

From: Centers for Medicare & Medicaid Services <cmslists@subscriptions.cms.hhs.gov>

Sent: Friday, August 2, 2024 3:51 AM

Subject: Centers for Medicare & Medicaid Services (CMS) Daily Digest Bulletin

CMS FACT SHEET: Fiscal Year 2025 Skilled Nursing Facility Prospective Payment System Final Rule (CMS 1802-F)

08/01/2024



FACT SHEET

July 31, 2024

Contact: CMS Media Relations

(202) 690-6145 | [CMS Media Inquiries](#)

Fiscal Year 2025 Skilled Nursing Facility Prospective Payment System Final Rule (CMS 1802-F)

On July 31, 2024, the Centers for Medicare & Medicaid Services (CMS) issued a final rule updating Medicare payment policies and rates for skilled nursing facilities under the Skilled Nursing Facility Prospective Payment System (SNF PPS) for fiscal year (FY) 2025. CMS is publishing this final rule that is consistent with the legal requirement to update Medicare payment policies for SNFs annually. This fact sheet discusses the major provisions of the final rule.

To view the final rule, visit the Federal Register at www.federalregister.gov/public-inspection/current.

FY 2025 Updates to the SNF Payment Rates

CMS is updating SNF payment policies, which would result in a net increase of 4.2%, or approximately \$1.4 billion, in Medicare Part A payments to SNFs in FY 2025. The 4.2% increase is calculated based on the SNF market basket percentage increase of 3.0%, plus a 1.7 percentage point forecast error adjustment, less a 0.5 percentage point productivity adjustment. These impact figures do not incorporate the SNF Value-Based Purchasing (VBP) reductions for certain SNFs subject to the

net reduction in payments under the SNF VBP; those adjustments are estimated to total \$196.5 million in FY 2025.

In addition to the SNF PPS rate update, CMS is rebasing and revising the SNF market basket to reflect a 2022 base year. The rule also finalizes the proposal to update the SNF PPS wage index using the Core-Based Statistical Areas (CBSAs) defined within the new Office of Management and Budget (OMB) Bulletin 23-01^[1] to improve the accuracy of wages and wage-related costs for the area in which the facility is located.

Changes in Patient-Driven Payment Model (PDPM) ICD-10 Code Mappings

The PDPM utilizes the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10) codes in several ways, including using the person's primary diagnosis to assign patients to clinical categories. CMS is finalizing several changes to the PDPM ICD-10 code mappings to allow providers to provide more accurate, consistent, and appropriate primary diagnoses that meet the criteria for skilled intervention during a Part A SNF stay. The changes to the ICD-10 code mappings and lists used under PDPM are available on the PDPM website at <https://www.cms.gov/Medicare/MedicareFee-for-Service-Payment/SNFPPS/PDPM>. CMS also summarizes comments received on the Request for Information (RFI) that solicited comment on potential future updates to the Non-Therapy Ancillary (NTA) component of PDPM.

Nursing Home Enforcement

This final rule changes CMS' enforcement policies to impose more equitable and consistent civil monetary penalties (CMPs) for health and safety violations as part of CMS' ongoing work to increase the safety and care provided in the nation's nursing homes. In February 2022, the Biden-Harris Administration announced its commitment to ensure all residents living in Medicare- and Medicaid-certified nursing homes receive safe, quality care.^[2] This included reexamining how CMPs were applied and robustly using existing nursing home enforcement authority. Given this commitment and the following analysis, CMS is expanding its ability to impose financial penalties to drive sustained correction of health and safety deficiencies. These revisions will provide CMS flexibility in determining the mix and number of penalties in response to situations that put residents' health and safety at risk and, therefore, encourage facilities to promptly correct and maintain lasting compliance with CMS' health and safety requirements.

CMS' enforcement authority allows for the imposition of CMPs for noncompliance with federal requirements. Penalties can be imposed per day or per instance of non-compliance depending on the health and safety deficiencies identified, with per day CMPs applied until the noncompliance is corrected and per instance CMPs for isolated instances. However, per-day and per-instance penalties could not be imposed for deficiencies identified during the same survey, and per-instance penalties could not be imposed concurrently for the same deficiency. The severity of enforcement sanctions is based on the harm or potential harm to residents

caused by non-compliance. This regulatory limitation prevented CMS and the state from imposing CMPs that were more commensurate with the identified noncompliance by restricting the use of multiple penalties for one deficiency, which prevents full use of CMPs to encourage faster correction and sustained compliance with health and safety requirements.

