

Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) Regulatory and Legislative History

Updated: August 2025

Historically, each rule or update notice issued under the annual Inpatient Rehabilitation Facility (IRF) prospective payment system (PPS) rulemaking cycle included a detailed discussion of the various regulatory and legislative provisions that have affected the IRF PPS over the years. This document now serves to provide that discussion and will be updated as needed.

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 2025, 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 index 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 index 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) (hereinafter referred to as the rehabilitation, psychiatric, and long-term care (RPL) market basket). 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.

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 2025, is available on the CMS Website at <https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/InpatientRehabFacPPS>.

In late 2019, the United States began responding to an outbreak of a virus named “SARS-CoV-2” and the disease it causes, which is named “coronavirus disease 2019” (abbreviated “COVID-19”). Due to our prioritizing efforts in support of containing and combatting the PHE for COVID-19, and devoting significant resources to that end, 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 also removed the post-admission physician evaluation documentation requirement at 42 CFR 412.622(a)(4)(ii) permanently 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 COVID19. In addition to the policies adopted in our IFCs, we responded to the PHE with numerous blanket waivers² and other flexibilities,³ some of which are applicable to the IRF PPS.

B. Provisions of the PPACA 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 (PPACA) (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 PPACA, was enacted on March 30, 2010. In this final rule, we refer to the two statutes collectively as the “Patient Protection and Affordable Care Act” or “PPACA”.

The PPACA 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 PPACA 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 2023 is discussed in section VI.B. of this final 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.

Sections 3004(b) of the PPACA 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 PPACA 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 2CMS, “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>). 3CMS, “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>). 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 less than such 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 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 <http://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/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 an informational-only bill (type of bill (TOB) 111), which includes Condition Code 04 to their MAC. 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 <http://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 <http://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).

D. Regulatory and Legislative Updates to the IRF PPS

In the FY 2007 IRF PPS final rule (71 FR 48354), we further refined the IRF PPS casemix classification system (the CMG relative weights) and the case-level adjustments, to ensure that IRF PPS payments would continue to reflect as accurately as possible the costs of care. For a detailed discussion of the FY 2007 policy revisions, please refer to the FY 2007 IRF PPS final rule.

In the FY 2008 IRF PPS final rule (72 FR 44284), we updated the prospective payment rates and the outlier threshold, revised the IRF wage index policy, and clarified how we determine high-cost outlier payments for transfer cases. For more information on the policy changes implemented for FY 2008, please refer to the FY 2008 IRF PPS final rule.

After publication of the FY 2008 IRF PPS final rule (72 FR 44284), section 115 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Pub. L. 110-173, enacted December 29, 2007) (MMSEA) amended section 1886(j)(3)(C) of the Act to apply a zero percent increase factor for FYs 2008 and 2009, effective for IRF discharges occurring on or after April 1, 2008. Section 1886(j)(3)(C) of the Act required the Secretary to develop an increase factor to update the IRF prospective payment rates for each FY. Based on the legislative change to the increase factor, we revised the FY 2008 prospective payment rates for IRF discharges occurring on or after April 1, 2008. Thus, the final FY 2008 IRF prospective payment rates that were published in the FY 2008 IRF PPS final rule (72 FR 44284) were effective for discharges occurring on or after October 1, 2007, and on or before March 31, 2008, and the revised FY 2008 IRF prospective payment rates were effective for discharges occurring on or after April 1, 2008, and on or before September 30, 2008. The revised FY 2008 prospective payment rates are available on the CMS website at <http://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/InpatientRehabFacPPS/Data-Files.html>.

In the FY 2009 IRF PPS final rule (73 FR 46370), we updated the CMG relative weights, the average LOS values, and the outlier threshold; clarified IRF wage index policies regarding the treatment of “New England deemed” counties and multi-campus hospitals; and revised the regulation text in response to section 115 of the MMSEA to set the IRF compliance percentage at 60 percent (the “60 percent rule”) and continue the practice of including comorbidities in the calculation of compliance percentages. We also applied a zero percent market basket increase factor for FY 2009 in accordance with section 115 of the MMSEA. For more information on the policy changes implemented for FY 2009, please refer to the FY 2009 IRF PPS final rule.

