Medicare Program Fiscal Year 2023 Inpatient Psychiatric Facilities Prospective Payment System and Quality Reporting Updates Final Rule

On July 29, 2022, the fiscal year (FY) 2023 Inpatient Psychiatric Facilities (IPF) Prospective Payment System (PPS) final rule (CMS-1769-F) was published in the *Federal Register* (87 FR 46846). IPFs include psychiatric hospitals and psychiatric units of acute care hospitals or critical access hospitals. The FY 2023 IPF PPS final rule describe updates to IPF rates and payment adjustments and the IPF Quality Reporting Program for FY 2023.

This final rule establishes a permanent limit on decreases to the IPF wage index of 5 percent annually. The proposed rule included requests for information (RFI) on a contractor report analyzing the IPF PPS facility and patient level and adjustments and incorporating measures of health equity and disparities across CMS quality programs. CMS indicates that it will consider those comments in future rulemaking.

The changes in this final rule are effective for IPF discharges occurring October 1, 2022 through September 30, 2023 (FY 2023). Addenda that show payment rates and other relevant information for determination of FY 2023 IPF PPS rates are available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools. Wage index information is available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/WageIndex.

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I. Background

Under the IPF PPS, facilities are paid based on a standardized federal per diem base rate adjusted by a series of patient-level and facility-level adjustments. The final rule reviews in detail the statutory basis and regulatory history of the IPF PPS. The system was implemented in January 2005 and was updated annually based on a calendar year. Beginning with FY 2013, the IPF PPS has been on a federal FY updating cycle.

The base payment rate was initially based on the national average daily IPF costs in 2002 updated for inflation and adjusted for budget neutrality. IPF payment rates have been updated based on statutory requirements in annual notices or rulemaking since then. Additional payment policies apply for outlier cases, interrupted stays, and a per treatment payment for patients who undergo electroconvulsive therapy (ECT). The ECT per treatment payment rate is also subject to annual updates.

CMS continues to use payment adjustment factors for the IPF PPS that were established in 2005 and derived from a regression analysis of the FY 2002 Medicare Provider and Analysis Review (MedPAR) data file (69 FR 66935-66936). The patient-level adjustments address age, Medicare Severity Diagnosis-Related Group (MS-DRG) assignment, and comorbidities; higher per diem costs at the beginning of a patient's stay; and lower costs for later days of the stay. Facility-level adjustments are for the area wage index, rural location, teaching status, a cost-of-living adjustment for IPFs located in Alaska and Hawaii, and an adjustment for the presence of a qualifying emergency department (ED).

In order to bill for ECT services IPFs must include a valid procedure code. CMS did not propose any changes to the ECT procedure codes as a result of the update to the ICD-10-PCS code set for FY 2023.

II. Provisions of the FY 2023 IPF PPS Final Rule

A. Market Basket Update

For FY 2023, CMS proposed an inflation update of 3.1 percent less 0.4 percentage points for total factor productivity (or 2.7 percent). This proposed update reflected IHS Global Inc.'s (IGI) 4th quarter 2021 forecast with historical data through the 3rd quarter of 2021. Public comments generally were in the following categories:

1. The proposed rule update is too low and does not take into account more recent inflation that IPFs have experienced due to labor shortages, use of higher cost contract labor and additional staffing needed to serve higher acuity and underserved patients.
2. The FY 2021 and FY 2022 updates underinflate the base rate by a combined 1.9 percentage points. CMS should revise the FY 2023 update to account for IPF rates being too low.
3. The logic behind the reduction for total factor productivity is flawed in that it assumes hospitals can increase productivity at the same rate as the general economy. These comments acknowledged the productivity adjustment is required by law but asked CMS to waive its application under section 1135 of the Social Security Act (the Act) for all years covered under the COVID-19 public health emergency (PHE).

CMS responds that the market basket increase is a fixed weight index intended to measure only price growth for a fixed quantity of labor. It is not designed to recognize higher labor costs associated with using more staffing or a shift from employed to contract labor. These factors would be accounted for when CMS rebases the market basket. While CMS indicates it does not make forecast error corrections, it also states the FY 2020 IPF update was overstated by 0.7

percentage points (i.e., forecast errors can go in either direction). The final rule indicates that CMS does not have the authority under section 1135 of the Act to waive application of the total factor productivity adjustment.

