Federation of American Hospitals®

Charles N. Kahn III
President and CEO

May 28, 2024

The Honorable Chiquita Brooks-LaSure
Administrator Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

**RE: Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2025 and Updates to the IRF Quality Reporting Program (CMS-1804-P)**

Dear Administrator Brooks-LaSure:

The Federation of American Hospitals ("FAH") is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services.

The FAH appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services ("CMS") regarding its Proposed Rule, Inpatient Rehabilitation Facility ("IRF") Prospective Payment System for Federal Fiscal Year 2025 and Updates to the IRF Quality Reporting Program ("Proposed Rule") published in the Federal Register on March 29, 2024.

**MARKET BASKET UPDATE**

For FY 2025, CMS proposes to update the 2021-based IRF market basket to reflect projected price increases according to the IHS Global Inc.'s (IGI) 4th quarter 2023 forecast with historical data through the 3rd quarter of 2023. Using that forecast, the proposed IRF market basket for FY 2025 is 3.2 percent. Using data from the same period, CMS estimates an offset to the IRF market basket for total multifactor productivity of 0.4 percentage points. Consequently,

CMS proposes an IRF PPS update of 2.8 percent for FY 2025 for hospitals that submit quality data.

The FAH has serious concerns that the proposed market basket forecast is neither accurate nor adequately capturing the unique factors influencing the hospital and health care market today in general, and the market in which IRFs compete specifically. The scope and scale of the COVID-19 pandemic is unprecedented in our times with the constant barrage of challenges and pressures that hospitals have and continue to face. Chronic, preexisting nurse and caregiver shortages have exploded during the pandemic fueled by increased demand and workforce burnout from, among other factors, quarantines, surges, and stress.

Hospitals have had to weather an unrelenting cascade of market pressures during the COVID-19 public health emergency (PHE), compounded by historically high, spiraling inflation. These inflationary cost pressures for IRFs and all of America's hospitals do not seem to be captured in IGI's estimate of 3.2 percent for IRF market basket inflation for FY 2025. We are concerned that the 4-quarter rolling average and methods used to estimate inflation in IRF spending are not capturing the readily evident pandemic-initiated shocks to the health care market that are significantly driving up costs, especially labor, across the spectrum of hospital inputs. We urge CMS to consider these pandemic and inflationary triggers that do not seem to be reflected in the market basket forecast and make a one-time exception to further increase IRF rates to better adjust FY 2025 payments to IRFs to account for both the PHE and unaccounted for inflation.

It is noteworthy that CMS and IGI estimates for FY 2021 through FY 2024 market basket inflationary increases were underestimated as shown in the table below:

| IRF Market Basket[1] | FY 2021 | FY 2022 | FY 2023 | FY 2024 |
|---|---|---|---|---|
| Forecast Used in the Update | 2.4 | 2.6 | 4.2 | 3.6 |
| Actual Based on Later Utilization | 2.8 | 5.3 | 4.8 | 3.8 |
| Difference | -0.4 | -2.7 | -0.6 | -0.2 |

As this table reflects, market basket updates to IRFs between FY 2021 and FY 2023 when the COVID-19 pandemic was fully reflected are estimated to under-inflate the base IRF rate by 3.7 percentage points. Preliminary data suggests that FY 2024 will also be understated. This means that the base rate for FY 2025 is at least 3.7 percentage points too low – further compounding the inadequate FY 2025 rate increase.

The FAH urges CMS to consider a one-time adjustment for forecast error to ensure that the FY 2025 rate increase is applied to a base rate that more accurately incorporates actual inflation just as CMS is doing in two other contexts: the proposed FY 2025 skilled nursing facility (SNF) PPS update and the proposed FY 2025 capital IPPS update.

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[1] OACT, 4th quarter 2023 release of the market basket information with historical data through the 3rd quarter of 2023 (Market Basket Data | CMS) for the actual update based on later utilization.

