also collect the same seven SDOH items in these PAC providers’ respective patient/resident assessment instruments (84 FR 38817, 84 FR 42590, and 84 FR 60610, respectively).

Access to standardized data relating to SDOH on a national level permits us to conduct periodic analyses, and to assess their appropriateness as risk adjusters or in future quality measures. Our ability to perform these analyses and to make adjustments relies on existing data collection of SDOH items from PAC settings. We adopted these SDOH items using common standards and definitions across the four PAC providers to promote interoperable exchange of longitudinal information among these PAC providers, including IRFs, and other providers. We believe this information may facilitate coordinated care, continuity in care planning, and the discharge planning process from PAC settings.

We noted in our FY 2020 IRF PPS final rule that each of the items was identified in the 2016 National Academies of Sciences, Engineering,

¹³ Centers for Disease Control and Prevention. Social Determinants of Health (SDOH) and PLACES Data. <https://www.cdc.gov/places/social-determinants-of-health-and-places-data/>.

¹⁴ “U.S. Playbook To Address Social Determinants Of Health” from the White House Office Of Science And Technology Policy (November 2023).

¹⁵ These SDOH data are also collected for purposes outlined in section 2(d)(2)(B) of the Improving Medicare Post-Acute Care Transitions Act (IMPACT Act). For a detailed discussion on SDOH data collection under section 2(d)(2)(B) of the IMPACT Act, see the FY 2020 IRF PPS final rule (84 FR 39149 through 39161).

and Medicine (NASEM) report as impacting care use, cost, and outcomes for Medicare beneficiaries (84 FR 39150 through 39151). At that time, we acknowledged that other items may also be useful to understand. The SDOH items we are proposing to adopt as standardized patient assessment data elements under the SDOH category in this proposed rule were also identified in the 2016 NASEM report¹⁶ or the 2020 NASEM report¹⁷ as impacting care use, cost, and outcomes for Medicare beneficiaries. The items have the capacity to take into account treatment preferences and care goals of patients and their caregivers, to inform our understanding of patient complexity and SDOH that may affect care outcomes and ensure that IRFs are in a position to impact through the provision of services and supports, such as connecting patients and their caregivers with identified needs with social support programs.

Health-related social needs (HRSNs) are the resulting effects of SDOH, which are individual-level, adverse social conditions that negatively impact a person's health or health care.¹⁸ Examples of HRSNs include lack of access to food, housing, or transportation, and have been associated with poorer health outcomes, greater use of emergency departments and hospitals, and higher health care costs.¹⁹ Certain HRSNs can lead to unmet social needs that directly influence an individual's physical, psychosocial, and functional status. This is particularly true for food security, housing stability, utilities security, and access to transportation.²⁰

¹⁶ Social Determinants of Health. Healthy People 2020. <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>. (February 2019).

¹⁷ National Academies of Sciences, Engineering, and Medicine. 2020. Leading Health Indicators 2030: Advancing Health, Equity, and Well-Being. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25682>.

¹⁸ Centers for Medicare & Medicaid Services. "A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool: Promising Practices and Key Insights." August 2022. Available at: <https://www.cms.gov/priorities/innovation/media/document/ahcm-screeningtool-companion>.

¹⁹ Berkowitz, S.A., T.P. Baggett, and S.T. Edwards. "Addressing Health-Related Social Needs: Value-Based Care or Values-Based Care?" *Journal of General Internal Medicine*, vol. 34, no. 9, 2019, pp. 1916–1918, <https://doi.org/10.1007/s11606-019-05087-3>.

²⁰ Hugh Alderwick and Laura M. Gottlieb, "Meanings and Misunderstandings: A Social Determinants of Health Lexicon for Health Care Systems: Milbank Quarterly," *Milbank Memorial Fund*, November 18, 2019, <https://www.milbank.org/quarterly/articles/meanings-and-misunderstandings-a-social-determinants-of-health-lexicon-for-health-care-systems/>.

We are proposing to require IRFs collect and submit four new items in the IRF–PAI as standardized patient assessment data elements under the SDOH category because these items would collect information not already captured by the current SDOH items. Specifically, we believe the ongoing identification of SDOH would have three significant benefits. First, promoting screening for SDOH could serve as evidence-based building blocks for supporting healthcare providers in actualizing their commitment to address disparities that disproportionately impact underserved communities. Second, screening for SDOH improves health equity through identifying potential social needs so the IRF may address those with the patient, their caregivers, and community partners during the discharge planning process, if indicated.²¹ Third, these SDOH items could support our ongoing IRF QRP initiatives by providing data with which to stratify IRFs' performance on measures and or in future quality measures.

Additional collection of SDOH items would permit us to continue developing the statistical tools necessary to maximize the value of Medicare data and improve the quality of care for all beneficiaries. For example, we recently developed and released the Health Equity Confidential Feedback Reports, which provided data to IRFs on whether differences in quality measure outcomes are present for their patients by dual-enrollment status and race and ethnicity.²² We note that advancing health equity by addressing the health disparities that underlie the country's health system is one of our strategic

²¹ American Hospital Association. (2020). Health Equity, Diversity & Inclusion Measures for Hospitals and Health System Dashboards. December 2020. Accessed: January 18, 2022. Available at: https://ifdhe.aha.org/system/files/media/file/2020/12/ifdhe_inclusion_dashboard.pdf.

²² In October 2023, we released two new annual Health Equity Confidential Feedback Reports to IRFs: The Discharge to Community (DTC) Health Equity Confidential Feedback Report and the Medicare Spending Per Beneficiary (MSPB) Health Equity Confidential Feedback Report. The PAC Health Equity Confidential Feedback Reports stratified the DTC and MSPB measures by dual-enrollment status and race/ethnicity. For more information on the Health Equity Confidential Feedback Reports, please refer to the Education and Outreach materials available on the IRF QRP Training web page at <https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/irf-quality-reporting/irf-quality-reporting-training>.

pillars²³ and a Biden-Harris Administration priority.²⁴

3. Proposal To Collect Four New Items as Standardized Patient Assessment Data Elements Beginning With the FY 2028 IRF QRP

We are proposing to require IRFs to collect and submit four new items as standardized patient assessment data elements under the SDOH category using the IRF–PAI: one item for Living Situation, as described in section VII.3.(a) of this proposed rule; two items for Food, as described in section VII.3.(b) of this proposed rule; and one item for Utilities, as described in VII.3.(c) of this proposed rule.

We selected the proposed SDOH items from the Accountable Health Communities (AHC) HRSN Screening Tool developed for the AHC Model. The AHC HRSN Screening Tool is a universal, comprehensive screening for HRSNs that addresses five core domains as follows: (1) housing instability (for example, homelessness, poor housing quality), (2) food insecurity, (3) transportation difficulties, (4) utility assistance needs, and (5) interpersonal safety concerns (for example, intimate-partner violence, elder abuse, child maltreatment).²⁵

We believe that requiring IRFs to report new items that are currently included in the AHC HRSN Screening Tool would further standardize the screening of SDOH across quality programs. For example, our proposal would align, in part, with the requirements of the Hospital Inpatient Quality Reporting (IQR) Program and the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program. As of January 2024, hospitals are required to report whether they have screened patients for the standardized SDOH categories of housing instability, food insecurity, utility difficulties, transportation needs, and interpersonal safety to meet the Hospital IQR Program requirements.²⁶ Additionally, beginning January 2025, IPFs will also be required

²³ Brooks-LaSure, C. (2021). My First 100 Days and Where We Go from Here: A Strategic Vision for CMS. Centers for Medicare & Medicaid. Available at: <https://www.cms.gov/blog/my-first-100-days-and-where-we-go-here-strategic-vision-cms>.

²⁴ The Biden-Harris Administration's strategic approach to addressing health related social needs can be found in The U.S. Playbook to Address Social Determinants of Health (SDOH) (2023): <https://www.whitehouse.gov/wp-content/uploads/2023/11/SDOH-Playbook-3.pdf>.

²⁵ More information about the AHC HRSN Screening Tool is available on the website at <https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf>.

²⁶ Centers for Medicare & Medicaid Services, FY2023 IPPS/LTCH PPS final rule (87 FR 49191 through 49194).

to report whether they have screened patients for the same set of SDOH categories.²⁷ As we continue to standardize data collection across PAC settings, we believe using common standards and definitions for new items is important to promote interoperable exchange of longitudinal information between IRFs and other providers to facilitate coordinated care, continuity in care planning, and the discharge planning process.

Below we describe each of the four proposed items in more detail.

(a) Living Situation

Healthy People 2030 prioritizes economic stability as a key SDOH, of which housing stability is a component.^{28,29} Lack of housing stability encompasses several challenges, such as having trouble paying rent, overcrowding, moving frequently, or spending the bulk of household income on housing.³⁰ These experiences may negatively affect one's physical health and access to health care. Housing instability can also lead to homelessness, which is housing deprivation in its most severe form.³¹ On a single night in 2023, roughly 653,100 people, or 20 out of every 10,000 people in the United States, were experiencing homelessness.³² Studies also found that people who are homeless have an increased risk of premature death and experience chronic disease more often than among the general population.³³

²⁷ Centers for Medicare & Medicaid Services, FY2024 Inpatient Psychiatric Prospective Payment System—Rate Update (88 FR 51107 through 51121).

²⁸ <https://health.gov/healthypeople/priority-areas/social-determinants-health>.

²⁹ Healthy People 2030 is a long-term, evidence-based effort led by the U.S. Department of Health and Human Services (HHS) that aims to identify nationwide health improvement priorities and improve the health of all Americans.

³⁰ Kushel, M.B., Gupta, R., Gee, L., & Haas, J.S. (2006). Housing instability and food insecurity as barriers to health care among low-income Americans. *Journal of General Internal Medicine*, 21(1), 71–77. doi: <https://doi.org/10.1111/j.1525-1497.2005.00278.x>.