Based on IGI's second quarter 2022 forecast with historical data through the first quarter of 2022, the FY 2023 IPF market basket update is 4.1 percent (reflecting forecasted compensation price growth of 4.5 percent), and the total factor productivity adjustment is 0.3 percentage points. The net update, therefore, is 3.8 percent. CMS indicates this is the highest update since the beginning of IPF PPS.

IPFs that do not report quality data or fail to meet the quality data reporting requirements are subject to a 2.0 percentage point reduction in the update or 1.8 percent.

B. Labor-Related Share

The area wage index adjustment is applied to the labor-related share of the standardized federal per diem base rate. The labor-related share is the national average portion of costs related to, influenced by, or varying with the local labor market, and is determined by summing the relative importance of labor-related cost categories included in the 2016-based market basket.[1] For FY 2023, CMS proposed a labor-related share of 77.4 percent, up from 77.2 for FY 2022.

One commenter objected to the increase in the labor-related share as being punitive to IPFs with a wage index less than 1.0. CMS rejected this comment indicating that their proposal is consistent with the determination of the labor-related share going back to adoption of the IPF PPS in 2007. The change is also based on the latest available data. CMS is finalizing its proposal.

C. FY 2023 Payment Rates

CMS determines the FY 2023 payment rates by applying the update factor (3.8 percent), and the wage index budget neutrality adjustment (1.0012, as discussed in section II.E.3 below) to FY 2022 rates. For hospitals that do not report quality data or meet the quality data reporting requirements, CMS determines the FY 2023 payment rate by applying the update factor (1.8 percent) and the wage index budget neutrality adjustment (1.0012) to the full unreduced FY 2022 payment rates.

The table below compares the final federal per diem base rate and the ECT payments per treatment for FY 2022 and FY 2023.

	FY 2022	**FY 2023**
Federal per diem base rate	$832.94	$865.63
Labor share	*$643.03 (77.2%)*	*$670.00 (77.4%)*

[1] The labor-related market basket cost categories are Wages and Salaries; Employee Benefits; Professional Fees: Labor-Related; Administrative and Facilities Support Services; Installation, Maintenance, and Repair; All Other: Labor-Related Services; and a portion (46 percent) of the Capital-Related cost weight. The relative importance reflects the different rates of price change for these cost categories between the base year (FY 2016) and FY 2022.

	FY 2022	FY 2023
Non-labor share	*$189.91 (22.8%)*	*$195.63 (22.6%)*
ECT payment per treatment	$358.60	$372.67
Rates for IPFs that fail to meet the IPFQR Program requirements		
Per diem base rate	$832.94	$848.95
Labor share	*$643.03 (77.2%)*	*$ 657.09 (77.4%)*
Non-labor share	*$189.91 (22.8%)*	*$ 191.86 (22.6%)*
ECT payment per treatment	$358.60	$365.49

D. Patient-Level Adjustment Factors

Payment adjustments are made for the following patient-level characteristics: MS–DRG assignment based on a psychiatric principal diagnosis, selected comorbidities, patient age, and variable costs during different points in the patient stay. For FY 2023, CMS proposed to continue the existing payment adjustments with some updates.

1. Update to MS-DRG Assignment

For FY 2023, CMS proposed to continue the existing payment adjustment for psychiatric diagnoses that group to one of the existing 17 IPF MS-DRGs listed in Addendum A. Psychiatric principal diagnoses that do not group to one of the 17 designated MS-DRGs will still receive the federal per diem base rate and all other applicable adjustments, but the payment will not include an MS-DRG adjustment. There were no public comments and CMS is finalizing this proposal without change.

The diagnoses for each IPF MS-DRG will be updated as of October 1, 2022, using the inpatient prospective payment system (IPPS) FY 2023 ICD-10-CM/PCS code sets. The FY 2023 IPPS rule will include tables of the changes to the ICD-10-CM/PCS code sets, which underlie the FY 2023 IPF MS-DRGs. At the time this summary was prepared, the FY 2023 IPPS final rule had not been released. However, the relevant tables will be found at: https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps. In the list of items on the left-hand side of the page, scroll down to FY 2023 IPPS final rule home page once the IPPS final rule is public.