In this final rule, CMS revises the regulation to expand the type of CMPs that can be imposed to allow for more per instance and per day CMPs to be imposed, as appropriate. The revisions in this rule will permit both types of penalties to be imposed, providing CMS with greater flexibility to impose penalties in a manner that more directly reflects the health and safety impact on residents and incentivizes permanent correction. It is important to note, however, that these CMPs are still subject to statutory daily limits, and CMS can exercise discretion with regard to a nursing home's financial condition in determining the appropriate CMP. CMS remains focused on improving the health and safety of nursing home residents by ensuring quality care and ensuring access to care with these policies.

Skilled Nursing Facility Quality Reporting Program

CMS is finalizing updates to the SNF Quality Reporting Program (QRP) to better account for adverse social conditions that negatively impact individuals' health or health care. CMS is adding four new social determinants of health (SDOH) items and modifying one SDOH assessment item for the SNF QRP. Additionally, CMS is finalizing a policy requiring SNFs included in the SNF QRP to participate in a process to validate data submitted under the SNF QRP beginning with the FY 2027 SNF QRP.

The SNF QRP is a pay-for-reporting program. SNFs that do not meet reporting requirements are subject to a 2-percentage points reduction in their Annual Payment Update (APU) in accordance with section 1886(e)(6)(A) of the Act. Additionally, CMS publicly reports each SNF's performance on measures adopted into the SNF QRP on the Care Compare website.

Updates to the SNF QRP:

- Beginning with the FY 2027 SNF QRP (beginning with residents admitted on October 1, 2025), CMS is finalizing the adoption of four new items in the minimum data set (MDS) under the SDOH category: (1) Living Situation (1 item), (2) Food (2 items), and (3) Utilities (1 item). Among other reasons, screening for SDOH via collecting these items may assist SNFs in better addressing those identified needs with the residents, their caregivers, and community partners during the discharge planning process, if indicated.
- Beginning with the FY 2027 SNF QRP (beginning with residents admitted on and after October 1, 2025), CMS is finalizing modification of the Transportation item in the MDS, collected under the SDOH category. As part of CMS' routine item and measure monitoring work, CMS has identified an opportunity to improve the data collection for this item. Specifically, the finalized modifications of the Transportation item will improve and align data

collection in three ways: (1) specify the look-back period for identifying if and when a patient experienced a lack of reliable transportation, (2) simplify the response options for the resident, and (3) require collection at admission only, which will decrease provider burden since the current assessment item is collected at both admission and discharge.

- Beginning with the FY 2027 SNF QRP, CMS is finalizing a policy requiring that SNFs participating in the SNF QRP participate in a validation process. Specifically, CMS is finalizing the adoption of a validation process for the SNF QRP that is similar to the process CMS has adopted for the SNF Value-Based Purchasing Program in the FY 2024 SNF PPS final rule (88 FR 53323 through 53325). Approximately 1,500 SNFs will be randomly selected to share a very limited set of medical records for validation. CMS is required by section 1888(h)(12)(A) of the Act (as added by section 111(a)(4) of Division CC of the Consolidated Appropriations Act, 2021 (Pub. L. 116–260)) to apply a process to validate data submitted under the SNF QRP.

Skilled Nursing Facility Value-Based Purchasing (VBP) Program

For the SNF VBP program, CMS is finalizing several operational and administrative proposals as part of this year's rule. Operationally, this includes adopting a measure selection, retention, and removal policy for the SNF VBP program, as well as a technical measure update policy and a review and correction policy update.

The SNF VBP program is a pay-for-performance program. As required by statute, CMS withholds 2% of SNFs' Medicare fee-for-service Part A payments to fund the SNF VBP Program. This 2% is referred to as the "withhold." CMS is then required to redistribute between 50% and 70% of this withhold to SNFs as incentive payments depending on their performance in the program.

Updates to the SNF VBP:

- CMS is adopting a measure retention and removal policy to help ensure that the SNF VBP Program's measure set remains focused on the best and most appropriate metrics for assessing care quality in the SNF setting. CMS is also adopting a measure selection, retention, and removal policy that aligns with a similar policy currently in place in the SNF QRP program.
- CMS is also adopting a technical measure update policy allowing the agency to update previously finalized SNF VBP measure specifications using a sub-regulatory process.
- CMS is finalizing administrative policy updates, including an update to the review and corrections policy that CMS previously finalized for the program, to ensure that SNFs can review and correct data used to calculate their measure rates.