³¹ Homelessness is defined as “lacking a regular nighttime residence or having a primary nighttime residence that is a temporary shelter or other place not designed for sleeping.” Crowley, S. (2003). The affordable housing crisis: Residential mobility of poor families and school mobility of poor children. *Journal of Negro Education*, 72(1), 22–38. doi: <https://doi.org/10.2307/3211288>.

³² The 2023 Annual Homeless Assessment Report (AHAR) to Congress. The U.S. Department of Housing and Urban Development 2023. <https://www.huduser.gov/portal/sites/default/files/pdf/2023-AHAR-Part-1.pdf>.

³³ Baggett, T.P., Hwang, S.W., O'Connell, J.J., Porneala, B.C., Stringfellow, E.J., Orav, E.J., Singer, D.E., & Rigotti, N.A. (2013). Mortality among homeless adults in Boston: Shifts in causes of death over a 15-year period. *JAMA Internal Medicine*, 173(3), 189–195. doi: <https://doi.org/10.1001>

We believe that IRFs can use information obtained from the Living Situation item during a patient's discharge planning. For example, IRFs could work in partnership with community care hubs and community-based organizations to establish new care transition workflows, including referral pathways, contracting mechanisms, data sharing strategies, and implementation training that can track HRSNs to ensure unmet needs, such as housing, are successfully addressed through closed loop referrals and follow-up.³⁴ IRFs could also take action to help alleviate a patient's other related costs of living, like food, by referring the patient to community-based organizations that would allow the patient's additional resources to be allocated towards housing without sacrificing other needs.³⁵ Finally, IRFs could use the information obtained from the Living Situation item to better coordinate with other healthcare providers, facilities, and agencies during transitions of care, so that referrals to address a patient's housing stability are not lost during vulnerable transition periods.

Due to the potential negative impacts housing instability can have on a patient's health, we are proposing to adopt the Living Situation item as a new standardized patient assessment data element under the SDOH category. This proposed Living Situation item is based on the Living Situation item currently collected in the AHC HRSN Screening Tool,^{36,37} and was adapted from the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) tool.³⁸ The

jamainternmed.2013.1604. Schanzer, B., Dominguez, B., Shrout, P.E., & Caton, C.L. (2007). Homelessness, health status, and health care use. *American Journal of Public Health*, 97(3), 464–469. doi: <https://doi.org/10.2105/ajph.2005.076190>.

³⁴ U.S. Department of Health & Human Services (HHS), Call to Action, “Addressing Health Related Social Needs in Communities Across the Nation.” November 2023. <https://aspe.hhs.gov/sites/default/files/documents/3e2f6140d0087435cc6832bf8cf32618/hhs-call-to-action-health-related-social-needs.pdf>.

³⁵ Henderson, K.A., Manian, N., Rog, D.J., Robison, E., Jorge, E., AlAbdulmunem, M. “Addressing Homelessness Among Older Adults” (Final Report). Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. October 26, 2023.

³⁶ More information about the AHC HRSN Screening Tool is available on the website at <https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf>.

³⁷ The AHC HRSN Screening Tool Living Situation item includes two questions. In an effort to limit IRF burden, we are only proposing the first question.

³⁸ National Association of Community Health Centers and Partners, National Association of Community Health Centers, Association of Asian

proposed Living Situation item asks, “What is your living situation today?” The proposed response options are: (1) I have a steady place to live; (2) I have a place to live today, but I am worried about losing it in the future; (3) I do not have a steady place to live; (7) Patient declines to respond; and (8) Patient unable to respond. A draft of the proposed Living Situation item to be adopted as a standardized patient assessment data element under the SDOH category can be found in the Downloads section of the IRF-PAI and IRF-PAI Manual web page at <https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility/irf-pai-and-irf-qip-manual>.

(b) Food

The U.S. Department of Agriculture, Economic Research Service defines a lack of food security as a household-level economic and social condition of limited or uncertain access to adequate food.³⁹ Adults who are food insecure may be at an increased risk for a variety of negative health outcomes and health disparities. For example, a study found that food-insecure adults may be at an increased risk for obesity.⁴⁰ Another study found that food-insecure adults have a significantly higher probability of death from any cause or cardiovascular disease in long-term follow-up care, in comparison to adults that are food secure.⁴¹

While having enough food is one of many predictors for health outcomes, a diet low in nutritious foods is also a factor.⁴² The United States Department of Agriculture (USDA) defines nutrition security as “consistent and equitable access to healthy, safe, affordable foods essential to optimal health and well-

Pacific Community Health Organizations, Association OPC, Institute for Alternative Futures. “PRAPARE.” 2017. <https://prapare.org/the-prapare-screening-tool/>.

³⁹ U.S. Department of Agriculture, Economic Research Service. (n.d.). *Definitions of food security*. Retrieved March 10, 2022, from <https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-u-s/definitions-of-food-security/>.

⁴⁰ Hernandez, D.C., Reesor, L.M., & Murillo, R. (2017). Food insecurity and adult overweight/obesity: Gender and race/ethnic disparities. *Appetite*, 117, 373–378.

⁴¹ Banerjee, S., Radak, T., Khubchandani, J., & Dunn, P. (2021). Food Insecurity and Mortality in American Adults: Results From the NHANES-Linked Mortality Study. *Health promotion practice*, 22(2), 204–214. <https://doi.org/10.1177/1524839920945927>.

⁴² National Center for Health Statistics. (2022, September 6). Exercise or Physical Activity. Retrieved from Centers for Disease Control and Prevention: <https://www.cdc.gov/nchs/fastats/exercise.htm>.

being.”⁴³ Nutrition security builds on and complements long standing efforts to advance food security. Studies have shown that older adults struggling with food insecurity consume fewer calories and nutrients and have lower overall dietary quality than those who are food secure, which can put them at nutritional risk.⁴⁴ Older adults are also at a higher risk of developing malnutrition, which is considered a state of deficit, excess, or imbalance in protein, energy, or other nutrients that adversely impacts an individual’s own body form, function, and clinical outcomes.⁴⁵ About 50 percent of older adults are affected by malnutrition, which is further aggravated by a lack of food security and poverty.⁴⁶ These facts highlight why the Biden-Harris Administration launched the White House Challenge to End Hunger and Build Health Communities.⁴⁷

We believe that adopting items to collect and analyze information about a patient’s food security at home could provide additional insight to their health complexity and help facilitate coordination with other healthcare providers, facilities, and agencies during transitions of care, so that referrals to address a patient’s food security are not lost during vulnerable transition periods. For example, an IRF’s dietitian or other clinically qualified nutrition professional could work with the patient and their caregiver to plan healthy, affordable food choices prior to

discharge.⁴⁸ IRFs could also refer a patient that indicates lack of food security to government initiatives such as the Supplemental Nutrition Assistance Program (SNAP) and food pharmacies (programs to increase access to healthful foods by making them affordable), two initiatives that have been associated with lower health care costs and reduced hospitalization and emergency department visits.⁴⁹

We are proposing to adopt two Food items as new standardized patient assessment data elements under the SDOH Category. These proposed items are based on the Food items currently collected in the AHC HRSN Screening Tool, and were adapted from the USDA 18-item Household Food Security Survey (HFSS).⁵⁰ The first proposed Food item states, “Within the past 12 months, you worried that your food would run out before you got money to buy more.” The second proposed Food item states, “Within the past 12 months, the food you bought just didn’t last and you didn’t have money to get more.” We propose the same response options for both items: (1) Often true; (2) Sometimes true; (3) Never True; (7) Patient declines to respond; and (8) Patient unable to respond. A draft of the proposed Food items to be adopted as standardized patient assessment data elements under the SDOH category can be found in the Downloads section of the IRF-PAI and IRF-PAI Manual web page at <https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility/irf-pai-and-irf-qrp-manual>.

(c) Utilities

A lack of energy (utility) security can be defined as an inability to adequately meet basic household energy needs.⁵¹ According to the United States Department of Energy, one in three households in the U.S. are unable to adequately meet basic household energy needs.⁵² The consequences associated

with a lack of utility security are represented by three primary dimensions: economic, physical, and behavioral. Patients with low incomes are disproportionately affected by high energy costs, and they may be forced to prioritize paying for housing and food over utilities.⁵³ Some patients may face limited housing options and therefore are at increased risk of living in lower-quality physical conditions with malfunctioning heating and cooling systems, poor lighting, and outdated plumbing and electrical systems.⁵⁴ Patients with a lack of utility security may use negative behavioral approaches to cope, such as using stoves and space heaters for heat.⁵⁵ In addition, data from the Department of Energy’s U.S. Energy Information Administration confirm that a lack of energy security disproportionately affects certain populations, such as low-income and African American households.⁵⁶ The effects of a lack of utility security include vulnerability to environmental exposures such as dampness, mold, and thermal discomfort in the home, which have a direct impact on a person’s health.⁵⁷ For example, research has shown associations between a lack of energy security and respiratory conditions as well as mental health-related disparities and poor sleep quality in vulnerable populations such as the elderly, children, the socioeconomically disadvantaged, and the medically vulnerable.⁵⁸

We believe adopting an item to collect information upon a patient’s admission to an IRF about their utility security

Paying Energy Bills in 2015.” 2017 Oct 13. <https://www.eia.gov/consumption/residential/reports/2015/energybills/>.

⁵³ Hernández D., “Understanding ‘energy insecurity’ and why it matters to health.” *Soc Sci Med.* 2016; 167:1–10.

⁵⁴ Hernández D., Understanding ‘energy insecurity’ and why it matters to health. *Soc Sci Med.* 2016 Oct; 167:1–10. doi: 10.1016/j.socscimed.2016.08.029. Epub 2016 Aug 21. PMID: 27592003; PMCID: PMC5114037.

⁵⁵ Hernández D., “What ‘Merle’ Taught Me About Energy Insecurity and Health.” *Health Affairs, VOL.37, NO.3: Advancing Health Equity Narrative Matters.* March 2018. <https://doi.org/10.1377/hlthaff.2017.1413>.

⁵⁶ U.S. Energy Information Administration. “One in Three U.S. Households Faced Challenges in Paying Energy Bills in 2015.” 2017 Oct 13. <https://www.eia.gov/consumption/residential/reports/2015/energybills/>.