CMS discusses the Code First policy, which follows the ICD-10-CM Official Guidelines for Coding and Reporting. Under the Code First policy, when a primary (psychiatric) diagnosis code has a "code first" note, the provider would follow the instructions in the ICD-10-CM text to determine the proper sequencing of codes. For FY 2023, CMS proposed to remove 2 codes from the IPF Code First table and add 48 codes. There were no public comments and CMS is finalizing this policy without change. Addendum B includes the FY 2023 Code First Table.

2. Comorbidity Adjustment

The comorbidity adjustment provides additional payments for certain existing medical or psychiatric conditions that are secondary to the patient's principal diagnosis and are expensive to treat. Diagnoses that relate to an earlier episode of care have no bearing on the current hospital

stay are excluded and must not be reported on IPF claims. Comorbid conditions must exist at the time of admission or develop subsequently and affect the treatment received, the length of stay, or both.

For FY 2023, CMS proposed:

- To add 10 ICD-10-CM/PCS codes and remove 1 ICD-10-CM/PCS code from the Coagulation Factor category;
- To add 3 ICD-10-CM/PCS codes and remove 11 ICD-10-CM/PCS codes from the Oncology Treatment comorbidity category; and
- Add 4 ICD-10-CM/PCS codes to the Poisoning comorbidity category.

The final FY 2023 comorbidity codes are shown in Addenda B.

CMS reviewed the FY 2023 ICD-10-CM codes to remove codes that were site "unspecified" where codes are available to specify right or left side of the body. None of the additions to the FY 2023 ICD-10-CM/PCS codes were site "unspecified."

There were no public comments and CMS is finalizing these proposals without change.

3. Age Adjustment

The current payment adjustments for age range from 1.01 for patients age 45 to 50 to 1.17 for patients age 80 and older. CMS proposed to continue the age adjustment factors for FY 2023 without change. The age adjustments are shown in Addendum A. There were no public comments and CMS is finalizing its proposal without change.

4. Variable Per Diem Adjustments

Variable per diem adjustments recognize higher ancillary and administrative costs that occur disproportionately in the first days after admission to an IPF and are shown in Addendum A. For FY 2023, CMS proposed to continue the FY 2022 variable per diem adjustments without change. The adjustment is highest on day 1 of the stay and gradually declines through day 22. The day 1 adjustment factor is 1.31 if the IPF has a qualifying ED; otherwise, the adjustment factor is 1.19. For days 22 and later the adjustment is 0.92. The qualifying ED adjustment is discussed in section II.E.6 below. There were no public comments and CMS is finalizing its proposal without change.

E. Facility-Level Adjustment Factors

Facility-level adjustments provided under the IPF PPS are for the wage index, IPFs located in rural areas, teaching IPFs, cost of living adjustments for IPFs located in Alaska and Hawaii, and IPFs with a qualifying ED.

1. Wage Index Adjustment

To recognize geographic variation in wages, CMS uses the pre-floor, pre-reclassified IPPS hospital wage data for the IPF wage index. CMS believes that IPFs generally compete in the same labor market as IPPS hospitals, and that the pre-floor, pre-reclassified IPPS hospital wage index is the best available to use as a proxy for an IPF specific wage index. Beginning with FY 2020, CMS uses the IPPS wage index for the concurrent fiscal year. For example, the FY 2022 IPF wage index is based on the FY 2022 pre-floor, pre-reclassified IPPS hospital wage index. (Previous policy was to use the IPPS wage index data for the prior fiscal year.)

There were three public comments that were out-of-scope as CMS did not make any proposals on the issues that were the subject of comment (using a post-rural floor, post-reclassified wage index, a non-budget neutral floor on wage index adjustments, allowing IPFs to reclassify and a cap on high wage indexes). CMS will consider these ideas in future rulemaking but indicates that the rural floor only applies under the law to IPPS hospitals. The rule also indicates that use of the pre-reclassified wage index is appropriate as it reflects the prevailing wage in an area.

The geographic areas used for the wage index are based on the Office of Management and Budget (OMB) Core Based Statistical Area (CBSA) delineations. These delineations are generally subject to major revisions every 10 years to reflect information from the decennial census, but OMB also issues minor revisions in the intervening years through OMB Bulletins. When OMB changes delineations that modify the IPPS wage index, these changes are also adopted for purposes of the IPF wage index. The OMB Bulletins are available at https://www.whitehouse.gov/omb/information-for-agencies/bulletins/.