###

Get CMS news at [cms.gov/newsroom](https://www.cms.gov/newsroom), sign up for CMS news [via email](#) and follow CMS on X (Formerly Twitter) [@CMSgov](#)

^[1] <https://www.whitehouse.gov/wp-content/uploads/2023/07/OMB-Bulletin-23-01.pdf>

^[2] <https://www.whitehouse.gov/briefing-room/statements-releases/2022/02/28/fact-sheet-protecting-seniors-and-people-with-disabilities-by-improving-safety-and-quality-of-care-in-the-nations-nursing-homes/>

CMS FACT SHEET: Fiscal Year 2025 Medicare Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) and Quality Reporting (IPFQR) Updates Final Rule (CMS-1806-F)

08/01/2024



FACT SHEET

July 31, 2024

Contact: CMS Media Relations

(202) 690-6145 | [CMS Media Inquiries](#)

Fiscal Year 2025 Medicare Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) and Quality Reporting (IPFQR) Updates Final Rule (CMS-1806-F)

On July 31, 2024, the Centers for Medicare & Medicaid Services (CMS) issued a final rule to update Medicare payment policies and rates for the Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) for fiscal year (FY) 2025. CMS is publishing this final rule consistent with the legal requirements to update Medicare payment policies for IPFs on an annual basis.

Policies included in this final rule support the provision of high-quality behavioral health treatment in inpatient psychiatric facilities, consistent with the [Biden-Harris Administration's Unity Agenda](#) and focus on addressing the mental health crisis. This fact sheet discusses the major provisions of the final rule, including annual updates to the prospective payment rates, the outlier threshold, and the wage index. The rule finalizes CMS' proposal to revise patient-level adjustment factors and to increase the per-treatment amount for Electroconvulsive Therapy (ECT). Additionally, the rule finalizes the proposal to update the wage index using the latest Core-Based Statistical Area (CBSA) Labor Market Areas from the Office of Management and Budget (OMB). CMS believes these policies will improve or maintain individual access to high-quality care by ensuring that payment rates reflect the best available data on the resources involved in inpatient psychiatric care and the costs of these resources.

In addition, this rule includes a clarification of the eligibility criteria for IPFs to elect to file an all-inclusive cost report. CMS will issue revised cost reporting guidance and make operational changes to improve the quality of ancillary charge data on IPF claims by enforcing these eligibility criteria, resulting in the appropriate collection of more cost data from IPFs erroneously filing an "all-inclusive" rate cost report. CMS believes these operational changes will support its ongoing efforts to analyze variation in costs between patients with different characteristics and will increase the accuracy of future payment refinements to the IPF PPS while also aligning with the President's Executive Order on Promoting Competition in the American Economy by facilitating accurate payment, cost efficiency, and transparency.^[1]

This final rule also includes summaries of comments received in response to two requests for information on future revisions to the IPF PPS facility-level adjustment factors and development of the new standardized IPF Patient Assessment Instrument (IPF-PAI), required by the Consolidated Appropriations Act, 2023 (CAA, 2023), which IPFs participating in the IPF Quality Reporting (IPFQR) Program will be required to report beginning with Rate Year 2028.

For the IPFQR Program, CMS is finalizing adoption of the 30-Day Risk-Standardized All-Cause Emergency Department Visit Following an Inpatient Psychiatric Facility Discharge measure. CMS is not finalizing its proposal to require IPFs to submit data on a quarterly basis for patient-level measures; data reporting for these measures will remain annual.

Changes to Payments Under the IPF PPS

Updates to IPF Payment Rates

For FY 2025, CMS is updating the IPF PPS payment rates by 2.8%, based on the 2021-based IPF market basket increase of 3.3%, reduced by a 0.5 percentage point productivity adjustment. Additionally, CMS is updating the outlier threshold so that estimated outlier payments remain at 2.0% of total payments. CMS estimates that updating the outlier threshold will result in a 0.3% decrease in aggregate payments. Total estimated payments to IPFs are estimated to increase by 2.5%, or \$65 million, in FY 2025 relative to IPF payments in FY 2024.

Revisions to IPF PPS Patient-Level Adjustment Factors and Request for Information

The CAA, 2023, requires CMS to revise the IPF PPS methodology for determining payment rates for FY 2025 and subsequent years. CMS is finalizing revisions to the methodology for

determining the payment rates under the IPF PPS for psychiatric hospitals and psychiatric units based on a review of the data and information collected in prior years in accordance with section 1886(s)(5)(A) of the Social Security Act, as added by the CAA, 2023. CMS is finalizing revisions to the IPF PPS patient-level adjustment factors. The patient-level adjustments include Medicare Severity Diagnosis Related Groups (MS-DRGs) assignment of the patient's principal diagnosis, selected comorbidities, patient age, and a variable per diem adjustment.