In the FY 2010 IRF PPS final rule (74 FR 39762) and in correcting amendments to the FY 2010 IRF PPS final rule (74 FR 50712), we updated the prospective payment rates, the CMG relative weights, the average LOS values, the rural, LIP, teaching status

adjustment factors, and the outlier threshold; implemented new IRF coverage requirements for determining whether an IRF claim is reasonable and necessary; and revised the regulation text to require IRFs to submit patient assessments on Medicare Advantage (MA) (formerly called Medicare Part C) patients for use in the 60 percent rule calculations. Any reference to the FY 2010 IRF PPS final rule in this final rule also includes the provisions effective in the correcting amendments. For more information on the policy changes implemented for FY 2010, please refer to the FY 2010 IRF PPS final rule.

After publication of the FY 2010 IRF PPS final rule (74 FR 39762), section 3401(d) of the Patient Protection and Affordable Care Act (Pub. L. 111-148, enacted March 23, 2010), as amended by section 10319 of the same Act and by section 1105 of the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152, enacted March 30, 2010) (collectively, hereinafter referred to as “PPACA”), amended section 1886(j)(3)(C) of the Act and added section 1886(j)(3)(D) of the Act. Section 1886(j)(3)(C) of the Act requires the Secretary to estimate a multifactor productivity (MFP) adjustment to the market basket increase factor, and to apply other adjustments as defined by the Act. The productivity adjustment applies to FYs from 2012 forward. The other adjustments apply to FYs 2010 to 2019.

Sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(i) of the Act defined the adjustments that were to be applied to the market basket increase factors in FYs 2010 and 2011. Under these provisions, the Secretary was required to reduce the market basket increase factor in FY 2010 by a 0.25 percentage point adjustment. Notwithstanding this provision, in accordance with section 3401(p) of the PPACA, the adjusted FY 2010 rate was only to be applied to discharges occurring on or after April 1, 2010. Based on the self-implementing legislative changes to section 1886(j)(3) of the Act, we adjusted the FY 2010 prospective payment rates as required and applied these rates to IRF discharges occurring on or after April 1, 2010, and on or before September 30, 2010. Thus, the final FY 2010 IRF prospective payment rates that were published in the FY 2010 IRF PPS final rule (74 FR 39762) were used for discharges occurring on or after October 1, 2009, and on or before March 31, 2010, and the adjusted FY 2010 IRF prospective payment rates applied to discharges occurring on or after April 1, 2010, and on or before September 30, 2010. The adjusted FY 2010 prospective payment rates are available on the CMS website at <https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/InpatientRehabFacPPS/IRF-Rules-and-Related-Files.html>.

In addition, sections 1886(j)(3)(C) and (D) of the Act also affected the FY 2010 IRF outlier threshold amount because they required an adjustment to the FY 2010 RPL

market basket increase factor, which changed the standard payment conversion factor for FY 2010. Specifically, the original FY 2010 IRF outlier threshold amount was determined based on the original estimated FY 2010 RPL market basket increase factor of 2.5 percent and the standard payment conversion factor of \$13,661. However, as adjusted, the IRF prospective payments were based on the adjusted RPL market basket increase factor of 2.25 percent and the revised standard payment conversion factor of \$13,627. To maintain estimated outlier payments for FY 2010 equal to the established standard of 3 percent of total estimated IRF PPS payments for FY 2010, we revised the IRF outlier threshold amount for FY 2010 for discharges occurring on or after April 1, 2010, and on or before September 30, 2010. The revised IRF outlier threshold amount for FY 2010 was \$10,721.

Sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(i) of the Act also required the Secretary to reduce the market basket increase factor in FY 2011 by a 0.25 percentage point adjustment. The FY 2011 IRF PPS notice (75 FR 42836) and the correcting amendments to the FY 2011 IRF PPS notice (75 FR 70013) described the required adjustments to the FY 2010 and FY 2011 IRF PPS prospective payment rates and outlier threshold amount for IRF discharges occurring on or after April 1, 2010, and on or before September 30, 2011. It also updated the FY 2011 prospective payment rates, the CMG relative weights, and the average LOS values. Any reference to the FY 2011 IRF PPS notice in this final rule also includes the provisions effective in the correcting amendments. For more information on the FY 2010 and FY 2011 adjustments or the updates for FY 2011, please refer to the FY 2011 IRF PPS notice.