For FY 2021, CMS modified the IPF wage index to reflect changes included in OMB Bulletin No. 18-04, issued on September 14, 2018. Adopting the revised delineations included in OMB Bulletin No. 18-04 changed 34 counties and 5 providers from urban to rural; another 47 counties and 4 providers from rural to urban; and shifted some urban counties between existing and new CBSAs.

CMS adopted a transition policy to limit the decrease in any IPF's wage index from FY 2020 to FY 2021 by 5 percent. It applied regardless of the reason for the wage index decline—that is, whether or not the decline was the result of changes to the wage area delineations. CMS proposed no cap on reductions to the wage index for FY 2022.

While CMS did not extend the 5 percent cap on reductions in the wage index adopted in FY 2021 to FY 2022, it proposed a permanent cap of 5 percent on reductions to the wage index for any reason beginning with FY 2023. CMS believes providers generally experience fluctuations in the wage index annually of less than 5 percent. Thus, the proposed cap would generally affect few hospitals and minimize the required budget neutrality adjustment while also addressing concerns about instability in payments from year to year.

Under CMS' proposal if a wage index is calculated with the application of the 5 percent cap, the following year's wage index would not be less than 95 percent of the IPF's capped wage index in

the prior year. CMS further proposed that a new IPF would be paid the wage index for the area where it is geographically located for its first full or partial FY with no cap applied.

Comments/Responses: Public comments both supported and opposed the annual 5 percent cap on reductions to the wage index. One commenter suggested a cap on reductions of between 1 to 2 percent. CMS responded that the 5 percent cap on reductions was intended to balance between payment stability for providers experiencing a large reduction in the wage index and lessening the magnitude of the budget neutrality adjustment. A cap of 1 to 2 percent would affect between 12.2 and 32.1 percent of providers compared to a 5 percent cap that only affects 1.3 percent of providers and results in a budget neutrality adjustment of approximately -0.01 percent.

MedPAC supported CMS' proposal but indicated the cap should apply to increases as well as decreases. CMS disagrees and does not believe a limit on increases is needed to assist hospitals more effectively budget and plan their operations.

Other comments asked CMS to apply the policy non-budget neutral and retroactively. CMS responded that it traditionally adopts changes to the wage index budget neutral and the impact of applying a budget neutrality adjustment for this policy is minimal. Further, it declined to apply the policy retroactively as the policy's intent is to mitigate any significant decreases effective beginning with FY 2023.

Some commenters objected to the transition policy as it could result in different wage indexes for hospitals in the same area creating unfair competitive situations. These situations would include new providers and when new CBSA delineations locate hospitals in the same area for the first time. CMS acknowledges this point but responds that the situation would be temporary as the wage index, over time, would converge to the same level.[2]

CMS is finalizing its proposed policy without any changes.

2. Adjustment for Rural Location

CMS proposed to continue the 17 percent increase for IPFs located in a rural area. This adjustment has been part of the IPF PPS since its inception. There were no public comments. CMS is finalizing its proposal without change.

3. Wage Index Budget Neutrality Adjustment

CMS proposed to make changes to the IPF wage index budget neutral. For the final rule, CMS estimates aggregate IPF PPS payments for FY 2022 and FY 2023 using the March 2022 update of FY 2021 IPF claims and each respective year's labor-related share and wage index values. The ratio of FY 2023 to FY 2022 payments is the budget neutrality adjustment applied to the federal per diem base rate for FY 2023. CMS determined a budget neutrality adjustment of 1.0013 associated with revisions the wage index and 0.9999 for the 5 percent cap on reductions to the wage index. The net adjustment is 1.0012.

[2] Not discussed is that such a policy is a regular feature of the IPPS wage index system that results from reclassifications and many other adjustments that could affect individual but not all hospitals in a labor market area.

4. Teaching Adjustment

For FY 2023, CMS proposed to continue the coefficient value of 0.5150 for the teaching adjustment to recognize the higher indirect operating costs experienced by hospitals that participate in graduate medical education programs. The teaching adjustment formula follows, where ADC = average daily census.

$$(1 + Interns\ and\ Residents/ADC)\text{^}0.5150$$

For example, the teaching adjustment for an IPF with a ratio of interns and residents to ADC of 0.2 equals 1.098. This adjustment is applied to the federal per diem base rate. IPFs are subject to a cap on the number FTE residents that trained in the IPF's most recent cost report filed before November 15, 2004 (adjusted similarly as the indirect medical education cap for an IPPS hospital to account for residents displaced because of a hospital or residency training program closure). CMS proposed to continue this policy without change. It received no comments and is finalizing its proposal to continue the teaching adjustment unchanged for FY 2023.