⁵⁷ Hernández D., Understanding ‘energy insecurity’ and why it matters to health. *Soc Sci Med.* 2016 Oct; 167:1–10. doi: 10.1016/j.socscimed.2016.08.029. Epub 2016 Aug 21. PMID: 27592003; PMCID: PMC5114037.

⁵⁸ Hernández D., Siegel E., Energy insecurity and its ill health effects: A community perspective on the energy-health nexus in New York City. *Energy Res Soc Sci.* 2019 Jan; 47:78–83. doi: 10.1016/j.jerss.2018.08.011. Epub 2018 Sep 8. PMID: 32280598; PMCID: PMC7147484.

⁴³ Ziliak, J.P., & Gundersen, C. (2019). *The State of Senior Hunger in America 2017: An Annual Report.* Prepared for Feeding America. Available at <https://www.feedingamerica.org/research/senior-hunger-research/senior>.

⁴⁴ Ziliak, J.P., & Gundersen, C. (2019). *The State of Senior Hunger in America 2017: An Annual Report.* Prepared for Feeding America. Available at <https://www.feedingamerica.org/research/senior-hunger-research/senior>.

⁴⁵ The Malnutrition Quality Collaborative. (2020). *National Blueprint: Achieving Quality Malnutrition Care for Older Adults, 2020 Update.* Washington, DC: Avalere Health and Defeat Malnutrition Today. Available at: <https://defeatmalnutrition.today/advocacy/blueprint/>.

⁴⁶ Food Research & Action Center (FRAC). “Hunger is a Health Issue for Older Adults: Food Security, Health, and the Federal Nutrition Programs.” December 2019. <https://frac.org/wp-content/uploads/hunger-is-a-health-issue-for-older-adults-1.pdf>.

⁴⁷ The White House Challenge to End Hunger and Build Health Communities (Challenge) was a nationwide call-to-action released on March 24, 2023, to stakeholders across all of society to make commitments to advance President Biden’s goal to end hunger and reduce diet-related diseases by 2030—all while reducing disparities. More information on the White House Challenge to End Hunger and Build Health Communities can be found: <https://www.whitehouse.gov/briefing-room/statements-releases/2023/03/24/fact-sheet-biden-harris-administration-launches-the-white-house-challenge-to-end-hunger-and-build-healthy-communities-announces-new-public-private-sector-actions-to-continue-momentum-from-hist/>.

⁴⁸ Schroeder K., Smaldone A., Food Insecurity: A Concept Analysis. *Nurse Forum.* 2015 Oct–Dec; 50(4):274–84. doi: 10.1111/nuf.12118. Epub 2015 Jan 21. PMID: 25612146; PMCID: PMC4510041.

⁴⁹ Tsega M., Lewis C., McCarthy D., Shah T., Coutts K., Review of Evidence for Health-Related Social Needs Interventions. July 2019. The Commonwealth Fund. https://www.commonwealthfund.org/sites/default/files/2019-07/COMBINED_ROI_EVIDENCE_REVIEW_7.15.19.pdf.

⁵⁰ More information about the HFSS tool can be found at <https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-u-s/survey-tools/>.

⁵¹ Hernández D., Understanding ‘energy insecurity’ and why it matters to health. *Soc Sci Med.* 2016 Oct; 167:1–10. Doi: 10.1016/j.socscimed.2016.08.029. Epub 2016 Aug 21. PMID: 27592003; PMCID: PMC5114037.

⁵² U.S. Energy Information Administration. “One in Three U.S. Households Faced Challenges in

would facilitate the identification of patients who may not have utility security and who may benefit from engagement efforts. For example, IRFs may be able to use the information on utility security to help connect some patients in need to programs that can help older adults pay for their home energy (heating/cooling) costs, like the Low-Income Home Energy Assistance Program (LIHEAP).⁵⁹ IRFs may also be able to partner with community care hubs and community-based organizations to assist the patient in applying for these and other local utility assistance programs, as well as helping them navigate the enrollment process.⁶⁰

We are proposing to adopt a new item, Utilities, as a new standardized patient assessment data element under the SDOH category. This proposed item is based on the Utilities item currently collected in the AHC HRSN Screening Tool and was adapted from the Children's Sentinel Nutrition Assessment Program (C-SNAP) survey.⁶¹ The proposed Utilities item asks, "In the past 12 months, has the electric, gas, oil, or water company threatened to shut off services in your home?" The proposed response options are: (1) Yes; (2) No; (3) Already shut off; (7) Patient declines to respond; and (8) Patient unable to respond. A draft of the proposed Utilities item to be adopted as a standardized patient assessment data element under the SDOH category can be found in the Downloads section of the IRF-PAI and IRF-PAI Manual web page at <https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility/irf-pai-and-irf-grp-manual>.

4. Stakeholder Input

We developed our proposal to add these items after considering feedback we received in response to our Health Equity Update in the FY 2024 IRF PPS final rule. While there were commenters who urged CMS to balance reporting requirements so as not to create undue administrative burden and avoid making generalizations about differences in health and health care on

certain data elements, it was also suggested CMS incentivize collection of data on SDOH such as housing stability and food security. Two commenters emphasized that any additional stratification of quality measures, including social risk factors and SDOH, would be of value to PAC providers, including IRFs. The FY 2024 IRF PPS final rule (88 FR 51037 through 51039) includes a summary of the public comments that we received in response to the Health Equity Update and our responses to those comments.

Additionally, we considered feedback we received when we proposed the creation of the SDOH category of standardized patient assessment data elements in the FY 2020 IRF PPS proposed rule (84 FR 17319 through 17326). Commenters were generally in favor of the concept of collecting SDOH items and stated that if implemented appropriately the data could be useful in identifying and addressing health care disparities, as well as refining the risk adjustment of outcome measures. One commenter specifically recommended CMS consider including data collection of housing status, since unmet housing needs can put patients at higher risk for readmission. The FY 2020 IRF PPS final rule (84 FR 39149 through 39161) includes a summary of the public comments that we received and our responses to those comments. We incorporated this input into the development of this proposal.

We invite comment on the proposal to adopt four new items as standardized patient assessment data elements in the IRF-PAI under the SDOH category beginning with the FY 2028 IRF QRP: one Living Situation item; two Food items; and one Utilities item.

5. Proposal To Modify the Transportation Item Beginning With the FY 2028 IRF QRP

Beginning October 1, 2022, IRFs began collecting seven items adopted as standardized patient assessment data elements under the SDOH category on the IRF-PAI.⁶² One of these items, A1250. Transportation, collects data on whether a lack of transportation has kept a patient from getting to and from medical appointments, meetings, work, or from getting things they need for daily living. This item was adopted as a standardized patient assessment data element under the SDOH category in the FY 2020 IRF PPS final rule (84 FR 39160 through 39161). As we discussed in the

FY 2020 IRF PPS final rule (84 FR 39158), we continue to believe that access to transportation for ongoing health care and medication access needs, particularly for those with chronic diseases, is essential to successful chronic disease management and the collection of a Transportation item would facilitate the connection to programs that can address identified needs.

As part of our routine item and measure monitoring work, we continually assess the implementation of the new SDOH items. We have identified an opportunity to improve the data collection for A1250. Transportation in the IRF-PAI by aligning it with the Transportation category collected in our other programs.^{63 64} Specifically, we are proposing to modify the current Transportation item in the IRF-PAI so that it aligns with a Transportation item collected on the AHC HRSN Screening Tool available to the IPFQR and Hospital IQR Programs.

A1250. Transportation currently collected in the IRF-PAI asks: "Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?" The response options are: (A) Yes, it has kept me from medical appointments or from getting my medications; (B) Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need; (C) No; (X) Patient unable to respond; and (Y) Patient declines to respond. The Transportation item collected in the AHC HRSN Screening Tool asks, "In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?" The two response options are: (1) Yes; and (2) No. Consistent with the AHC HRSN Screening Tool, we are proposing to modify the A1250. Transportation item currently collected in the IRF-PAI in two ways: (1) revise the look-back period for when the patient experienced lack of reliable transportation; and (2) simplify the response options.

First, the proposed modification of the Transportation item would use a defined 12-month look back period, while the current Transportation item uses a look back period of six to 12 months. We believe the distinction of a 12-month look back period would reduce ambiguity for both patients and

⁶³ Centers for Medicare & Medicaid Services, FY2024 Inpatient Psychiatric Prospective Payment System—Rate Update (88 FR 51107 through 51121).

⁶⁴ Centers for Medicare & Medicaid Services, FY2023 IPPS/LTCH PPS Final rule (87 FR 49202 through 49215).

⁵⁹ <https://www.fcc.gov/broadbandbenefit>.

⁶⁰ National Council on Aging (NCOA). "How to Make It Easier for Older Adults to Get Energy and Utility Assistance." Promising Practices Clearinghouse for Professionals. Jan 13, 2022. <https://www.ncoa.org/article/how-to-make-it-easier-for-older-adults-to-get-energy-and-utility-assistance>.

⁶¹ This validated survey was developed as a clinical indicator of household energy security among pediatric caregivers. Cook, J.T., D.A. Frank., P.H. Casey, R. Rose-Jacobs, M.M. Black, M. Chilton, S. Ettinger de Cuba, et al. "A Brief Indicator of Household Energy Security: Associations with Food Security, Child Health, and Child Development in US Infants and Toddlers." *Pediatrics*, vol. 122, no. 4, 2008, pp. e874–e875. <https://doi.org/10.1542/peds.2008-0286>.