For the FY 2025 SNF update, CMS is proposing to increase the market basket update of 2.8 percent by 1.7 percentage points for forecast error in application of the FY 2023 update.[2] For the FY 2024 capital IPPS update, CMS is proposing to increase the capital input price index (CIPI) of 2.5 percent by 0.5 percentage points for forecast error in application of the FY 2023 CIPI update.[3]

In the FY 2024 IRF PPS final rule, CMS declined to provide an adjustment for forecast error indicating that "due to the uncertainty regarding future price trends, forecast errors can be both positive and negative."[4] However, CMS' policy is to adjust the SNF market basket update for forecast error if the difference between the forecast update and the actual update based on later information is more than 0.5 percentage points. For the capital IPPS update, CMS' policy is to adjust the capital input price index forecast error if the difference between the forecast update and the actual update based on later information is more than 0.25 percentage points. If CMS had a comparable policy for the IRF PPS, the update would have been adjusted upward in 3 of the last 4 years with final data still pending for the 4th year (FY 2024). Given the existing policy in the SNF PPS and the capital IPPS, forecast error corrections were needed to address the lower than forecasted market basket updates.  A similar one-time adjustment should be afforded to the IRF market basket update.

For both the SNF PPS and the capital IPPS, CMS is making the forecast error adjustments based on a threshold level of difference between the update and the market basket that was adopted through rulemaking in prior years. CMS may argue that it is not permitted by rulemaking procedures under section 1871 of the Act to adopt a forecast error adjustment for the FY 2025 IPF PPS update because such a policy was not proposed. However, the IRF market basket update for FY 2025 has been made subject to public comment in the FY 2025 IRF PPS proposed rule.

The FAH's suggestion is a logical outgrowth of a policy adjustment that is subject to public comment consistent with section 1871(a)(4) of the Act. If CMS were to reject any comment that makes a suggestion to revise a market basket policy that was not explicitly proposed, there would be no point in making a public comment. CMS could reject any suggestion as being out-of-scope of the proposed rule as CMS did not make any explicit proposals to change its methodology for determining the market basket. As the FAH's comment is a logical outgrowth of a policy subject to public comment, CMS may certainly adopt our suggestion consistent with the rulemaking procedures in section 1871 of the Act.

**For these reasons, the FAH requests CMS adopt a one-time forecast error adjustment to the FY 2025 IRF PPS update based on the 3.7 percentage point difference in the IRF PPS market basket in FYs 2021, 2022, and 2023. Adopting our suggestion would make the market basket equal to 3.2 percent plus 3.7 percentage points less 0.4 percentage points or 6.5 percent.**

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[2] 89 Federal Register (FR), 23428, April 3, 2024

[3] 89 FR 36579, May 2, 2024.

[4] 88 FR 50984, August 2, 2023.

The FAH is further concerned that the IRF update for FY 2025 includes a reduction for private non-farm multifactor productivity growth of 0.4 percent. While this annual productivity offset is based on a provision of the Affordable Care Act of 2010 and required by law, we urge CMS to consider the appropriateness of this reduction and the further slide in payment adequacy the reduction could lead to for IRFs.

Even before the pandemic, OACT indicated that hospital productivity will be less than general economy wide productivity that is being used as an offset to the hospital market baskets. In a memorandum dated June 2, 2022, OACT stated: "over the period 1990-2019, the average growth rate of hospital TFP using the two methodologies ranges from 0.2 percent to 0.5 percent, compared to the average growth of private nonfarm business TFP of 0.8 percent." The memorandum also indicates that an assumed future rate of hospital industry productivity growth of 0.4 percent per year remains reasonable compared to an assumed rate of productivity growth in the private nonfarm business sector of 1.0 percent.[5] While the annual TFP offset is based on a provision of the Affordable Care Act of 2010 and is required by law, the FAH urges CMS to consider the appropriateness of this reduction when deciding whether to incorporate a forecast error adjustment to the FY 2025 IRF PPS update based on the understatement of the IRF PPS market basket baskets from FY 2021 to FY 2023 of 3.7 percentage points.