5. Cost of Living Adjustment for Alaska and Hawaii

CMS proposed to apply the IPF PPS cost of living adjustment (COLA) factors for Alaska and Hawaii for FY 2023. The COLA is applied to the non-labor related share of the IPF standardized amounts. CMS received no comments on this issue. It is finalizing its proposed policy without change.

The COLAs are shown below.

TABLE 2: COLA Factors: IPFs Located in Alaska and Hawaii

Area	FY 2022 through FY 2025
Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.22
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.22
City of Juneau and 80-kilometer (50-mile) radius by road	1.22
Rest of Alaska	1.24
Hawaii	
City and County of Honolulu	1.25
County of Hawaii	1.22
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

6. Adjustment for IPFs with a Qualifying ED

The IPF PPS includes a facility-level adjustment for IPFs with qualifying EDs, which is applied through the variable per diem adjustment. The adjustment applies to a psychiatric hospital, an IPPS-excluded psychiatric unit of an IPPS hospital, or a critical access hospital (CAH) with a qualifying ED. The adjustment is intended to account for the costs of maintaining a full-service ED. This includes costs of preadmission services otherwise payable under the Medicare Hospital

Outpatient Prospective Payment System that are furnished to a beneficiary on the date of the beneficiary's admission to the hospital and during the day immediately preceding the date of admission to the IPF, and the overhead cost of maintaining the ED.

The ED adjustment is incorporated into the variable per diem adjustment for the first day of each stay. Those IPFs with a qualifying ED receive a variable per diem adjustment factor of 1.31 for day 1; IPFs that do not have a qualifying ED receive a first-day variable per diem adjustment factor of 1.19.

With one exception, this facility-level adjustment applies to all admissions to an IPF with a qualifying ED, regardless of whether the patient receives preadmission services in the hospital's ED. The exception is for cases when a patient is discharged from an IPPS hospital or CAH and admitted to the same IPPS hospital's or CAH's excluded psychiatric unit. The adjustment is not made in this case because the costs associated with ED services are reflected in the MS-DRG payment to the IPPS hospital or through the reasonable cost payment made to the CAH. In these cases, the IPF receives the day 1 variable per diem adjustment of 1.19. CMS did not propose any changes to these adjustments. There were no public comments and the policy is continuing unchanged for FY 2023.

F. Other Payment Adjustments and Policies

The IPF PPS provides for outlier payments when an IPF's estimated total cost for a case exceeds a fixed loss threshold amount (multiplied by the IPF's facility-level adjustments) plus the federal per diem payment amount for the case. For qualifying cases, the outlier payment equals 80 percent of the difference between the estimated cost for the case and the adjusted threshold amount for days 1 through 9 of the stay, and 60 percent of the difference for day 10 and thereafter. The differential in payment between days 1 through 9 and 10 and above is intended to avoid incenting longer lengths of stay.

For FY 2023, CMS proposed to continue to set the fixed loss threshold amount so that outlier payments account for 2 percent of total payments made under the IPF PPS. CMS' normal practice is to use data from the 2nd fiscal year that precedes the payment year to simulate payments for setting the fixed loss threshold (e.g., FY 2020 data for setting the FY 2022 outlier threshold). However, because of the impact of the COVID-19 PHE on 2020 utilization, CMS continued to use FY 2019 data to determine the FY 2022 IPF fixed loss threshold.

For FY 2023, CMS proposed to return to its historical practice of using the latest available data—in this case, FY 2021—to set the fixed loss threshold. CMS proposed to use the same methodology to determine the fixed loss threshold for FY 2023 that it has used dating back to FY 2008 except that it proposed to exclude providers with a change in simulated costs per day that is more than three standard deviations from the mean.

Based on an analysis of the December 2021 update of FY 2021 IPF claims and the FY 2022 rate increases, CMS estimates that outlier payments for FY 2022 will be 3.2 percent of total payments or 1.2 percentage points higher than the target of 2.0 percent. For this reason, CMS believed it was necessary to propose an increase in the fixed loss threshold to better target 2.0

percent IPF payments as outliers. For FY 2023, CMS proposed to increase the fixed loss threshold from $16,040 in FY 2022 to $24,270 in FY 2023.