Historically, the IPF PPS used the patient and facility-level adjustment factors derived from the regression model implemented in 2005. In this final rule, we have updated the regression model used to determine IPF PPS payment adjustments to reflect costs and claims data for CY 2019, 2020, and 2021. Based on our analysis of the more recent claims and costs data, as well as public comments received in the FY 2022 and FY 2023 IPF PPS rules, we are finalizing changes to the patient-level adjustments for which we adjust payment. We are finalizing these revisions in a budget-neutral manner (that is, estimated payments to IPFs for FY 2025 would be the same with or without the finalized revisions).

In addition to these updates for FY 2025, CMS sought input on potential future revisions to the IPF PPS facility-level adjustments based on the results of more recent IPF cost and claim analysis. An analysis of 2019 through 2021 IPF claims and costs data identified potential changes in the regression factors for IPFs with a rural location and teaching status and suggested there may be value in including a new facility-level variable for the safety net patient population. We also analyzed a potential adjustment based on the Medicare Safety Net Index (MSNI), developed by MedPAC as a recommended alternative to the current statutorily required methodology for disproportionate share payments to IPPS hospitals. In the proposed rule, we discussed considerations related to applicability and modeling that demonstrate the effect of revising the rural and teaching status adjustment factors, as well as the inclusion of a new facility-level variable for safety net patient populations. In future rulemaking, updating these facility-level adjustment factors could more accurately pay for care, support psychiatry residency training, and support IPFs in rural and underserved areas. Commenters offered various suggestions of facility-level characteristics and factors we could consider for analysis. CMS will take these comments into consideration for future rulemaking.

Increase to the Electroconvulsive Therapy Payment per Treatment

In addition, an analysis of the latest IPF PPS claims and cost data found that ancillary costs for stays that include electroconvulsive therapy (ECT) treatments have increased more than the ECT per treatment payment has since 2005. To remedy this, we are increasing the IPF PPS ECT per treatment amount. For FY 2025, the ECT payment per treatment will be \$661.52, an increase from the FY 2024 ECT payment per treatment of \$385.58. We believe this increase will help ensure that the patients who need ECT are more able to access it.

FY 2025 Wage Index Update for Revised Census Data

IPF PPS regulations require CMS to use the best Medicare data available to estimate the average inpatient operating and capital-related costs per day, including an appropriate wage index to adjust for wage differences. We update the wage index annually based on the most recent available acute care hospital wage index, without any floors or reclassifications applicable under the Medicare Inpatient Prospective Payment System. Historically, we have

also updated the Core-Based Statistical Area (CBSA) delineations in accordance with the latest available Office of Management and Budget (OMB) Bulletin. For FY 2025, we are adopting the CBSA Labor Market Areas for the IPF PPS wage index as defined in the OMB [Bulletin 23-01](#). We are also implementing a transition period for providers transitioning from rural to urban based on these CBSA revisions. The affected providers will receive two-thirds of the rural adjustment in FY 2025, one-third of the rural adjustment in FY 2026, and no rural adjustment in FY 2027. This approach is consistent with how we have implemented this policy in previous years and will help affected providers adjust to the loss of the payment adjustment for rural locations over time.

The CAA, 2023, requires the collection of data and information, such as charges related to ancillary services, to revise the IPF PPS. Currently, CMS expects IPFs with a charge structure to report ancillary costs and charges on cost reports. In contrast, IPFs without this cost structure have the option to use an alternative method of cost reporting by filing all-inclusive cost reports. All-inclusive cost reporting accommodates these hospitals' inability to allocate costs to charges and allows them to use an alternative cost allocation method. Historically, there have been a small number of hospitals that file all-inclusive cost reports, which consistently do not include or have very minimal ancillary cost data. These have mostly included Indian Health Service (IHS) hospitals, tribally owned and government-owned psychiatric, and acute care hospitals. However, CMS has observed a notable increase in the number of IPFs erroneously filing all-inclusive cost reports.

CMS is clarifying the eligibility criteria for the option to elect to file an all-inclusive cost report and is making operational changes to ensure that only government-owned, IHS, or tribally owned IPF hospitals are permitted to file an all-inclusive cost report for cost reporting periods beginning on or after October 1, 2024. By improving the reporting of ancillary costs and charges, CMS will be able to increase accuracy of future payment refinements to the IPF PPS, which will further advance behavioral health treatment and support IPFs that provide care to people with more complex and costlier conditions.