In light of this once-in-a-generation convergence of inflationary and COVID-19 pandemic forces, the FAH recommends CMS consider its update for IRF PPS payments to ensure that the FY 2025 rate reflects a more realistic measure of inflationary pressures, is applied to a base rate that more accurately incorporates actual inflation during the pandemic, and recognizes the disconnect between expectations for providers to be at least as productive as the 10-year average during a pandemic which has had a profound impact on ability for hospitals to increase productivity. **We urge CMS to consider its regulatory authority to modify this adjustment or make a PHE and inflation related exception in its application for the FY 2025 update.**

**CMG RELATIVE WEIGHTS AND AVERAL LENGTH OF STAY FOR FY 2023**

CMS has proposed updates to Case-Mix Group ("CMG") relative weights and average length of stay values using fiscal years ("FY") 2023 IRF claims and 2022 IRF cost reporting data. **The FAH supports CMS' update to the CMG relative weights and average length of stay values for FY 2024 and encourages CMS to use the latest available data to update these in the Final Rule.**

**WAGE INDEX**

Consistent with past practice, CMS proposes to use the FY 2025 pre-floor, pre-reclassified IPPS hospital wage index for the FY 2025 IPF wage index. Each wage index assigned to an IRF is based on the labor market area in which the IRF is geographically located.

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[5] Paul Spitalnic, Stephen Heffler, Bridget Dickensheets and Mollie Knight, "Hospital Multifactor Productivity: An Update Presentation of Two Methodologies Using Data through 2019." Hospital Multifactor Productivity: An Updated Presentation of Two Methodologies Using Data through 2019 (cms.gov).

IRF labor market areas are delineated based on the Core-Based Statistical Area (CBSAs) established by the OMB. Generally, OMB issues major revisions to statistical areas every 10 years, based on the results of the decennial census. On July 21, 2023, OMB issued Bulletin 23–01, which revises the CBSA delineations based on the latest available data from the 2020 census.

CMS is proposing to implement the new OMB delineations effective beginning with the FY 2025 IRF PPS wage index. As a result of the new proposed CBSA delineations, the proposed rule indicates that 8 providers are located in areas that were previously considered rural but would now be considered urban under the revised OMB delineations. CMS provides a 14.9 percent rural adjustment factor for IRFs located in a rural area.

For IRFs currently located in rural areas that are proposed to be urban under the new CBSA delineations, CMS proposes to phase-out the rural adjustment over three years in 1/3 increments. This policy would allow IRFs located in counties that are classified as rural in FY 2024 becoming urban in FY 2025 to receive two-thirds of the rural adjustment for FY 2025. For FY 2026, these IRFs would receive one-third of the rural adjustment. For FY 2027, these IRFs would not receive a rural adjustment. **The FAH supports CMS' proposal to phase-out the rural adjustment for rural IPFs becoming urban over three years.**

Changes to use the proposed CBSA delineations may change an IRF's wage index relative to using the current CBSA delineations. In the past, CMS has proposed a transition to new wage indexes based on the revised CBSA delineations. However, CMS no longer believes a transition is necessary as it adopted a 5 percent cap on reductions to an IRF's wage index in a single year beginning with FY 2023. CMS is not proposing a transition to the IRF wage index using the new CBSA delineations but will instead apply its current policy of limiting the single year reduction to a hospital's wage index to 5 percent.

The FAH appreciates CMS' recognition of how disruptive drops in the area wage index can create significant challenges for IPFs. For this reason, the FAH strongly supports a 5 percent stop-loss to minimize annual reductions in the area wage index value and to help mitigate wide annual swings that are beyond a hospital's ability to control. **The FAH urges CMS to adopt the 5 percent stop-loss in a non-budget neutral manner.**

The FAH appreciates CMS' much needed efforts to address the problems and financial challenges that rural hospitals face. CMS policy must ultimately ensure that Medicare payment formulas do not operate to magnify the stress on the rural health delivery system and contribute to access issues for Medicare beneficiaries living in rural areas. For the IPPS CMS has proposed to continue its policy of increasing the wage index values for hospitals with a wage index value in the lowest quartile of the wage index values across all hospitals. For hospitals in the lowest quartile, CMS has temporarily increased the hospital wage index values below the 25th percentile by half of the difference between the hospital's wage index value and the 25th percentile wage index value. The FAH encourages CMS to consider developing and applying a corresponding low wage index hospital policy for rural and low wage index IRFs to ensure that IRFs in low wage index and rural areas, which typically draw from the same labor pool as IPPS hospitals, have adequate resources to continue to provide access to care for vulnerable Medicare beneficiaries that need inpatient rehabilitation care. ***The FAH also urges CMS to implement this***

*policy without applying a budget neutrality adjustment to the IPF PPS standardized amounts, as we believe such budget neutral adjustments are not required.*