Comments/Responses: Several commenters expressed concern about the increase to the fixed loss threshold. They suggested CMS use alternatives to mitigate the increase such as using an alternative inflation factor and changes to cost-to-charge ratios calculated from data preceding the pandemic, using multiple years of claims, or averaging outlier thresholds from multiple years.

CMS rejected these ideas stating that because trends it began observing in FY 2020 continued into FY 2021, it is reasonable to expect they may continue into FY 2023. The final rule indicates that the charge inflation factor is based on the latest available forecast of the IPF market basket rather than increases in historical charges that are used to calculate the IPPS outlier threshold. CMS believes this IPF market basket adequately reflects the average change in the price of goods and services IPFs need to provide services. The final rule rejects the other suggestions as inconsistent with prior policy, and CMS' regression analysis sets the outlier pool at 2 percent of total payment to balance between protecting IPFs from extraordinarily costly cases while ensuring the adequacy of rates for all other cases.

MedPAC encouraged CMS to provide additional data explaining the increase to the outlier fixed loss threshold. Below are highlights of CMS' findings:

- Average cost per day increased approximately 12 percent from FY 2021 to FY 2022 in CMS' outlier simulations.
- Laboratory charges per day in 2021 were approximately 12.7 percent higher than in 2019.
- Covered days have been declining (approximately 32 percent after applying data trims) between FY 2019 and FY 2023.
- Simulated FY 2022 payments were approximately 30 percent below FY 2021 IPF PPS payments.
- Case mix does not appear to be driving the increase in outlier cases.

CMS explains that the decrease to the number of days and total estimated IPF PPS payments increases the percentage of outlier payments relative to total payments, which contributes to the upward trend in the outlier fixed dollar loss threshold amount.

Using the March 2022 update of FY 2021 IPF claims and the FY 2022 rate increases, CMS is setting an updated outlier threshold of $24,630 (compared to $24,270 in the proposed rule) to maintain estimated outlier payments at 2 percent of total estimated aggregate IPF payments for FY 2023.

In estimating the total cost of a case for comparison to the fixed loss threshold amount, CMS multiplies the hospital's charges on the claim by the hospital's cost-to-charge ratio (CCR). CMS substitutes the national median urban or rural CCR if the IPF's CCR exceeds a ceiling that is 3 times the standard deviation from the applicable (i.e., urban or rural) geometric mean CCR. The national median also applies to new IPFs and those for which the data are inaccurate or incomplete. The FY 2023 final national median and ceiling CCRs are:

National Median and Ceiling CCRs, FY 2023		
CCRs	**Rural**	**Urban**
National Median	0.5720	0.4200
National Ceiling	2.0472	1.7279

CMS did not receive any comments on this proposal that it is finalizing without change.

III. Comment Solicitation on IPF PPS Adjustments

In the November 15, 2004 final rule, CMS indicated it would update the regression analysis of the IPF PPS facility and patient adjustments once it had experience IPF PPS. CMS' preliminary analysis discussed in the FY 2016 IPF PPS final rule (80 FR 46693-46694) revealed variation in cost and claims data with some providers having very low labor costs, or very low or missing drug or laboratory costs or charges, relative to other providers. In response, CMS required that cost reports from psychiatric hospitals, except all-inclusive rate providers, include certain ancillary costs. More comprehensive and complete data from these requirements is now available to CMS.

With these more recent data, CMS has undertaken further analysis of more IPF cost and claims information. CMS' contractor report analysis is available at: https://www.cms.gov/files/document/technical-report-medicare-program-inpatient-psychiatric-facilities-prospective-payment-system.pdf. The updated analysis finds that the existing IPF PPS model continues to be generally appropriate but suggests that certain updates to the codes, categories, adjustment factors, and ECT payment amount per treatment could improve payment accuracy.

CMS requested comment on:

- Technical changes to the DRG and comorbidity adjustment factors, consolidation of the age categories for the patient age adjustment, and changes to the adjustment factors for age and length of stay;
- A higher ECT payment amount per treatment to better align IPF PPS payments with the costs of furnishing ECT;
- Increasing the outlier percentage above 2 percent of IPF PPS payments and its distributional effects;
- Updated adjustment factors for teaching facilities, rural facilities, and facilities with an ED;
- Removing control variables from the rural adjustment factor in the regression model that may result in a higher adjustment; and
- Areas for additional research such as social determinants of health, additional patient characteristics that affect the cost of providing IPF services, and constructing a disproportionate share like adjustment for IPFs that treat a high proportion of low-income patients.