Request for Information (RFI) about IPF PPS Patient Assessment Instrument (IPF-PAI) Required by the Consolidated Appropriations Act, 2023 (CAA, 2023)

The CAA, 2023, requires IPFs to collect and submit standardized patient assessment data on specified categories. This data will enable CMS to propose future revisions to the IPF PPS that would more accurately pay for care, monitor quality, and assess for disparities in behavioral health care. Therefore, CMS included an RFI in the proposed rule to solicit comments with the goal of engaging the public to identify meaningful data elements for collection that are appropriate for the acute inpatient psychiatric care setting and potential criteria for the development and implementation of the instrument. In addition, we sought to understand the burden on IPFs that this additional data collection would impose and solicited comment on ways we might minimize this burden by evaluating whether any data that is currently collected through one or more existing assessment instruments in other settings or collected as part of IPFs' existing processes, could be collected as standardized patient assessment data elements for the IPF-PAI. We summarized the comments we received on this RFI in this final rule. CMS

will take these comments into consideration for development of the IPF-PAI and in future rulemaking.

Updates to the Inpatient Psychiatric Facilities Quality Reporting (IPFQR) Program

The IPFQR Program requires that all IPFs paid under the IPF PPS submit certain specified quality data to CMS in a form and manner and within the timeframes that CMS prescribes. IPFs that do not submit the specified data on quality measures as required by the IPFQR Program receive a 2.0 percentage point reduction to their annual payment update. The IPFQR Program aims to assess and foster improvement in the quality of care provided to patients in IPFs. By requiring IPFs to submit quality data to CMS and by CMS publicly reporting these data under the IPFQR Program, CMS ensures that patients can make more informed decisions about their health care options.

In this final rule, CMS is finalizing its proposal to adopt one new measure, the 30-Day Risk-Standardized All-Cause Emergency Department Visit Following an Inpatient Psychiatric Facility Discharge measure (also referred to as the IPF ED Visit measure). This claims-based measure will assess the proportion of patients 18 and older with an emergency department visit, including observation stays, within 30 days of discharge from an IPF without subsequent admission. Patients subsequently admitted to an acute care hospital or IPF are represented under the Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility measure, which is already in the IPFQR Program. By adopting the IPF ED Visit measure, the IPFQR Program will provide a more complete assessment of post-discharge acute care and encourage improvements in discharge planning and care coordination.

Additionally, CMS is not finalizing its proposal to require IPFs to submit patient-level quality data for certain measures on a quarterly basis (as opposed to the current annual basis). CMS proposed this update to align the IPFQR Program with other quality reporting programs that require patient-level data submission on a quarterly basis and to reduce data strains on IPF systems. However, after reviewing public comment on this proposal, CMS determined that some IPFs may be unable to meet this requirement in the proposed timeframe. Therefore, CMS decided not to finalize this proposal and to maintain the current annual reporting for these measures.

###

^[1] <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/07/09/executive-order-on-promoting-competition-in-the-american-economy/>

CMS FACT SHEET: Fiscal Year 2025 Inpatient Rehabilitation Facility Prospective Payment System Final Rule (CMS-1804-F)



FACT SHEET

July 31, 2024

Contact: CMS Media Relations

(202) 690-6145 | [CMS Media Inquiries](#)

Fiscal Year 2025 Inpatient Rehabilitation Facility Prospective Payment System Final Rule (CMS-1804-F)

On July 31, 2024, the Centers for Medicare & Medicaid Services (CMS) issued a final rule to update Medicare payment policies and rates under the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) and the IRF Quality Reporting Program (QRP) for fiscal year (FY) 2025. CMS is publishing this final rule in accordance with the legal requirements to update Medicare payment policies for IRFs on an annual basis.

For FY 2025, CMS finalized the update to the IRF PPS payment rates by 3.0% based on the final IRF market basket update of 3.5%, less a 0.5 percentage point productivity adjustment. The final rule includes annual updates to the prospective payment rates, the outlier threshold, the case-mix-group relative weights and average length of stay values, the wage index, and associated impact analysis. In addition, the rule includes an update to the IRF PPS wage index using the latest Core-Based Statistical Areas (CBSAs) from the Office of Management and Budget and provides a transition for those IRFs who lose the rural adjustment due to their labor market area transitioning from rural to urban.