⁶² The seven SDOH items are ethnicity, race, preferred language, interpreter services, health literacy, transportation, and social isolation (84 FR 39149 through 39161).

clinicians, and therefore improve the validity of the data collected. Second, we are proposing to simplify the response options. Currently, IRFs separately collect information on whether a lack of transportation has kept the patient from medical appointments or from getting medications, and whether a lack of transportation has kept the patient from non-medical meetings, appointments, work, or from getting things they need. Although transportation barriers can directly affect a person’s ability to attend medical appointments and obtain medications, a lack of transportation can also affect a person’s health in other ways, including accessing goods and services, obtaining adequate food and clothing, and social activities.⁶⁵ The proposed modified Transportation item would collect information on whether a lack of reliable transportation has kept the patient from medical appointments, meetings, work, or from getting things needed for daily living, rather than collecting the information separately. As discussed previously, we believe reliable transportation services are fundamental to a person’s overall health, and as a result, the burden of collecting this information separately outweighs its potential benefit.

For the reasons stated previously, we are proposing to modify A1250. Transportation based on the Transportation item adopted for use in the AHC HRSN Screening Tool and adapted from the PRAPARE tool. The proposed Transportation item asks, “In

the past 12 months, has a lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?” The proposed response options are: (0) Yes; (1) No; (7) Patient declines to respond; and (8) Patient unable to respond. A draft of the proposed modified Transportation item can be found in the Downloads section of the IRF–PAI and IRF–PAI Manual web page at <https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility/irf-pai-and-irf-qrp-manual>.

We invite comment on the proposal to modify the current Transportation item previously adopted as a standardized patient assessment data element under the SDOH category beginning with the FY 2028 IRF QRP.

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

We are seeking input on the importance, relevance, appropriateness, and applicability of each of the concepts under consideration listed in Table 13 for future years in the IRF QRP. In the FY 2024 IRF PPS proposed rule (88 FR 21000 through 21003), we published a request for information (RFI) on a set of principles for selecting and prioritizing IRF QRP measures, identifying measurement gaps, and suitable measures for filling these gaps. Within this proposed rule, we also sought input on data available to develop measures, approaches for data collection, perceived challenges or barriers, and

approaches for addressing identified challenges. We refer readers to the FY 2024 IRF PPS final rule (88 FR 51036 through 51037) for a summary of the public comments we received in response to the RFI.

Subsequently, our measure development contractor convened a Technical Expert Panel (TEP) on December 15, 2023 to obtain expert input on the future measure concepts that could fill the measurement gaps identified in our FY 2024 RFI.⁶⁶ The TEP discussed the alignment of PAC and Hospice measures with CMS’ “Universal Foundation” of quality measures.⁶⁷ The Universal Foundation aims to focus provider attention, reduce burden, identify disparities in care, prioritize development of interoperable, digital quality measures, allow for comparisons across programs, and help identify measurement gaps.

In consideration of the feedback, we have received from interested parties through these activities, we are seeking input on three concepts for the IRF QRP. One is a composite of vaccinations,⁶⁸ which could represent overall immunization status of patients such as the Adult Immunization Status measure⁶⁹ in the Universal Foundation. A second concept on which we are seeking feedback is the concept of depression for the IRF QRP, which may be similar to the Clinical Screening for Depression and Follow-up measure⁷⁰ in the Universal Foundation. Finally, we are seeking feedback on the concept of pain management.

TABLE 14: Future Measure Concepts Under Consideration for the IRF QRP

Quality Measure Concepts
Vaccination Composite
Pain Management
Depression

⁶⁵ Centers for Medicare & Medicaid Services, FY2024 Inpatient Psychiatric Prospective Payment System—Rate Update (88 FR 51107 through 51121).

⁶⁶ The Post-Acute Care (PAC) and Hospice Quality Reporting Program Cross-Setting TEP summary report will be published in early summer or as soon as technically feasible. IRFs can monitor the Partnership for Quality Measurement website at <https://mmshub.cms.gov/get-involved/technical-expert-panel/updates-for-updates>.

⁶⁷ Centers for Medicare & Medicaid Services. Aligning Quality Measures Across CMS—the Universal Foundation. November 17, 2023. <https://www.cms.gov/aligning-quality-measures-across-cms-universal-foundation>.

⁶⁸ A composite measure can summarize multiple measures through the use of one value or piece of information. More information can be found at [https://www.cms.gov/medicare/quality-initiatives-](https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/mms/downloads/composite-measures.pdf)

[patient-assessment-instruments/mms/downloads/composite-measures.pdf](https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/mms/downloads/composite-measures.pdf).

⁶⁹ CMS Measures Inventory Tool. Adult immunization status measure found at <https://cmit.cms.gov/cmit/#/FamilyView?familyId=26>.

⁷⁰ CMS Measures Inventory Tool. Clinical Depression Screening and Follow-Up measure found at <https://cmit.cms.gov/cmit/#/FamilyView?familyId=672>.

While we will not be responding to specific comments in response to this RFI in the FY 2025 IRF PPS final rule, we intend to use this input to inform our future measure development efforts.

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

Section 1886(j)(7)(E) of the Act requires that the Secretary establish procedures for making data submitted under the IRF QRP available to the public. Such procedures must ensure the IRFs participating in the IRF QRP have the opportunity to review the IRF-submitted data prior to such data being made public. The Secretary must publicly report quality measures that relate to services furnished in IRFs on the CMS website. We currently publicly report data we receive on measures under the IRF QRP on our Care Compare website.⁷¹

Care Compare displays star ratings for many provider types, specifically: doctors and clinicians, hospitals, nursing homes, home health, hospice, and dialysis facilities. Rating methodologies vary by provider type. Star ratings summarize performance using symbols to help consumers quickly and easily understand quality of care information. Star ratings are designed to enhance and supplement existing publicly reported quality information, and also serve to spotlight differences in health care quality and identify areas for improvement.⁷² Some providers receive “overall star ratings,” which are a composite score calculated using different data sources, such as quality measures or survey results. Others receive “patient survey star ratings,” a composite score derived from patient experience of care surveys. Depending on the provider type, some utilize one—or both—of these rating methodologies.

Star ratings serve an important function for patients, caregivers, and families, helping them to more quickly comprehend complex information about a health care providers' care quality and to easily assess differences among providers. This transparency serves an important educational function, while also helping to promote competition in health care markets. Informed patients and consumers are more empowered to select among health care providers, fostering continued quality improvement. CMS' commitment to

establishing star ratings systems across health care settings is consistent with the Biden-Harris Administration's goal to promote an open, transparent, and competitive economy as outlined in Executive Order 14036, Promoting Competition in the American Economy (86 FR 36987, July 14, 2021).⁷³

We are seeking feedback on the development of a five-star methodology for IRFs that can meaningfully distinguish between quality of care offered by IRFs. Star ratings for IRFs would be designed to help consumers quickly identify differences in quality when selecting a provider. We are committed to developing a well-tested, data-driven methodology that encourages continuous quality improvement. We plan to engage with the IRF community and provide multiple opportunities for IRFs and other interested parties to give input on the development of a star rating system for IRFs. We note that IRFs would have the ability to preview their own facility's quality data before public posting of the IRF's star rating on the Care Compare website in accordance with section 1886(j)(7)(E) of the Act.

Specifically, we invite public comment on the following questions:

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

While we will not be responding to specific comments in response to this RFI in the FY 2025 IRF PPS final rule, we intend to use this input to inform our future star rating development efforts. We intend to consider how a rating system would determine an IRF's star rating, the methods used for such calculations, and an anticipated timeline for implementation. We will consider comments in response to this RFI for future rulemaking.

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

1. Background

We refer readers to the regulatory text at § 412.634(b)(1) for information regarding the current policies for reporting specified data for the IRF QRP.

2. Proposed Reporting Schedule for the Submission of Proposed New Items as Standardized Patient Assessment Data Elements and the Transportation Item Beginning With the FY 2028 IRF QRP

As discussed in sections VII.C.3. and VII.C.5. of this proposed rule, we are proposing to adopt four new items as standardized patient assessment data elements under the SDOH category (one Living Situation item, two Food items, and one Utilities item) and to modify the Transportation standardized patient assessment data element previously adopted under the SDOH category beginning with the FY 2028 IRF QRP.

We are proposing that IRFs would be required to report these new items and the transportation item using the IRF-PAI beginning with patients admitted on October 1, 2026, for purposes of the FY 2028 IRF QRP. Starting in CY 2027, IRFs would be required to submit data for the entire calendar year with the FY 2029 IRF QRP.

We are also proposing that IRFs that submit the Living Situation, Food, and Utilities items proposed for adoption as standardized patient assessment data elements under the SDOH category with respect to admission only would be deemed to have submitted those items with respect to both admission and discharge. We propose that IRFs would be required to submit these items at admission only (and not at discharge) because it is unlikely that the assessment of those items at admission would differ from the assessment of the same item at discharge. This would align the data collection for these proposed items with other SDOH items (that is, Race, Ethnicity, Preferred Language, and Interpreter Services) which are only collected at admission.⁷⁴ A draft of the proposed items is available in the Downloads section of the IRF-PAI and IRF-PAI Manual web page at <https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility/irf-pai-and-irf-qrp-manual>.

As we noted in section VII.C.5. of this proposed rule, we continually assess the implementation of the new SDOH items, including A1250. Transportation, as part of our routine item and measure monitoring work. We received feedback from stakeholders in response to the FY 2020 IRF PPS proposed rule (84 FR 39149 through 39161) noting their concern with the burden of collecting the Transportation item at admission and discharge. Specifically, commenters stated that a patient's access to transportation is unlikely to change between admission and discharge (84

⁷¹ Centers for Medicare & Medicaid Services (CMS). Care Compare. 2023. <https://www.medicare.gov/care-compare>.

⁷² Centers for Medicare & Medicaid Services (CMS). Home Health Star Ratings. 2023. <https://www.cms.gov/medicare/quality/home-health/home-health-star-ratings>.

⁷³ The White House. Executive Order on Promoting Competition in the American Economy. 2023. <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/07/09/executive-order-on-promoting-competition-in-the-american-economy/>.

⁷⁴ FY 2020 IRF PPS final rule (84 FR 39161 through 39162).

FR 39159). We analyzed the data IRFs reported from October 1, 2022, through June 30, 2023 (Quarter 4 CY 2022 through Quarter 2 CY 2023), and found that patient responses do not significantly change from admission to discharge.⁷⁵ Specifically, the proportion of patients⁷⁶ who responded “Yes” to the Transportation item at admission versus at discharge differed by only 0.19 percentage points during this period. We find these results convincing, and therefore are proposing to require IRFs to collect and submit the proposed modified standardized patient assessment data element, Transportation, at admission only.