CMS received 10 comments in response to its solicitation. Commenters included MedPAC, state-level and national provider and patient advocacy organizations, and individual IPF hospitals and health systems. CMS will take these comments into consideration to inform future rulemaking.

IV. Inpatient Psychiatric Facilities Quality Reporting (IPFQR) Program

A. Background

Psychiatric hospitals and psychiatric units within acute care and critical access hospitals that treat Medicare patients paid under the IPF PPS are subject to the IPFQR program. Per statute, an IPF that does not meet the requirements of participation in the IPFQR Program for a rate year is subject to a 2.0 percentage point reduction in the update factor for that year. The IPFQR Program follows many of the policies established for the IPPS Quality Reporting (IQR) Program but has a distinct set of quality measures.

B. IPFQR Program Measure Set for FY 2023

CMS did not propose any policy changes for the IPFQR Program for FY 2023 and did not propose any changes to the program's measure set for FY 2023. CMS acknowledges receiving comments suggesting additions to the measure set, including a patient experience-of-care measure and development of a value-based purchasing program, but indicates that these comments are out of scope of the current rulemaking.[3] For more information about the program, see https://qualitynet.cms.gov/ipf/ipfqr and https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS.

The IPFQR program's measure set remains unchanged from that published as Table 5 in the FY 2022 IPF PPS final rule (shown below, see 86 FR 42653).

IPFQR Program Measure Set
FY 2023 Payment Determination with Finalized Measure Adoption

NQF #	Measure ID	Measure
0640	HBIPS-2	Hours of Physical Restraint Use
0641	HBIPS-3	Hours of Seclusion Use
0560	HPIPS-5	Patient Discharged on Multiple Antipsychotic Medications with Appropriate Justification
0576	FUH	Follow-Up After Hospitalization for Mental Illness
N/A*	SUB-2 and SUB-2a	Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention
N/A*	SUB-3 and SUB-3a	Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge
N/A*	TOB-2 and TOB-2a	Tobacco Use Treatment Provided or Offered and TOB-2a Tobacco Use Treatment
N/A*	TOB-3 and TOB-3a	Tobacco Use Treatment Provided or Offered at Discharge and TOB-3a Tobacco Use Treatment at Discharge
1659	IMM-2	Influenza Immunization

[3] CMS indicates having received nearly 350 comments in support of adding a patient experience-of-care measure.

NQF #	Measure ID	Measure
N/A*	N/A	Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
N/A*	N/A	Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or any Other Site of Care)
N/A*	N/A	Screening for Metabolic Disorders
2860	N/A	Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility
3205	Med Cont	Medication Continuation Following Inpatient Psychiatric Discharge
TBD	COVID HCP	COVID-19 Healthcare Personnel (HCP) Vaccination Measure

* Measure is no longer endorsed by the NQF but was endorsed at time of adoption.

C. RFI: Measuring Equity and Healthcare Quality Disparities Across Quality Programs

CMS solicited comments in response to an RFI concerning principles for measuring equity and healthcare quality disparities across the CMS quality enterprise, including the IPFQR Program. The proposed rule's RFI focused on key measurement considerations and potential measures of health equity, and much of the RFI is repeated in this final rule. CMS provides a summary of the 20 comments received, from which highlights are excerpted below.

- Many supported stratified results reporting provided confidentially to IPFs.
    - Concerns were expressed about the burden of collecting data for use in stratification given the primarily chart-abstracted structure of the IPFQR program and limited uptake of electronic health records (EHRs) in the IPF setting.
    - Support was received for aligning data collection across payors.
- Multiple concerns were expressed about the reliability of potential measures due to the small sample sizes inherent in the IPFQR program and made worse by stratification.
- Support was received for several social risk factors and indices for use in disparities analyses along with the diagnoses requiring IPF treatment.
- Many voiced substantial concerns about potential adaptation of the Health Equity Summary Score used in the Medicare Advantage program to the IPFQR program.
- Considerable support was received for the concept underlying the measure *Degree of Hospital Leadership Engagement in Health Equity* as described in the RFI, though the lack of evidence linking the measure to better outcomes was noted.
- Many supported a patient experience-of-care measure for the IPFQR program as a means of capturing the patient's voice, improving care quality, and advancing health equity.