In the FY 2012 IRF PPS final rule (76 FR 47836), we updated the IRF prospective payment rates, rebased and revised the RPL market basket, and established a new QRP for IRFs in accordance with section 1886(j)(7) of the Act. We also consolidated, clarified, and revised existing policies regarding IRF hospitals and IRF units of hospitals to eliminate unnecessary confusion and enhance consistency. For more information on the policy changes implemented for FY 2012, please refer to the FY 2012 IRF PPS final rule.

The FY 2013 IRF PPS notice (77 FR 44618) described the required adjustments to the FY 2013 prospective payment rates and outlier threshold amount for IRF discharges occurring on or after October 1, 2012, and on or before September 30, 2013. It also updated the FY 2013 prospective payment rates, the CMG relative weights, and the average LOS values. For more information on the updates for FY 2013, please refer to the FY 2013 IRF PPS notice.

In the FY 2014 IRF PPS final rule (78 FR 47860), we updated the prospective payment rates, the CMG relative weights, and the outlier threshold amount. We also updated the facility-level adjustment factors using an enhanced estimation methodology, revised the list of diagnosis codes that count toward an IRF's 60 percent rule compliance calculation to determine "presumptive compliance," revised sections of the IRF patient assessment instrument (IRF-PAI), revised requirements for acute care hospitals that have IRF units, clarified the IRF regulation text regarding limitation of review, updated references to previously changed sections in the regulations text, and updated requirements for the IRF QRP. For more information on the policy changes implemented for FY 2014, please refer to the FY 2014 IRF PPS final rule.

In the FY 2015 IRF PPS final rule (79 FR 45872) and the correcting amendments to the FY 2015 IRF PPS final rule (79 FR 59121), we updated the prospective payment rates, the CMG relative weights, and the outlier threshold amount. We also revised the list of diagnosis codes that count toward an IRF's 60 percent rule compliance calculation to determine "presumptive compliance," revised sections of the IRF-PAI, and updated requirements for the IRF QRP. Any reference to the FY 2015 IRF PPS final rule in this final rule also includes the provisions effective in the correcting amendments. For more information on the policy changes implemented for FY 2015, please refer to the FY 2015 IRF PPS final rule.

In the FY 2016 IRF PPS final rule (80 FR 47036), we updated the prospective payment rates, the CMG relative weights, and the outlier threshold amount. We also adopted an IRF-specific market basket that reflects the cost structures of only IRF providers, a blended 1-year transition wage index based on the adoption of new OMB area delineations, a 3-year phase-out of the rural adjustment for certain IRFs due to the new OMB area delineations, and updates for the IRF QRP. For more information on the policy changes implemented for FY 2016, please refer to the FY 2016 IRF PPS final rule.

In the FY 2017 IRF PPS final rule (81 FR 52056) and the correcting amendments to the FY 2017 IRF PPS final rule (81 FR 59901), we updated the prospective payment rates, the CMG relative weights, and the outlier threshold amount. We also updated requirements for the IRF QRP. Any reference to the FY 2017 IRF PPS final rule in this final rule also includes the provisions effective in the correcting amendments. For more information on the policy changes implemented for FY 2017, please refer to the FY 2017 IRF PPS final rule.

In the FY 2018 IRF PPS final rule (82 FR 36238), we updated the prospective payment rates, the CMG relative weights, and the outlier threshold amount. We also revised the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-

CM) diagnosis codes that are used to determine presumptive compliance under the “60 percent rule,” removed the 25 percent payment penalty for IRF-PAI late transmissions, removed the voluntary swallowing status item (Item 27) from the IRF-PAI, summarized comments regarding the criteria used to classify facilities for payment under the IRF PPS, provided for a subregulatory process for certain annual updates to the presumptive methodology diagnosis code lists, adopted the use of height/weight items on the IRF-PAI to determine patient body mass index (BMI) greater than 50 for cases of single-joint replacement under the presumptive methodology, and updated requirements for the IRF QRP. For more information on the policy changes implemented for FY 2018, please refer to the FY 2018 IRF PPS final rule.