We invite public comment on our proposal to collect data on the following items proposed as standardized patient assessment data elements under the SDOH category at admission beginning October 1, 2026 with the FY 2028 IRF QRP: (1) Living Situation as described in section VII.C.3.(a) of this proposed rule; (2) Food as described in section VII.C.3.(b) of this proposed rule; and (3) Utilities as described in section VII.C.3.(c) of this proposed rule. We also invite comment on our proposal to submit the proposed modified standardized patient assessment data element, Transportation, at admission only beginning October 1, 2026, with the FY 2028 IRF QRP as described in section VII.C.5. of this proposed rule.

3. Proposal To Remove the Admission Class Item From the IRF–PAI Beginning October 1, 2026

(a) Background

In the CY 2002 PPS for IRFs final rule (66 FR 41324 through 41342), we finalized the use of the IRF–PAI, through which IRFs are now required to collect and electronically submit patient data for all Medicare Part A FFS and Medicare Part C (Medicare Advantage) patients admitted and discharged from an IRF through September 30, 2024⁷⁷ and for all patients regardless of payer beginning October 1, 2024.⁷⁸ Item 14–Admission Class has been included on the IRF–PAI since the IRF–PAI was first

⁷⁵ Due to data availability of IRF SDOH standardized patient assessment data elements, this is based on three quarters of Transportation data.

⁷⁶ The analysis is limited to patients who responded to the Transportation item at both admission and discharge.

⁷⁷ In the FY 2010 IRF PPS final rule (74 FR 39798 through 39800), CMS revised the regulation text in §§ 412.604, 412.606, 412.610, 412.614, and 412.618 to require that all IRFs submit IRF–PAI data on all of their Medicare Part C patients.

⁷⁸ In the FY 2023 IRF PPS final rule (87 FR 47073 through 47092), CMS revised the regulation text in §§ 412.604, 412.606, 412.610, 412.614, and 412.618 to require that all IRFs submit IRF–PAI data on each patient receiving care in an IRF, regardless of payer.

implemented and is completed only at admission. The most recent version of the IRF–PAI is available for reference on the IRF–PAI and IRF QRP Manual web page at <https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility/irf-pai-and-irf-qrp-manual>. Item 14, Admission Class, includes the following response options: (i) Initial Rehab; (iii) Readmission; (iv) Unplanned Discharge; and (v) Continuing Rehabilitation.

(b) Removal of Item

We routinely review item sets for redundancies and identify opportunities to simplify data submission requirements. We propose to remove Item 14 entirely from the IRF–PAI, beginning October 1, 2026. We have identified this item is currently not used in the calculation of quality measures already adopted in the IRF QRP. It is also not used for previously established purposes unrelated to the IRF QRP, such as payment, survey, or care planning.

We invite public comment on our proposal to remove Item 14–Admission Class from the IRF–PAI, effective October 1, 2026.

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

We are not proposing any new policies regarding the public display of measure data at this time. For a more detailed discussion about our policies regarding public display of IRF QRP measure data and procedures for the opportunity to review and correct data and information, we refer readers to the FY 2017 IRF PPS final rule (81 FR 52125 through 52131).

VIII. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

This proposed rule refers to associated information collections that are not discussed in the regulation text contained in this document.

A. Requirements for Updates Related to the IRF QRP Beginning With the FY 2028 IRF QRP

An IRF that does not meet the requirements of the IRF QRP for a fiscal year will receive a 2-percentage point reduction to its otherwise applicable annual increase factor for that fiscal year.

In section VII.C. of the proposed rule, we are proposing to adopt four items as standardized patient assessment data elements and modify one item collected as a standardized patient assessment data element beginning with the FY 2028 IRF QRP. In section VII.F.3. of the proposed rule, we are proposing to remove one item, Admission Class, from the IRF–PAI.

As stated in sections VII.C.3. and VII.C.5. of the preamble of this proposed rule, we are proposing to adopt four items as standardized patient assessment data elements and modify one item collected as a standardized patient assessment data element beginning with the FY 2028 IRF QRP. The proposed and modified items would be collected using the IRF–PAI. The IRF–PAI, in its current form, has been approved under OMB control number 0938–0842.⁷⁹ Four items would need to be added to the IRF–PAI at admission to allow for collection of these data, and one item would be modified. Additionally, as stated in section VII.F.2. of this proposed rule, we are proposing that IRFs would submit the four new items and one modified item at admission only. The net result of collecting four new items at admission, modifying one item currently collected at admission, and removing the collection of one item at discharge is an increase of 0.9 minutes or 0.015 hour of clinical staff time at admission [(4 items × 0.005 hour) minus (1 item × 0.005 hour)]. We identified the staff type based on past IRF burden calculations, and our assumptions are based on the categories generally necessary to perform an assessment. We believe that the items would be completed equally by a Registered Nurse (RN) (50 percent of the time) and a Licensed Practical and Licensed Vocational Nurse (LPN/LVN) (50 percent of the time). However, IRFs determine the staffing resources necessary.

⁷⁹ <https://www.reginfo.gov/public/do/DownloadNOA?requestID=494186>.

For the purposes of calculating the costs associated with the collection of information requirements, we obtained median hourly wages for these staff from the U.S. Bureau of Labor Statistics' (BLS) May 2022 National Occupational

Employment and Wage Estimates.⁸⁰ To account for other indirect costs and fringe benefits, we doubled the hourly wage. These amounts are detailed in Table 15. We established a composite cost estimate using our adjusted wage

estimates. The composite estimate of \$65.31/hr was calculated by weighting each adjusted hourly wage equally (that is, 50%) $[(\$78.10/\text{hr} \times 0.5) + (\$52.52/\text{hr} \times 0.5) = \$65.31]$.

TABLE 15: U.S. Bureau of Labor and Statistics' May 2022 National Occupational Employment and Wage Estimates

Occupation Title	Occupation Code	Median Hourly Wage (\$/hr)	Other Indirect Costs and Fringe Benefit (\$/hr)	Adjusted Hourly Wage (\$/hr)
Registered Nurse (RN)	29-1141	\$39.05	\$39.05	\$78.10
Licensed Practical and Licensed Vocational Nurse (LPN/LVN)	29-2061	\$26.26	\$26.26	\$52.52

We estimate that the burden and cost for IRFs for complying with requirements of the FY 2028 IRF QRP would increase under this proposal. Using FY 2023 data, we estimate a total of 571,151 admissions to and 512,677 planned discharges from 1,154 IRFs annually for an increase of 8,859.64 hours in burden for all IRFs $[(571,151 \times 0.02 \text{ hour}) \text{ admissions} - (512,677 \times 0.005 \text{ hour}) \text{ planned discharges}]$. Given 0.02 hour at \$65.31 per hour to complete an average of 500 IRF-PAI admission assessments per IRF per year minus 0.005 at \$65.31 per hour to complete an average of 449 IRF-PAI Planned Discharge assessments per IRF per year, we estimate the total cost would be increased by \$501.41 per IRF annually, or \$578,622.76 for all IRFs annually.

In section VII.F.3. of this proposed rule, we are proposing to remove one

item, Admission Class, from the IRF-PAI beginning October 1, 2026. We believe that the removal of Admission Class will result in a decrease of 18 seconds (0.3 minutes or 0.005 hours) of clinical staff time at admission beginning with the FY 2028 IRF QRP. We believe the IRF-PAI item, Admission Class, is completed equally by a Registered Nurse (RN) and a Licensed Practical and Licensed Vocational Nurse (LPN/LVN). Individual IRFs determine the staffing resources necessary.

We estimate that the burden and cost for IRFs for complying with requirements of the FY 2028 IRF QRP would decrease under this proposal in section VII.F.3. Specifically, we believe that there will be a 2.47 hour decrease in clinical staff time to report data for each IRF-PAI completed at admission. Using data from FY 2023, we estimate

571,151 admission assessments from 1,154 IRFs annually. This equates to a decrease of 2,855.76 hours in burden at admission for all IRFs $(0.005 \text{ hour} \times 571,151 \text{ admissions})$. Given 0.005 hour at \$65.31 per hour to complete an average of 500 IRF-PAI admission assessments per IRF per year, we estimate the total cost will be decreased by \$161.62 $(\$186,509.36 \text{ total decrease} / 1,154 \text{ IRFs})$ per IRF annually, or \$186,509.36 for all IRFs annually, based on the proposal to remove one item from the IRF-PAI.

In summary, under OMB control number 0938-0842, the changes to the IRF QRP will result in a burden increase of \$339.79 per IRF $(\$392,113.40 / 1,154 \text{ IRFs})$. The total cost increase related to this proposed information collection is approximately \$392,113.40 and is summarized in Table 16.

⁸⁰ U.S. Bureau of Labor Statistics' (BLS) May 2022 National Occupational Employment and Wage

Estimates. https://www.bls.gov/oes/current/oes_nat.htm.

TABLE 16: Estimated Change in Burden Associated with OMB Control Number 0938-0842

Proposals	Per IRF		All IRFs	
	Estimated change in annual burden hours	Estimated change in annual cost	Estimated change in annual burden hours	Estimated change in annual cost
Estimated Change in Burden associated with Proposal to Collect Four New Items as Standardized Patient Assessment Data Elements and Modify One Item Collected as a Standardized Patient Assessment Data Element beginning with the FY 2028 IRF QRP	+7.68	+\$501.41	+8,859.64	+\$578,622.76
Estimated Change in Burden associated with Removal of the Admission Class item effective October 1, 2026	-2.47	-\$161.62	-2,855.76	-\$186,509.36
Estimated Change in burden for the IRF QRP associated with 0938-0842	5.20	\$339.79	6,003.88	\$392,113.40

We invite public comments on the proposed information collection requirements.