The IRF QRP is a pay-for-reporting program. IRFs that do not meet reporting requirements are subject to a 2-percentage point reduction in their Annual Increase Factor. Additionally, CMS publicly reports each IRF's performance on measures adopted into the IRF QRP on the [Care Compare website](#). For the IRF QRP, CMS finalized adding four assessment items, modifying one assessment item, and removing one from the IRF-Patient Assessment Instrument (PAI). CMS received feedback from two Requests for Information (RFIs), one on quality measure concepts under consideration for future IRF QRP years and one on a star rating system for publicly reporting IRF QRP measures on Care Compare.

This fact sheet discusses the provisions of the final rule. The FY 2025 Inpatient Rehabilitation Facility Prospective Payment System final rule (CMS-1804-F) can be downloaded from the *Federal Register* at <https://www.federalregister.gov/public->

[inspection/2024-16911/medicare-program-inpatient-rehabilitation-facility-prospective-payment-system-for-federal-fiscal](#)

Final Updates to the FY 2025 IRF PPS Payment Policies

For FY 2025, CMS finalized updates to the IRF PPS payment rates by 3.0% based on the final IRF market basket percentage increase of 3.5%, less a final 0.5 percentage point productivity adjustment. Additionally, CMS finalized updates to the outlier threshold to maintain outlier payments at 3% of total payments. We estimate the final technical rate setting changes will result in an estimated increase in IRF payments of \$280 million for FY 2025. This reflects a \$300 million increase from the update to the payment rates and a \$20 million decrease due to the update to the outlier threshold.

Final Wage Index Update for Revised Census Data

CMS also finalized the IRF PPS wage index using the most recent Office of Management and Budget (OMB) statistical area delineations based on the 2020 Decennial Census, which revises the existing core-based statistical areas in the [OMB Bulletin 23-01](#). Any wage index decreases will be mitigated by the permanent 5% cap on negative wage index changes (regardless of the underlying reason for the decrease). In addition, we are finalizing the phase out of the rural adjustment for IRFs that transition from rural to urban status under the new CBSAs. For FY 2025, CMS estimates that eight IRFs will change their status from rural to urban. These IRFs will receive two-thirds of the rural adjustment in FY 2025, one-third of the rural adjustment in FY 2026, and no rural adjustment in FY 2027. This approach is consistent with how we implemented this policy in FY 2016 and provides IRFs a transition period to adjust to the updated wage index.

Final Updates to the IRF QRP

Beginning with the FY 2028 IRF QRP (beginning with patients admitted on October 1, 2026), CMS is finalizing the adoption of four new items in the IRF-PAI as standardized patient assessment data elements under the Social Determinants of Health (SDOH) category: (1) Living Situation (one item), (2) Food (two items), and (3) Utilities (one item). Identifying and collecting patients' health-related social needs (HRSNs) these items may assist IRFs in better addressing those identified needs with the patient, their caregivers, and community partners during the discharge planning process, if indicated.

Beginning with the FY 2028 IRF QRP (beginning with patients admitted on October 1, 2026), CMS is finalizing a modification of the Transportation item in the IRF-PAI, collected under the SDOH category. As part of routine item and measure monitoring work, CMS has identified an opportunity to improve the data collection for this item. Specifically, the finalized modification of the Transportation item will improve and align data collection in three ways: (1) specify the look-back period for identifying if and when a patient experienced a lack of reliable transportation, (2) simplify the response options for the patient, and (3) require collection at admission only (rather

than at admission and discharge), which will decrease provider burden since the current assessment item is collected at both admission and discharge.

CMS routinely reviews the IRF-PAI for redundancies and opportunities to simplify data submission requirements. CMS is finalizing removing the Admission Class assessment item collected at admission from the IRF-PAI item set, as CMS identified that this item is currently not used in calculating quality measures already adopted in the IRF QRP or for purposes unrelated to the IRF QRP, such as payment, survey, or care planning. This removal will be effective beginning with the FY 2028 IRF QRP (beginning with patients admitted on October 1, 2026); however, IRFs will not be required to collect this item beginning with patients admitted on October 1, 2024.

Requests for Information (RFIs)

CMS requested public input on the following RFIs, which will help develop potential policies for rulemaking in future years. The agency received comments in all areas requested.

Future Measure Concepts for the IRF QRP

CMS continues to evaluate, refine, and develop new measures for the IRF QRP to ensure that people with Medicare and their caregivers have meaningful information for making informed health care decisions. IRF QRP measures examine provider performance across various dimensions of care, and providers benefit from having sufficient information to foster performance improvement. We sought feedback on the measure concepts of vaccination composite, pain management, and depression. We received robust feedback on these concepts and have provided a summary in the FY2025 IRF PPS final rule. CMS plans to use this feedback to inform future measure development.

