Response to Comments on the Burden Estimates for the FY 2024 IRF QRP Proposals*

The FY 2024 IRF PPS Notice of Proposed Rulemaking (88 FR 20950) was published on April 7, 2023. In response to the NPRM, CMS received five comments related to the proposed burden estimate. CMS responded to those comments in the FY 2024 PPS Final Rule that was published on August 2, 2023. Please see the response to comments document.

Comment: One commenter noted their disappointment that CMS continues to add and modify IRF QRP requirements while IRFs are still facing operational challenges related to the COVID-19 pandemic. They said the proposed modification to the HCP COVID-19 Vaccine measure beginning with the FY 2025 IRF QRP will add to their administrative burden and compliance costs. They also stated that the net effect of the removal of three current measures, the addition of two new measures, and the modification of one measure did not reduce any administrative burden associated with the IRF QRP.

Response: We acknowledge that the net effect of our policies finalized in this final rule is an increase of $27.73 per IRF per year. However, despite the operational challenges imposed by the COVID-19 pandemic, we must maintain our commitment to quality of care for all patients. In this final rule, we have sought to strike an appropriate balance between maintaining our commitment to quality of care with the impact on IRFs. The result is a reduction of the IRF QRP measure set from 18 to 17. We will continue to assess the IRF QRP measure set and use our Meaningful Measures Framework and measure removal criteria to guide decisions about future changes.

Comment: Two commenters stated the estimate of 18 seconds or 0.3 minutes of clinical staff time at discharge underestimates the burden of clinical staff to collect the Patient/Resident COVID-19 Vaccine measure. One of these commenters estimated the time required by a clinician to document a single item in the electronic medical record is around 7 seconds. This commenter also suggested the collection of the information from the patient to complete the data element will likely take far more than the remaining estimated 11 seconds, particularly due to the confusing nature and ongoing changes to the definition of "up to date," as well as the time necessary to conduct a patient interview, reconcile information provided by the patient, review the medical records, or contact a proxy for the information. The commenter stated that CMS' estimate does not account for the time needed to modify their electronic medical record system or to train staff for this measure. The other commenter suggested that the clinician type included in the burden estimate for the Patient/Resident COVID-19 Vaccine measure was not inclusive of the range of staff type that would need to receive an estimated hour of training. The commenter stated the training costs should be considered as a part of the burden estimate for completing the item.

Response: The 18 seconds (0.3 minutes) estimated for this item is based on past IRF burden calculations and represents the time it takes to encode the IRF-PAI. As the commenter pointed out in their example, the patient must be assessed, and information gathered. After the patient assessment is completed, the IRF-PAI is coded with the information and submitted to the Internet Quality Improvement and Evaluation System (iQIES), and it is these steps (after the patient assessment) that the estimated burden and cost captures. Finally, as we stated in section X.A. of the final rule, our assumptions for staff type were based on the categories generally necessary to perform an assessment, and subsequently encode it, which is consistent with past collection of information estimates. While we acknowledge that some IRFs may train and utilize other personnel, our estimates are based on the categories of personnel necessary to complete the IRF-PAI.

Comment: We received comments about the burden estimate for the DC Function Score measure. One commenter opposed the adoption of this measure given the growing burden of administering the IRF QRP, workforce shortages, and financial pressures. Two other commenters suggested that the measure's adoption will require software updates to implement and monitor the measure's complex calculations prior to CMS publishing results, as well as additional training and education for clinical

and administrative personnel. One of these commenters recommended CMS should consider these costs because they impact the values presented in the FY 2024 IRF PPS proposed rule. Another commenter observed IRFs will still need to educate and train their clinicians on the new measure, incorporate discussion of this measure into their interdisciplinary team meetings, and create a solution that will calculate imputation values and the risk-adjusted expected discharge function score values in order to manage performance.

Response: CMS continually looks for opportunities to minimize burden associated with collection of the IRF-PAI for information users through strategies that simplify collection and submission requirements. As discussed in sections IX.C.1.b. and X.A. of the final rule, this measure is modeled after the currently adopted Discharge Mobility Score and Discharge Self-Care Score measures, and we are not proposing changes to the number of items required or the reporting frequency of the items reported in the IRF-PAI for this DC Function measure. IRFs have been collecting the data elements used in the calculation of the new DC Function measure since FY 2017. At that time, we standardized the collection instructions across all IRFs, ensuring that all instructions and notices are written in plain language, and by providing step-by-step examples for completing the IRF-PAI. CMS provides a dedicated help desk to support users and respond to questions about the data collection. Additionally, a dedicated IRF QRP webpage houses multiple modes of tools, such as free training, case studies, user manuals, and frequently asked questions which support understanding of the items collected for the DC Function measure and the IRF-PAI generally, and these can be used by current users and assist new users of the IRF-PAI. CMS utilizes a listserv to facilitate outreach to users, such as communicating timely and important new material(s), and we will use those outreach resources when providing training and information about the new DC Function measure. CMS creates data collection specifications for IRF electronic health record (EHR) software with 'skip' patterns associated with the Quality Indicator items used for the DC Function measure to ensure the IRF-PAI is limited to the minimum data required to meet quality reporting requirements. These specifications are available free of charge to all IRFs and their technology partners. Further, these minimum requirements are standardized for all users of the IRF-PAI assessment forms. Finally, CMS calculates this measure for IRFs, and provides IRFs with various resources to review and monitor their own performance on this measure, including a free internet-based system through which users can access on-demand reports for feedback on the collection of the IRF-PAI associated with their facility.