CMS thanks commenters for their input noting having proposed equity-related measures for the FY 2023 IQR. Similar measures may be considered for future addition to the IPFQR program (e.g., screening for health-related social needs). Any new measure, including experience-of-care survey and equity-focused, will be subject to the agency's standard pre-rulemaking process (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Pre-Rulemaking).

V. Regulatory Impact Analysis

In the final rule, CMS estimates that payments to IPF providers for FY 2023 will increase by $90 million due to:

- $140 million for the market basket less $10 million for total factor productivity, and
- -$40 million due to outliers decreasing from 3.2 percent to 2.0 percent of IPF PPS payments.

Not included in this estimate are any reduced payments associated with the required 2.0 percentage point reduction to the market basket increase factor for any IPF that fails to meet the IPFQR Program requirements.

Table 3 in the final rule, reproduced below, shows the estimated effects of the IPF PPS final rule policies by type of IPF using the March 2022 update of FY 2021 MedPAR claims data.

TABLE 3: FY 2023 IPF PPS Final Rule Payment Impacts
Percent Change

Facility by Type	Number of Facilities	Outliers	Wage Index	Total Percent Change[1]
All Facilities	1,417	-1.2	0.0	2.5
Total Urban	1,150	-1.3	0.0	2.5
Urban unit	673	-2.0	0.0	1.7
Urban hospital	477	-0.5	0.1	3.4
Total Rural	267	-0.7	-0.2	2.9
Rural unit	210	-0.8	-0.1	2.8
Rural hospital	57	-0.5	-0.3	3.0
By Type of Ownership:				
Freestanding IPFs				
Urban Psychiatric Hospitals				
Government	116	-1.9	0.2	2.0
Non-Profit	94	-0.8	0.3	3.2
For-Profit	267	-0.1	0.0	3.7
Rural Psychiatric Hospitals				
Government	30	-0.7	-0.4	2.7
Non-Profit	12	-1.6	-0.1	2.1
For-Profit	15	-0.1	-0.3	3.4
IPF Units				
Urban				
Government	91	-2.9	0.0	0.8
Non-Profit	443	-2.2	-0.1	1.5
For-Profit	139	-1.0	0.1	2.9
Rural				
Government	46	-0.7	0.0	3.1
Non-Profit	123	-1.0	-0.2	2.6
For-Profit	41	-0.4	-0.1	3.2
By Teaching Status:				
Non-teaching	1,228	-1.0	0.1	2.8

Facility by Type	Number of Facilities	Outliers	Wage Index	Total Percent Change[1]
Less than 10% interns and residents to beds	100	-1.6	-0.2	2.0
10% to 30% interns and residents to beds	62	-3.4	-0.4	0.0
More than 30% interns and residents to beds	27	-3.3	0.2	0.6
By Region:				
New England	101	-1.8	-0.5	1.4
Mid-Atlantic	183	-1.7	0.1	2.1
South Atlantic	220	-0.7	-0.3	2.8
East North Central	232	-1.1	-0.4	2.3
East South Central	140	-0.8	-0.2	2.8
West North Central	102	-1.9	-0.2	1.6
West South Central	213	-0.5	0.4	3.7
Mountain	100	-0.8	0.0	3.0
Pacific	126	-1.8	0.8	2.7
By Bed Size:				
Psychiatric Hospitals				
Beds: 0-24	83	-0.6	0.2	3.4
Beds: 25-49	78	-0.2	0.1	3.7
Beds: 50-75	79	-0.2	-0.1	3.5
Beds: 76 +	294	-0.6	0.0	3.2
Psychiatric Units				
Beds: 0-24	483	-1.4	0.0	2.3
Beds: 25-49	234	-1.7	0.0	2.0
Beds: 50-75	102	-2.4	-0.1	1.2
Beds: 76 +	64	-2.3	0.0	1.3

[1] This column includes the impact of the updates in columns (3) through (5) above, and of the IPF market basket update factor for FY 2023 (4.1 percent), reduced by 0.3 percentage points for the productivity adjustment as required by section 1886(s)(2)(A)(i) of the Act.