The wage index values of the existing hospitals subject to the cap will continue to differ significantly from the currently published tables. Existing providers must refer to the rate-setting file to verify their correct wage index values to ensure the MACs are updating the correct values in the system. **We encourage CMS to release wage index tables in the Final Rule that incorporate the cap on CBSA's that meet the 5 percent decrease criteria, in order to avoid errors in the payment rates established by the Medicare Administrative Contractors ("MACs").**

## HIGH-COST OUTLIERS

The outlier policy is an important component of the IRF PPS that helps ensure that payments for high-cost patients more accurately reflect the more intensive level of services they receive, thereby supporting access to care. However, we have concerns that outlier payments under the IRF PPS are not always targeted to patients who require more intensive services with related higher costs.

CMS estimates that IRF outlier payments, as a percentage of total estimated payments, would be approximately 3.2 percent in FY 2024, or 0.2 percentage points higher than the target of 3.0 percent. For FY 2025, CMS proposes to increase the fixed loss threshold from $10,423 in FY 2024 to $12,158 in FY 2025 or approximately 14 percent. CMS will update the proposed outlier threshold in the final rule based on later data.

The FAH is concerned that outlier payments to providers have continued to be concentrated among an increasingly small number of providers. While outlier payments are important to help facilities with extremely costly cases, we are concerned that factors other than patient complexity and case mix may be driving these extra payments. To address this over reliance on outlier payments by some facilities, CMS may want to consider additional future policies such as a reconciliation process or possibly a cap on outlier payments, which is applied under the home health payment system. Some of this concentration of outlier payments may be driving up the fixed loss threshold excessively and well beyond the market basket and overall costs per case.

**The FAH encourages CMS to further evaluate the variation in outlier spending by provider and consider including historical outlier reconciliation dollars in the outlier projections to ensure more accurate calibration of outlier payment amounts.**

## IRF QUALITY REPORTING PROGRAM ("QRP")

Starting October 1, 2024, CMS will mandate IRFs to gather IRF- Standardized Patient Assessment Instruments (PAIs) for every patient, regardless of their payer. This includes patients with non-Medicare commercial plans and pediatric patients. Pediatric IRF patients face unique

challenges with IRF-PAI collection due to many questions being irrelevant or inappropriate for children. Questions about mental health and suicide are especially unsuitable for children and may be more distressing for those in an IRF setting. Given these new requirements and the penalties for non-compliance, **the FAH is requesting CMS to clarify which IRF-PAI items must be asked of pediatric patients.**

*Proposal to Collect Four New Items and Modify One Item as Standardized Patient Assessment Data Elements*

CMS proposes adding four new items under the social determinants of health (SDOH) category to the IRF-PAI: living situation, two items for food, and one for utilities. The FAH supports these additions but has concerns about the 12-month look-back period. This timeframe can be confusing for patients to recall specific events, like utility shut-offs, especially for those recovering from severe conditions. **The FAH recommends CMS consider a shorter look-back period to better reflect current risks and simplify response options.**

CMS plans to modify the Transportation SPADE item (A1250) to include a 12-month look-back period with simplified yes/no response options. While the FAH supports the simplification, we believe a 12-month look-back is too long for effective care coordination. **The FAH recommends this item be made optional for patients under 18, as it may not be relevant or valid to be collected for youth or children.**

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

CMS is seeking input on the importance, relevance, appropriateness, and applicability on potential future measures: Vaccination Composite, Pain Management, and Depression.

*Vaccine Composite*

CMS is seeking input for future years in the IRF QRP for a vaccine composite measure which could represent overall immunization status of patients such as the Adult Immunization Status Measure in the Universal Foundation.[6] The FAH does not support a vaccination status measure in the IRF QRP. Vaccinations should be managed by primary care physicians, and IRFs typically do not stock most vaccines. Such a measure would likely be ineffective in improving vaccination rates and could lead to its retirement, similar to the influenza vaccination measure.

*Pain Management*

CMS is seeking input on the feasibility and applicability of a pain management measure for future years in the IRF QRP. Although there is not currently a pain management measure in the IRF QRP, there are pain-related SPADEs in the IRF-PAI, including items that assess pain interference with daily activities, sleep, and participation in therapy, which could present an opportunity to develop a future quality measure. Additionally, pain is a common aspect of

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[6] CMS Measures Inventory Tool. Adult immunization status measure found at https://cmit.cms.gov/cmit/#/FamilyView?familyId=26.

intensive therapy in IRFs. A more appropriate future measure would be to assess IRF health professionals' responsiveness to and help manage patients' pain.