In the FY 2019 IRF PPS final rule (83 FR 38514), we updated the prospective payment rates, the CMG relative weights, and the outlier threshold amount. We also alleviated administrative burden for IRFs by removing the FIM™ instrument and associated Function Modifiers from the IRF-PAI beginning in FY 2020 and revised certain IRF coverage requirements to reduce the amount of required paperwork in the IRF setting beginning in FY 2019. Additionally, we incorporated certain data items located in the Quality Indicators section of the IRF-PAI into the IRF case-mix classification system using analysis of 2 years of data (FYs 2017 and 2018) beginning in FY 2020. For the IRF QRP, we adopted a new measure removal factor, removed two measures from the IRF QRP measure set, and codified a number of program requirements in our regulations. For more information on the policy changes implemented for FY 2019, please refer to the FY 2019 IRF PPS final rule.

In the FY 2020 IRF PPS final rule (84 FR 39054), we updated the prospective payment rates, the CMG relative weights, and the outlier threshold amount. We also rebased and revised the IRF market basket to reflect a 2016 base year rather than the 2012 base year. Additionally, we revised the CMGs and updated the CMG relative weights and average length of stay (LOS) values beginning with FY 2020, based on analysis of 2 years of data (FYs 2017 and 2018). We finalized the use of an unweighted motor score to assign patients to CMGs beginning with FY 2020. Additionally, we finalized the removal of one item from the motor score. We updated the IRF wage index to use the concurrent fiscal year inpatient prospective payment system (IPPS) wage index beginning with FY 2020. We amended the regulations to clarify that the determination as to whether a physician qualifies as a rehabilitation physician (that is, a licensed physician with specialized training and experience in inpatient rehabilitation) is made by the IRF. For the IRF Quality Reporting Program (QRP), we adopted two new measures, modifying an existing measure, and adopted new standardized patient assessment data elements. We also made updates to reflect our migration to a new

data submission system. For more information on the policy changes implemented for FY 2020, please refer to the FY 2020 IRF PPS final rule.

In the FY 2021 IRF PPS final rule (85 FR 48424), we updated the prospective payment rates, the CMG relative weights, and the outlier threshold amount. We also adopted more recent Office of Management and Budget statistical area delineations and applied a 5 percent cap on any wage index decreases compared to FY 2020 in a budget neutral manner. We also amended the IRF coverage requirements to remove the post-admission physician evaluation requirement and codified existing documentation instructions and guidance. Additionally, we amended the IRF coverage requirements to allow, beginning with the second week of admission to the IRF, a non-physician practitioner who is determined by the IRF to have specialized training and experience in inpatient rehabilitation to conduct 1 of the 3 required face-to-face visits with the patient per week, provided that such duties are within the non-physician practitioner's scope of practice under applicable state law. For more information on the policy changes implemented for FY 2021, please refer to the FY 2021 IRF PPS final rule.

In the FY 2022 IRF PPS final rule (86 FR 42362), we updated the prospective payment rates, the CMG relative weights, and the outlier threshold amount. For the IRF Quality Reporting Program (QRP), we updated certain requirements. For more information on the policy changes implemented for FY 2022, please refer to the FY 2022 IRF PPS final rule.

In FY 2023 IRF PPS final rule (87 FR 47038), we updated the prospective payment rates, the CMG relative weights, and the outlier threshold amount. We also codified CMS' existing teaching status adjustment policy through amendments to the regulation text and updates and clarified the IRF teaching policy with respect to IRF hospital closures and displaced residents. This final rule established a permanent cap policy to smooth the impact of year-to-year changes in IRF payments related to decreases in the IRF wage index. For more information on the policy changes implemented for FY 2023, please refer to the FY 2023 IRF PPS final rule.

In the FY 2024 IRF PPS final rule (88 FR 50956), we updated the prospective payment rates for IRFs for FY 2024. We included 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 2024. We also rebased and revised the IRF market basket to reflect a 2021 base year. We also confirmed when IRF units can become excluded and paid under the IRF PPS. This rule also included updates for the IRF QRP. For more information on the policy changes implemented for FY 2024, please refer to the FY 2024 IRF PPS final rule.

In the FY 2025 IRF PPS final rule (89 FR 64276), we updated the prospective payment rates for IRFs for FY 2025. The final rule included 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 also updated the OMB market area delineations for the IRF PPS wage index and applied a 3-year phase-out of the rural adjustment. This rule also includes updates for the IRF QRP. For more information on the policy changes implemented for FY 2025, please refer to the FY 2025 IRF PPS final rule.