IX. Regulatory Impact Analysis

A. Statement of Need

This proposed rule updates the IRF prospective payment rates for FY 2025 as required under section 1886(j)(3)(C) of the Act and in accordance with section 1886(j)(5) of the Act, which requires the Secretary to publish in the **Federal Register** on or before August 1 before each FY, the classification and weighting factors for CMGs used under the IRF PPS for such FY and a description of the methodology and data used in computing the prospective payment rates under the IRF PPS for that FY. This proposed rule would also implement section 1886(j)(3)(C) of the Act, which requires the Secretary to apply a productivity adjustment to the market basket percentage increase for FY 2012 and subsequent years.

Furthermore, this proposed rule proposes to adopt policy changes to the IRF QRP under the statutory discretion afforded to the Secretary under section 1886(j)(7) of the Act. This rule proposes updates to the IRF QRP requirements beginning with the FY 2028 IRF QRP.

B. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), Executive Order 14094 on Modernizing Regulatory Review (April 6, 2023), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), and Executive Order 13132 on Federalism (August 4, 1999).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 14094 (Modernizing Regulatory Review) amends section 3(f)(1) of Executive Order 12866 (Regulatory Planning and Review). The amended section 3(f) of Executive Order 12866 defines a “significant regulatory action” as an action that is likely to result in a rule: (1) having an annual effect on the

economy of \$200 million or more in any 1 year (adjusted every 3 years by the Administrator of OMB’s Office of Information and Regulatory Affairs (OIRA) for changes in gross domestic product), or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, territorial, or Tribal governments or communities; (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raise legal or policy issues for which centralized review would meaningfully further the President’s priorities or the principles set forth in the Executive order, as specifically authorized in a timely manner by the Administrator of OIRA in each case.

A regulatory impact analysis (RIA) must be prepared for major rules with significant regulatory action/s and/or with significant effects as per section 3(f)(1) (\$200 million or more in any 1 year). We estimate the total impact of the policy updates described in this proposed rule by comparing the estimated payments in FY 2025 with those in FY 2024. This analysis results

in an estimated \$255 million increase for FY 2025 IRF PPS payments. Additionally, we estimate that costs associated with updating the reporting requirements under the IRF QRP result in an estimated \$392,113.40 additional cost for IRFs in FY 2026 for purposes of meeting the FY 2028 IRF QRP. Based on our estimates, OMB's Office of Information and Regulatory Affairs has determined this rulemaking is significant per section 3(f)(1) as measured by the \$200 million or more in any 1 year, and hence also a major rule under Subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996 (also known as the Congressional Review Act). Accordingly, we have prepared an RIA that, to the best of our ability, presents the costs and benefits of the rulemaking.

C. Anticipated Effects

1. Effects on IRFs

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most IRFs and most other providers and suppliers are small entities, either by having revenues of \$ 9.0 million to \$ 47.0 million or less in any 1 year depending on industry classification, or by being nonprofit organizations that are not dominant in their markets. (For details, see the Small Business Administration's final rule that set forth size standards for health care industries, at 65 FR 69432 at https://www.sba.gov/sites/default/files/2019-08/SBA%20Table%20of%20Size%20Standards_Effective%20Aug%202019%2C%202019_Rev.pdf, effective January 1, 2017, and updated on August 19, 2019.) Because we lack data on individual hospital receipts, we cannot determine the number of small proprietary IRFs or the proportion of IRFs' revenue that is derived from Medicare payments. Therefore, we assume that all IRFs (an approximate total of 1,154 IRFs, of which approximately 50 percent are nonprofit facilities) are considered small entities and that Medicare payment constitutes the majority of their revenues. HHS generally uses a revenue impact of 3 to 5 percent as a significance threshold under the RFA. As shown in Table 17, we estimate that the net revenue impact of the proposed rule on all IRFs is to increase estimated payments by approximately 2.5 percent. The rates and policies proposed in this rule

would not have a significant impact (not greater than 5 percent) on a substantial number of small entities. The estimated impact on small entities is shown in Table 17. MACs are not considered to be small entities. Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare an RIA if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. As shown in Table 17, we estimate that the net revenue impact of this proposed rule on rural IRFs is to increase estimated payments by approximately 4.6 percent based on the data of the 130 rural units and 13 rural hospitals in our database of 1,154 IRFs for which data were available. We estimate an overall impact for rural IRFs in all areas between 0.8 percent and 10.4 percent. As a result, we anticipate that this proposed rule will not have a significant negative impact on a substantial number of small entities.

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-04, enacted March 22, 1995) (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of \$100 million in 1995 dollars, updated annually for inflation. In 2024, that threshold is approximately \$183 million. This proposed rule does not mandate any requirements for State, local, or Tribal governments, or for the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it issues a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has federalism implications. As stated, this proposed rule will not have a substantial effect on State and local governments, preempt State law, or otherwise have a federalism implication.

2. Detailed Economic Analysis

This rule proposes updates to the IRF PPS rates contained in the FY 2024 IRF PPS final rule (88 FR 509564). Specifically, this proposed rule proposes updates to the CMG relative weights and ALOS values, the wage index, and the outlier threshold for

high-cost cases. This proposed rule would apply a productivity adjustment to the FY 2025 IRF market basket percentage increase in accordance with section 1886(j)(3)(C)(ii)(I) of the Act.

We estimate that the impact of the changes and updates described in this proposed rule would be a net estimated increase of \$255 million in payments to IRFs. The impact analysis in Table 17 of this proposed rule represents the projected effects of the proposed updates to IRF PPS payments for FY 2025 compared with the estimated IRF PPS payments in FY 2024. We determine the effects by estimating payments while holding all other payment variables constant. We use the best data available, but we do not attempt to predict behavioral responses to these changes, and we do not make adjustments for future changes in such variables as number of discharges or case-mix.

We note that certain events may combine to limit the scope or accuracy of our impact analysis, because such an analysis is future-oriented and, thus, susceptible to forecasting errors because of other changes in the forecasted impact time period. Some examples could be legislative changes made by the Congress to the Medicare program that would impact program funding, or changes specifically related to IRFs. Although some of these changes may not necessarily be specific to the IRF PPS, the nature of the Medicare program is such that the changes may interact, and the complexity of the interaction of these changes could make it difficult to predict accurately the full scope of the impact upon IRFs.

In updating the rates for FY 2025, we are proposing to implement the standard annual revisions described in this proposed rule (for example, the update to the wage index and market basket percentage increase used to adjust the Federal rates). We are also reducing the FY 2025 IRF market basket percentage increase by a productivity adjustment in accordance with section 1886(j)(3)(C)(ii)(I) of the Act. We propose the estimate of the total increase in payments to IRFs in FY 2025, relative to FY 2024, would be approximately \$255 million.

This estimate is derived from the application of the FY 2025 IRF market basket percentage increase, reduced by a productivity adjustment in accordance with section 1886(j)(3)(C)(ii)(I) of the Act, which yields an estimated increase in aggregate payments to IRFs of \$280 million. However, there is an estimated \$25 million decrease in aggregate payments to IRFs due to the update to the outlier threshold amount. Therefore,

we estimate that these proposed updates would result in a net increase in estimated payments of \$255 million from FY 2024 to FY 2025.

The effects of the proposed updates that impact IRF PPS payment rates are shown in Table 17. The following proposed updates that affect the IRF PPS payment rates are discussed separately below:

- The effects of the proposed update to the outlier threshold amount, from approximately 3.2 percent to 3.0 percent of total estimated payments for FY 2025, consistent with section 1886(j)(4) of the Act.

- The effects of the proposed annual market basket update (using the 2021-based IRF market basket) to IRF PPS payment rates, as required by sections 1886(j)(3)(A)(i) and (j)(3)(C) of the Act, including a productivity adjustment in accordance with section 1886(j)(3)(C)(ii)(I) of the Act.

- The effects of applying the proposed budget-neutral labor-related share and wage index adjustment, as required under section 1886(j)(6) of the Act, accounting for the permanent cap on wage index decreases when applicable.

- The effects of the proposed budget-neutral changes to the CMG relative weights and ALOS values under the authority of section 1886(j)(2)(C)(i) of the Act.

- The total change in proposed estimated payments based on the FY 2025 payment changes relative to the estimated FY 2024 payments.

3. Description of Table 17

Table 17 shows the overall impact on the 1,154 IRFs included in the analysis.

The next 12 rows of Table 17 contain IRFs categorized according to their geographic location, designation as either a freestanding hospital or a unit of a hospital, and by type of ownership; all urban, which is further divided into urban units of a hospital, urban freestanding hospitals, and by type of ownership; and all rural, which is further divided into rural units of a hospital, rural freestanding hospitals, and by type of ownership. There are 1,011 IRFs located in urban areas

included in our analysis. Among these, there are 651 IRF units of hospitals located in urban areas and 360 freestanding IRF hospitals located in urban areas. There are 143 IRFs located in rural areas included in our analysis. Among these, there are 130 IRF units of hospitals located in rural areas and 13 freestanding IRF hospitals located in rural areas. There are 494 for-profit IRFs. Among these, there are 459 IRFs in urban areas and 35 IRFs in rural areas. There are 564 non-profit IRFs. Among these, there are 475 urban IRFs and 89 rural IRFs. There are 96 government-owned IRFs. Among these, there are 77 urban IRFs and 19 rural IRFs.

The remaining four parts of Table 17 show IRFs grouped by their geographic location within a region, by teaching status, and by DSH patient percentage (PP). First, IRFs located in urban areas are categorized for their location within a particular one of the nine Census geographic regions. Second, IRFs located in rural areas are categorized for their location within a particular one of the nine Census geographic regions. In some cases, especially for rural IRFs located in the New England, Mountain, and Pacific regions, the number of IRFs represented is small. IRFs are then grouped by teaching status, including non-teaching IRFs, IRFs with an intern and resident to average daily census (ADC) ratio less than 10 percent, IRFs with an intern and resident to ADC ratio greater than or equal to 10 percent and less than or equal to 19 percent, and IRFs with an intern and resident to ADC ratio greater than 19 percent. Finally, IRFs are grouped by DSH PP, including IRFs with zero DSH PP, IRFs with a DSH PP less than 5 percent, IRFs with a DSH PP between 5 and less than 10 percent, IRFs with a DSH PP between 10 and 20 percent, and IRFs with a DSH PP greater than 20 percent.