*Depression*

CMS is seeking feedback on the concept of depression for the IRF QRP for future years. The FAH supports the development of a depression and follow up measure for post-acute care, utilizing the PHQ-2 to -9 screening tool. This tool is already in use by IRFs and should be standardized across post-acute settings. Patients with prior depression diagnoses should not be excluded from this measure, as reassessment after significant events is crucial.

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

CMS is seeking feedback on the development of an "overall star rating" for IRFs that can meaningfully distinguish between quality of care offered by different IRFs. In this RFI, CMS specifically seeks comments on whether (1) there are specific criteria CMS should use to select measures for an IRF star rating system, and (2) how CMS can present IRF star ratings information in a way that it is most useful to consumers.

In general, the FAH agrees with CMS that "star ratings serve an important function for patients, caregivers, and families, helping them to more quickly comprehend complex information about a healthcare providers' care quality and to easily address differences among providers.[7]" Additionally, star ratings are a way to measure and change provider performance on specific areas of quality. Without patient-level data on IRF QRP claims-based measures, IRFs would be unable to identify and implement any changes necessary for measure improvement. The FAH is concerned with the lack of patient-level data provided for IRF QRP claims-based measures. **We strongly recommend CMS take steps to provide IRFs with patient-level data before utilizing these measures in a star rating system.**

*Considerations for Claims-Based Measures in Star Ratings*

There are several criteria CMS should use when considering measures for inclusion in an IRF Star Rating system. First, a measure should have comparative value as between IRFs, meaning measure performance should help distinguish IRFs from one another. Second, measures should hold clinical relevance, which would have a link to improved patient outcomes. Third, measures should allow providers to access the patient-level data, necessary to help improve performance on the measure over time. There are several existing IRF QRP measures which stand out as strong indicators of IRF quality for a star rating program, but none fulfill the third suggested criteria on permitting patient-level feedback data:

- Discharge to Community (CMIT Measure ID #00210)
- Potentially Preventable 30-Day Post-Discharge Readmission Measure (CMIT Measure ID #00575)
- Potentially Preventable Within Stay Readmission Measure (CMIT Measure ID #00576)

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[7] FY 2025 IRF PPS Proposed Rule (89 FR 22246 through 22292).

- IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (CMIT Measure ID #00404)
- IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (CMIT Measure ID #00403)

Each of the above measures focuses on fundamental goals of IRF care, returning a patient to home (and the patient remaining at home) and improving functional quality of life. CMS should ensure IRFs have the ability to receive no patient-level feedback data prior to being adopted into the program. Transparency of data and information in Medicare has become a critically important ingredient within the multiple dashboards, frameworks, and portals that have been designed to enable consumers and patients to evaluate quality of care and make better informed decisions about where to receive their care. This transparency should include furnishing IRFs with patient-specific data and information for IRF QRP claims-based quality measures, as it would enable IRFs to take steps toward improving and refining our processes and quality of care initiatives.

Without patient-level data for claims-based measure on a more frequent basis (at least quarterly), IRF providers have no real way to identify why their claims-based measure rates are what they are, or why they change. Timely patient-level data on claims-based measures, including the discharge destination measures, would empower IRFs to determine what could be done better in a certain case or set of cases. Only providing an annual hospital-level rate in comparison to the national rate – years after the data are collected – does not provide an IRF with useful information to impact their quality improvement activities. Before CMS considers including these important measures in a star rating program, which can carry considerable consequences for individual IRFs, CMS should allow IRF providers access to this patient-level information in a timely manner, so that appropriate hospital-level programs and adjustments can be made.