Creating an IRF QRP Star Rating System

CMS sought feedback on creating an IRF QRP Star Rating System. Currently, the IRF QRP does not have a star rating system to supplement existing, publicly reported, quality information for individuals to use when comparing IRF quality of care. We intend to develop a five-star methodology for IRFs that can meaningfully distinguish between quality of care offered by providers and would also be reported on both Care Compare and the Provider Data Catalog. Star ratings for IRFs will be designed to help consumers quickly identify differences in quality when selecting a provider while also helping to promote competition in health care markets. We received robust feedback on these concepts and have provided a summary in the FY 2025 IRF PPS final rule. CMS will use this feedback to inform any future rating system.

For more information about IRF QRP, please visit:

<https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility>

###

MLN Connects Newsletter: Aug 1, 2024

08/01/2024

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)



mlnconnects
Official CMS news from the Medicare Learning Network®

Thursday, August 1, 2024

Final Payment Rules

- [Skilled Nursing Facility FY 2025 Final Rule](#)
- [Inpatient Rehabilitation Facility FY 2025 Final Rule](#)
- [Inpatient Psychiatric Facility FY 2025 Final Rule](#)
- [Hospice FY 2025 Final Rule](#)

News

- [CMS Roundup \(July 26, 2024\)](#)
- [Opioid Treatment Program: Learn How to Bill Medicare](#)

Claims, Pricers, & Codes

- [DMEPOS: Provider Level Adjustment Codes on Remittance Advice](#)

Publications

- [Beneficiaries Dually Eligible for Medicare & Medicaid — Revised](#)

Multimedia

- [Post-Acute Care Quality Reporting Programs: Patient Mood Interview Video Tutorial](#)

[View the full edition](#)

[Report a problem viewing this newsletter.](#)

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health & Human Services (HHS). Paid for by HHS.



The next CMS Skilled Nursing Facilities (SNF)/Long Term Care (LTC) Open Door Forum scheduled for Tuesday, August 6, 2024, 2:00 PM – 3:00 PM Eastern Time (ET)

08/01/2024



Open Door Forum

The next CMS Skilled Nursing Facilities (SNF)/Long Term Care (LTC) Open Door Forum scheduled for:

Date: Tuesday, August 6, 2024

Start Time: 2:00 PM – 3:00 PM Eastern Time (ET);

Please dial-in at least 15 minutes before call start time.

Conference Leaders: Todd Smith & Jill Darling

****This Agenda is Subject to Change****

1. Opening Remarks

Chair – Todd Smith (Center for Medicare)

Moderator – Jill Darling (Office of Communications)

1. Announcements & Updates

- FY 2025 SNF PPS Final Rule
 - SNF PPS
 - FY 2025 Annual Update (Forecast Error Adjustment)
 - Rebasing and Revising the SNF PPS Market Basket
 - Wage Index Changes
 - Technical Updates to ICD-10 Codes for PDPM
 - QRP
 - SDOH Assessment Item Additions and Modification
 - Adoption of MDS Validation Process for the SNF QRP
 - RFI on Future Measure Concepts
 - VBP
 - Technical Measure Update Policy
 - Adoption of Measure Removal and Retention Policy
 - Nursing Home Enforcement
 - Civil Money Penalty Updates
- PDPM Grouper To Support XML Input
 - <https://www.cms.gov/medicare/quality/nursing-home-improvement/minimum-data-set-technical-information>
- SNF VBP - FY 2025 SNF VBP Program Performance Score Reports are Now Available
 - <https://www.cms.gov/medicare/quality/nursing-home-improvement/value-based-purchasing/confidential-feedback-reporting-review-and-corrections>
- Skilled Nursing Facility Quality Reporting Program
 - SNF QRP Reconsideration Period for FY2025 ends August 14, 2024
 - <https://www.cms.gov/medicare/quality/snf-quality-reporting-program/reconsideration-and-exception-extension>

III. Open Q&A

****DATE IS SUBJECT TO CHANGE****

Next ODF: TBD

Mailbox: SNF_LTCODF-L@cms.hhs.gov

This Open Door Forum is open to everyone, but if you are a member of the Press, you may listen in but please refrain from asking questions during the Q & A portion of the call. If you have inquiries, please contact CMS at Press@cms.hhs.gov. Thank you.