The estimated impacts of each policy described in this proposed rule to the facility categories listed are shown in the columns of Table 17. The description of each column is as follows:

- Column (1) shows the facility classification categories.

- Column (2) shows the number of IRFs in each category in our FY 2025 analysis file.

- Column (3) shows the number of cases in each category in our FY 2025 analysis file.

- Column (4) shows the estimated effect of the adjustment to the outlier threshold amount.

- Column (5a) shows the estimated effect of the FY 2025 update to the IRF labor-related share, the FY 2024 CBSA delineations, and FY 2025 wage index with the 5 percent cap, in a budget-neutral manner.

- Column (5b) shows the estimated effect of the update to the IRF labor-related share, FY2025 CBSA delineations and wage index with the 5 percent cap, in a budget-neutral manner.

- Column (6) shows the estimated effect of the update to the CMG relative weights and ALOS values, in a budget-neutral manner.

- Column (7) compares our estimates of the payments per discharge, incorporating all of the policies reflected in this proposed rule for FY 2025 to our estimates of payments per discharge in FY 2024.

The average estimated increase for all IRFs is approximately 2.5 percent. This estimated net increase includes the effects of the IRF market basket update for FY 2025 of 2.8 percent, which is based on a IRF market basket percentage increase of 3.2 percent, less a 0.4 percentage point productivity adjustment, as required by section 1886(j)(3)(C)(ii)(I) of the Act. It also includes the approximate 0.2 percent overall decrease in estimated IRF outlier payments from the update to the outlier threshold amount. Since we are proposing to make updates to the IRF wage index, labor-related share and the CMG relative weights in a budget-neutral manner, we estimate there is no expected impact to total estimated IRF payments in aggregate. However, as described in more detail in each section, we estimate there will be expected impacts to the estimated distribution of payments among providers.

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

Facility Classification	Number of IRFs	Number of Cases	Outlier	FY 2025 Wage Index (5% cap), FY 2024 CBSA delineations, and Labor-Related Share	FY 2025 Wage Index (5% cap), FY 2025 CBSA delineations, and Labor-Related Share	CMG Weights	Total Percent Change ¹
(1)	(2)	(3)	(4)	(5a)	(5b)	(6)	(7)
Total	1,154	413,171	-0.2	0.0	0.0	0.0	2.5
Urban unit	651	141,326	-0.5	-0.5	0.0	0.0	1.8
Rural unit	130	17,792	-0.4	1.8	0.3	0.0	4.6
Urban hospital	360	247,531	-0.1	0.1	0.0	0.0	2.8
Rural hospital	13	6,522	0.0	1.5	0.5	-0.1	4.7
Urban For-Profit	459	245,730	-0.1	0.1	-0.1	0.0	2.7
Rural For-Profit	35	9,689	-0.1	0.9	0.4	0.0	4.0
Urban Non-Profit	475	125,194	-0.4	-0.4	0.0	0.0	2.0
Rural Non-Profit	89	12,682	-0.5	2.3	0.3	0.0	5.1
Urban Government	77	17,933	-0.5	0.2	0.0	0.0	2.5
Rural Government	19	1,943	-0.4	1.4	0.4	0.1	4.3
Urban	1,011	388,857	-0.2	-0.1	0.0	0.0	2.4
Rural	143	24,314	-0.3	1.7	0.3	0.0	4.6
Urban by region							
Urban New England	30	14,274	-0.2	-1.6	0.1	0.1	1.1
Urban Middle Atlantic	116	41,445	-0.3	-0.8	0.0	0.0	1.7
Urban South Atlantic	180	90,206	-0.3	0.3	-0.2	0.0	2.7
Urban East North Central	164	46,765	-0.3	-0.4	0.1	0.0	2.2
Urban East South Central	56	27,196	-0.1	1.3	0.0	0.0	4.0
Urban West North Central	78	23,171	-0.3	-0.1	0.0	0.0	2.4
Urban West South Central	210	89,840	-0.1	0.4	0.0	0.0	3.1
Urban Mountain	79	31,110	-0.2	0.3	0.0	0.0	2.9

Facility Classification	Number of IRFs	Number of Cases	Outlier	FY 2025 Wage Index (5% cap), FY 2024 CBSA delineations, and Labor-Related Share	FY 2025 Wage Index (5% cap), FY 2025 CBSA delineations, and Labor-Related Share	CMG Weights	Total Percent Change ¹
Urban Pacific	98	24,850	-0.5	-1.6	-0.1	0.0	0.6
Rural by region							
Rural New England	5	1,108	-0.4	0.0	0.0	-0.1	2.3
Rural Middle Atlantic	11	1,472	-0.4	8.8	-1.0	0.0	10.4
Rural South Atlantic	17	5,819	-0.2	2.2	1.6	0.0	6.5
Rural East North Central	22	2,871	-0.3	1.4	-0.2	0.0	3.7
Rural East South Central	19	3,300	-0.3	1.1	-0.2	0.0	3.5
Rural West North Central	18	2,250	-0.5	1.4	0.0	0.1	3.8
Rural West South Central	43	6,763	-0.3	0.7	0.2	0.1	3.5
Rural Mountain	6	423	-0.7	2.5	0.2	0.1	4.9
Rural Pacific	2	308	-1.3	-0.7	0.0	0.1	0.8
Teaching status							
Non-teaching	1,051	365,667	-0.2	0.1	0.0	0.0	2.7
Resident to ADC less than 10%	55	34,285	-0.3	-0.4	0.1	0.0	2.2
Resident to ADC 10%-19%	37	11,749	-0.5	-1.8	0.0	0.1	0.6
Resident to ADC greater than 19%	11	1,470	-0.5	-1.6	0.0	-0.1	0.6
Disproportionate share patient percentage (DSH PP)							
DSH PP = 0%	72	14,302	-0.5	0.7	0.4	0.0	3.3
DSH PP <5%	130	64,148	-0.1	0.3	0.0	0.0	3.0
DSH PP 5%-10%	229	98,988	-0.2	0.4	-0.1	0.0	2.9

Facility Classification	Number of IRFs	Number of Cases	Outlier	FY 2025 Wage Index (5% cap), FY 2024 CBSA delineations, and Labor-Related Share	FY 2025 Wage Index (5% cap), FY 2025 CBSA delineations, and Labor-Related Share	CMG Weights	Total Percent Change ¹
DSH PP 10%-20%	418	152,107	-0.3	-0.3	0.0	0.0	2.2
DSH PP greater than 20%	305	83,626	-0.3	-0.2	0.1	0.0	2.3

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

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4. Impact of the Update to the Outlier Threshold Amount

The estimated effects of the update to the outlier threshold adjustment are presented in column 4 of Table 17.

For the FY 2025 proposed rule, we used FY 2023 IRF claims data and based on that analysis, we estimated that IRF outlier payments as a percentage of total estimated IRF payments would be 3.2 percent in FY 2024. Thus, we are adjusting the outlier threshold amount in this proposed rule to maintain total estimated outlier payments equal to 3 percent of total estimated payments in FY 2025.

The estimated change in total IRF payments for FY 2025, therefore, includes an approximate 0.2 percentage point decrease in payments because the estimated outlier portion of total payments is estimated to decrease from approximately 3.2 percent to 3.0 percent.

The impact of this update to the outlier threshold amount (as shown in column 4 of Table 17) is to decrease estimated overall payments to IRFs by 0.2 percentage point.

5. Impact of the Wage Index, Labor-Related Share, and Wage Index Cap

In column 5a of Table 17, we present the effects of the budget-neutral update of the wage index and labor-related share, taking into account the permanent 5 percent cap on wage index decreases when applicable, without taking into account the updated FY2025 CBSA delineations, which are presented separately in the next column. The changes to the wage index and the

labor-related share are discussed together because the wage index is applied to the labor-related share portion of payments, so the changes in the two have a combined effect on payments to providers. As discussed in section VI.E. of this proposed rule, we update the FY 2025 labor-related share from 74.1 percent in FY 2024 to 74.2 percent in FY 2025.

6. Impact of the Updated CBSA Delineations

In column 5b of Table 17, we present the effects of the revised FY2025 CBSA delineations. In aggregate, we do not estimate that these updates will affect overall estimated payments to IRFs. However, we do expect these updates to have small distributional effects. We estimate the largest decrease in payment from the update to the FY 2025 CBSA delineation and wage index and labor-related share (column 5b of Table 17) to be a 1.0 percent decrease for IRFs in the Rural Middle Atlantic and the largest increase in payment to be a 1.6 percent increase for IRFs in the Rural South Atlantic.

7. Impact of the Update to the CMG Relative Weights and ALOS Values

In column 6 of Table 17, we present the effects of the budget-neutral update of the CMG relative weights and ALOS values. In the aggregate, we do not estimate that these updates will affect overall estimated payments of IRFs. However, we do expect these updates to have small distributional effects between -0.1 to 0.1.

8. Effects of Requirements for the IRF QRP Beginning With the FY 2028 IRF QRP

In accordance with section 1886(j)(7)(A) of the Act, the Secretary must reduce by 2 percentage points the annual market basket increase factor otherwise applicable to an IRF for a fiscal year if the IRF does not comply with the requirements of the IRF QRP for that fiscal year. In section IX.A. of the proposed rule, we discussed the method for applying the 2 percentage points reduction to IRFs that fail to meet the IRF QRP requirements.