*Considerations for Patient Experience of Care*

During the 2016 Experience of Care (EOC) Technical Expert Panel (TEP) discussions, two barriers emerged to the implementation of an EOC in IRFs. First, as noted in the Executive Summary[8], top-box responses on some measures skewed very high indicating a "ceiling effect" from the lack of variance, meaning a high proportion of the respondents scored at or near the highest score. This made it difficult to meaningfully discern variation between providers. Second, there was a significant logistical problem with IRF patient volume for most IRFs, leading to difficulties in obtaining sufficient survey response volume. The administrative and financial costs associated with collecting the data, particularly for smaller, hospital-based units, would not be justified nor would it provide meaningful information given the inability of most providers to meet minimum sampling requirements and minimal variation between providers. We recommend that CMS not implement a patient experience or patient satisfaction measure in

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[8] See, Executive Summary of the Inpatient Rehabilitation Facilities Experience of Care Survey (cms.gov)

the IRF QRP given the high costs of collecting the data for some IRFs and inability to meet necessary sample sizes by most IRFs.

*Current Measures which Should Not be Considered*

    A. *Catheter Associated Urinary Tract Infections (CAUTI) Outcomes Measure (CMIT Measure ID #00459)*

The FAH does not recommend the inclusion of Catheter Associated Urinary Tract Infections (CAUTI) Outcomes Measure (CMIT Measure ID #00459) because it already meets CMS removal factor §412.634 (b)(2)(i) "[m]easure performance among IRFs is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made." The measure in its current form also misinforms patients and consumers as IRFs that are successful in preventing CAUTIs with zero instances are labeled 'Not Applicable' instead of 'Better than the National Benchmark' "because the lower limit of the confidence interval cannot be calculated if the number of observed infections equals zero."[9]

Of the 796 hospitals designated as 'Not Applicable,' 52% are IRFs that had zero infections. Instead of being designated as the safest care providers related to catheter associated urinary tract infections on IRF Compare for consumer comparison, they are not displayed with a comparative category at all, effectively misrepresenting which IRF providers are, in fact, "better" with not only fewer infections – but zero, as "Not Applicable."

Additionally, 97% of all IRFs were designated as either 'Not Applicable" or 'No Different than the National Benchmark.' Only 0.9% were considered 'Better than the National Benchmark' and 2.3% were considered 'Worse than the National Benchmark.' Since the measure is considered not to be applicable for the majority of IRFs, and less than 4% of IRFs are considered different than the national benchmark, this measure does not appear to provide meaningful distinctions in quality between IRFs and would not provide value to consumers to be calculated as part of a potential star rating program.

    B. *Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (CMIT Measure ID #00520)*

In addition to the CAUTI measure, the FAH does not recommend the inclusion of the current fall rate measure, Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (CMIT Measure ID #00520) due to its lack of alignment with current clinical guidelines. While falls are an important indicator of quality in IRFs and post-acute care, this measure was developed for long-stay residents in nursing homes who have received 101 or more days of cumulative nursing home care. In IRFs, where patients have an average length of stay of around two weeks, a fall rate and/or a fall rate with major injury would be more appropriate. Unfortunately, the current measure was developed for nursing home residents and calculates the percentage of patients that have a fall with major injury, not the number of falls that occurred during a period of time, i.e., a fall rate.

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[9] eCFR :: 42 CFR 412.634 -- Requirements under the Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP).

In practice, IRFs do not utilize the current IRF QRP measure to track falls because a true fall rate, one which tracks the number of falls and not the number of patients that have fallen, is needed for substantive quality improvement. Additionally, the data is currently collected in a way to calculate the existing measure, coding "none, one, or two or more" that does not allow for an actual N size of falls to be calculated. The FAH encourages CMS to utilize a more appropriate fall rate and/or fall rate with major injury to measure in IRFs.

Lastly, the IRF Care Compare site is the most appropriate place to present an IRF star rating, along with the other publicly reported IRF QRP measures. CMS should also design a star rating program that provides a rating for the preponderance of IRFs, which would be the most useful for consumers. Currently, in the Inpatient Prospective Payment System (IPPS), CMS lists 34% of hospitals as "N/A" for a star rating (n=1578).[10] Without a preponderance of IRFs receiving a star rating, consumers may not be able to accurately assess the quality of care for multiple IRFs in their market, if one or more IRFs lack a rating.

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The FAH appreciates the opportunity to offer comments on the FY 2025 IRF PPS Proposed Rule. If you have any questions or would like to discuss further, please do not hesitate to contact me or a member of my staff at (202) 624-1534.

Sincerely,

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[10] Hospitals - Overall hospital quality star rating | Provider Data Catalog (cms.gov)