NEW and UPDATED Open Door Forum Participation Instructions:

This call will be a Zoom webinar with registration and login instructions below.

To participate by webinar:

Register in advance for this webinar:

https://cms.zoomgov.com/webinar/register/WN_vfsU5LSKR3atiW9T_AhrDg

Meeting ID: 160 823 4591

Passcode: 200020

After registering, you will receive a confirmation email containing information about joining the webinar. You may also add the webinar to your calendar using the drop-down arrow on the “Webinar Registration Approved” webpage after registering. Although the ODFs are now a Zoom webinar, we will only use the audio function, no need for cameras to be on.

For ODF schedule updates and E-Mailing List registration, visit our website at <http://www.cms.gov/OpenDoorForums/>.

We encourage you to visit our CMS Podcasts and Transcript webpage where you can listen and view the most recent Skilled Nursing Facilities (SNF)/Long Term Care (LTC) ODF call at <https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts.html>. Thank you.

CMS provides free auxiliary aids and services including information in accessible formats. Click [here](#) for more information. This will point partners to our CMS.gov version of the “Accessibility & Nondiscrimination notice” page.

Open Door Forum
Outreach & Education

The next Home Health, Hospice & DME Open Door Forum is scheduled for Wednesday, August 7, 2024, PM at 2:00 PM – 3:00 PM Eastern Time (ET)

08/01/2024



Open Door Forum

The next Home Health, Hospice & DME Open Door Forum is scheduled for Wednesday, August 7, 2024, PM at 2:00 PM – 3:00 PM Eastern Time (ET).

Please log on at least 15 minutes prior to the forum start time.

****This Agenda is Subject to Change****

- Opening Remarks

Chair – Brian Slater, Center for Medicare, CMS

Co-Chair- Kelly Vontran, Center for Medicare, CMS

Moderator – Jill Darling, Office of Communications, CMS

- Announcements & Updates
- Upcoming conversion of the Home Health Grouper Software to Java 17
 1. Resource e-mail: HHGrouperQuestions@cms.hhs.gov
 2. <https://www.cms.gov/medicare/payment/prospective-payment-systems/home-health/home-health-grouper-software>
- July Interim Performance Report
- First Annual Performance Report with Payment Adjustment
 1. Upcoming Webinar: *The HHVBP CY 2024 Annual Performance Report (APR) – What You Need to Know!* Aug 13, 2024 03:00 PM
 2. Appeals Process
 3. Public Reporting
- Contact Information
 1. Help Desk: HHVBPquestions@cms.hhs.gov
 2. Model webpage: <https://www.cms.gov/priorities/innovation/innovation-models/expanded-home-health-value-based-purchasing-model>
- Hospice Quality Reporting Program
 1. Public Reporting
 2. Rulemaking
 3. New resources
- Home Health Quality Reporting Program
 1. Rulemaking
 2. New resources

III. Open Q&A

****DATE IS SUBJECT TO CHANGE****

Next Home Health, Hospice & DME ODF: TBA

Mailbox: HomeHealth_Hospice_DMEODF-L@cms.hhs.gov

This Open Door Forum is open to everyone, but if you are a member of the Press, you may listen in but please refrain from asking questions during the Q & A portion of the call. If you have inquiries, please contact CMS at Press@cms.hhs.gov. Thank you.

NEW and UPDATED Open Door Forum Participation Instructions:

This call will be a Zoom webinar with registration and login instructions below.

Register in advance for this webinar:

https://cms.zoomgov.com/webinar/register/WN_vfsU5LSKR3atiW9T_AhrDg

Meeting ID: 160 823 4591

Passcode: 200020

After registering, you will receive a confirmation email containing information about joining the webinar. You may also add the webinar to your calendar using the drop-down arrow on the “Webinar Registration Approved” webpage after registering. Although the ODFs are now a Zoom webinar, we will only use the audio function, no need for cameras to be on.

For ODF schedule updates and E-Mailing List registration, visit our website at <http://www.cms.gov/OpenDoorForums/>.

Were you unable to attend the recent Home Health, Hospice & DME ODF call? We encourage you to visit our CMS Podcasts and Transcript webpage where you can listen and view the most recent Home Health, Hospice & DME ODF call. Both the webinar recording and transcript will be posted to: <https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts.html>. Thank you.

CMS provides free auxiliary aids and services including information in accessible formats. Click [here](#) for more information. This will point partners to our CMS.gov version of the “Accessibility & Nondiscrimination notice” page.

Open Door Forum
Outreach & Education