As discussed in sections VII.C.3. and VII.C.5. of the preamble of this proposed rule, we are proposing to adopt four new items as standardized patient assessment data elements under the SDOH category and to modify one item currently collected as a standardized patient assessment data element. Although the proposed increase in burden will be accounted for in a revised information collection request under OMB control number (0938-0842), we are providing impact information. We believe the proposed items would be completed equally by a Registered Nurse (RN) (50 percent of the time) and a Licensed Practical and Vocational Nurses (LPN/LVN) (50 percent of the time). For the purposes of calculating the costs associated with the collection of information requirements, we obtained median hourly wages for these staff from the U.S. Bureau of Labor Statistics' (BLS) May 2022 National Occupational Employment and Wage

Estimates.⁸¹ To account for other indirect costs and fringe benefits, we

doubled the hourly wage. These amounts are detailed in Table 18.

TABLE 18: U.S. Bureau of Labor and Statistics' May 2022 National Occupational Employment and Wage Estimates

Occupation title	Occupation code	Median Hourly Wage (\$/hr)	Other Indirect Costs and Fringe Benefit (\$/hr)	Adjusted Hourly Wage (\$/hr)
Registered Nurse (RN)	29-1141	\$39.05	\$39.05	\$78.10
Licensed Practical and Licensed Vocational Nurse (LPN/LVN)	29-2061	\$26.26	\$26.26	\$ 52.52

With 571,151 admissions from 1,154 IRFs annually, we estimated an annual burden increase of 8,859.64 hours [(571,151 × 0.02 hour) admissions – (512,677 × 0.005 hour) planned discharges] and an increase of \$578,622.76 [8,859.64 hours × \$65.31/hr]. For each IRF, we estimate an annual burden increase of 7.68 hours (8,859.64 hours/1,154 IRFs) for an annual increase of \$501.41 (\$578,622.76/1,154 IRFs).

As discussed in section VII.F.3. of this proposed rule, we are proposing to remove one item, Admission Class, from the IRF-PAI beginning October 1, 2026. We estimate the removal of this item would result in a decrease of 0.005 hour of clinical staff time beginning with

admission assessments completed on October 1, 2026. Although the proposed decrease in burden will be accounted for in a revised information collection request under OMB control number 0938-0842, we are providing impact information. We estimate this item is completed equally by an RN (50 percent of the time) and by an LPN/LVN (50 percent of the time). For the purposes of calculating the costs associated with the collection of information requirements, we obtained median hourly wages for these staff from the U.S. Bureau of Labor Statistics' (BLS) May 2022 National Occupational Employment and Wage Estimates.⁸² To account for other indirect costs and fringe benefits, we doubled the hourly wage. These

amounts are detailed in Table 18. With 571,151 admissions from 1,154 IRFs annually, we estimate an annual burden decrease of 2,855.76 hours (571,151 admissions × 0.005 hour) and a decrease of \$186,509.36 [2,855.76 hours × \$65.31/hr]. For each IRF we estimate an annual burden decrease of 2.47 hours (2,855.76 hours/1,154 IRFs) for an annual decrease of \$161.62 (\$186,509.36/1,154 IRFs).

In summary, under OMB control number 0938-0842, the proposed changes to the IRF QRP would result in an estimated increase in programmatic burden for 1,154 IRFs. The total burden increase is approximately \$392,113.40 for all IRFs and \$339.79 per IRF and is summarized in Table 19.

⁸¹ U.S. Bureau of Labor Statistics' (BLS) May 2022 National Occupational Employment and Wage Estimates. https://www.bls.gov/oes/current/oes_nat.htm.

⁸² U.S. Bureau of Labor Statistics' (BLS) May 2022 National Occupational Employment and Wage Estimates. https://www.bls.gov/oes/current/oes_nat.htm.

TABLE 19: Estimated IRF QRP Program Impacts for FY 2028

Proposals	Per IRF		All IRFs	
	Estimated change in annual burden hours	Estimated change in annual cost	Estimated change in annual burden hours	Estimated change in annual cost
Estimated change in burden associated with Proposal to Collect Four New Items as Standardized Patient Assessment Data Elements and Modify One Item Collected as a Standardized Patient Assessment Data Element beginning with the FY 2028 IRF QRP	+7.68	+\$501.41	+8,859.64	+\$578,622.76
Estimated change in burden associated with Removal of the Admission Class item effective October 1, 2026	-2.47	-\$161.62	-2,855.76	-\$186,509.36
Estimated total increase in burden for the IRF QRP if finalized	5.20	\$339.79	6,003.88	\$392,113.40

We invite public comments on the overall impact of the IRF QRP proposals for FY 2028.

D. Alternatives Considered

The following is a discussion of the alternatives considered for the IRF PPS updates contained in this proposed rule.

As noted previously in the proposed rule, section 1886(j)(3)(C) of the Act requires the Secretary to update the IRF PPS payment rates by an increase factor that reflects changes over time in the prices of an appropriate mix of goods and services included in the covered IRF services and section 1886(j)(3)(C)(ii)(I) of the Act requires the Secretary to apply a productivity adjustment to the market basket percentage increase for FY 2025. Thus, in accordance with section 1886(j)(3)(C) of the Act, we are updating the IRF prospective payments in this proposed rule by 2.8 percent (which equals the 3.2 percent proposed IRF market basket percentage increase for FY 2025 reduced by a proposed 0.4 percentage point productivity adjustment as determined under section 1886(b)(3)(B)(xi)(II) of the Act (as required by section 1886(j)(3)(C)(ii)(I) of the Act)).

We considered maintaining the existing CMG relative weights and average length of stay values for FY 2025. However, in light of recently available data and our desire to ensure that the CMG relative weights and

average length of stay values are as reflective as possible of recent changes in IRF utilization and case mix, we believe that it is appropriate to propose updates to the CMG relative weights and average length of stay values at this time to ensure that IRF PPS payments continue to reflect as accurately as possible the current costs of care in IRFs.

We considered maintaining the existing outlier threshold amount for FY 2025. However, analysis of updated FY 2024 data indicates that estimated outlier payments would be more than 3 percent of total estimated payments for FY 2025, unless we updated the outlier threshold amount. Consequently, we are proposing to adjust the outlier threshold amount to maintain estimated outlier payments at 3 percent of estimated aggregate payments in FY 2025.

With regard to the proposal to collect four new items as standardized patient assessment data elements under the SDOH category and modify one item collected as a standardized patient assessment data element under the SDOH category beginning with the FY 2028 IRF QRP, we believe these proposals would advance the CMS National Quality Strategy Goals of equity and engagement. We considered the alternative of delaying the proposal to collect these assessment items but given the fact they would encourage meaningful collaboration among

healthcare providers, caregivers, and community-based organizations to address SDOH prior to discharge from the IRF, we believe further delay is unwarranted.

With regard to the proposal to remove one item, Admission Class, from the IRF-PAI, we routinely review the IRF-PAI for redundancies and opportunities to simplify data submission requirements. We have identified that this item is currently not used in the calculation of quality measures already adopted in the IRF QRP, payment, survey, or care planning, and therefore no alternatives were considered.

E. Regulatory Review Costs

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this proposed rule, we should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review the rule, we assume that the total number of unique commenters on the FY 2025 IRF PPS proposed rule will be the number of reviewers of last year's proposed rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this proposed rule. It is possible that not all commenters reviewed the FY 2024 IRF PPS proposed rule in detail, and it is also possible that some reviewers chose not to comment

on the FY 2024 proposed rule. For these reasons, we thought that the number of commenters would be a fair estimate of the number of reviewers of this proposed rule.

We also recognize that different types of entities are in many cases affected by mutually exclusive sections of this proposed rule, and therefore, for the purposes of our estimate we assume that each reviewer reads approximately 50 percent of the rule.

Using the national mean hourly wage data from the May 2022 BLS for Occupational Employment Statistics (OES) for medical and health service

managers (SOC 11–9111), we estimate that the cost of reviewing this rule is \$123.06 per hour, including overhead and fringe benefits (https://www.bls.gov/oes/current/oes_nat.htm). Assuming an average reading speed, we estimate that it would take approximately 3 hours for the staff to review half of proposed rule. For each reviewer of the rule, the estimated cost is \$369.18 (3 hours × \$123.06). Therefore, we estimate that the total cost of reviewing this regulation is \$16,613.10 (\$369.18 × 45 reviewers).

F. Accounting Statement and Table

As required by OMB Circular A–4 (available at https://www.whitehouse.gov/wp-content/uploads/legacy_drupal_files/omb/circulars/A4/a-4.pdf), in Table 20 we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this proposed rule. Table 20 provides our best estimate of the increase in Medicare payments under the IRF PPS as a result of the updates presented in this proposed rule based on the data for 1,154 IRFs in our database.

TABLE 20: Accounting Statement: Classification of Estimated Expenditure

	Category	Transfers
Change in Estimated Transfers from FY 2024 IRF PPS to FY 2025 IRF PPS	Annualized Monetized Transfers	\$255 million
	From Whom to Whom?	Federal Government to IRF Medicare Providers
Estimated Costs Associated with the FY 2028 IRF QRP Proposals	Annualized monetized cost in FY 2028 due to proposed data collection requirements	\$392,113.40
Estimated Costs Associated with Review Cost for FY 2025 IRF PPS	Cost associated with regulatory review cost	\$16,613.10

G. Conclusion

Overall, the estimated payments per discharge for IRFs in FY 2025 are projected to increase by 2.5 percent, compared with the estimated payments in FY 2024, as reflected in column 7 of Table 17.

IRF payments per discharge are estimated to increase by 2.4 percent in urban areas and 4.6 percent in rural areas, compared with estimated FY 2024 payments. Payments per discharge to rehabilitation units are estimated to increase 1.8 percent in urban areas and

4.6 percent in rural areas. Payments per discharge to freestanding rehabilitation hospitals are estimated to increase 2.8 percent in urban areas and 4.7 percent in rural areas.

Overall, IRFs are estimated to experience a net increase in payments as a result of the policies in this proposed rule. The largest payment increase is estimated to be a 10.4 percent increase for IRFs located in the Rural Middle Atlantic region. The analysis above, together with the remainder of this preamble, provides an RIA.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by OMB.

Chiquita Brooks-LaSure, Administrator of the Centers for Medicare & Medicaid Services, approved this document on March 19, 2024.

Xavier Becerra,
Secretary, Department of Health and Human Services.

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