Medicare Program
Fiscal Year 2024 Inpatient Psychiatric Facilities Prospective Payment System and Quality Reporting Updates Proposed Rule

The Centers for Medicare and Medicaid Services released the fiscal year (FY) 2024 Inpatient Psychiatric Facilities (IPF) Prospective Payment System (PPS) proposed rule (CMS-1783-P) on April 4, 2023. The proposed rule will be published in the *Federal Register* on April 10, 2023. IPFs include psychiatric hospitals and psychiatric units of acute care hospitals or critical access hospitals. The FY 2024 IPF PPS proposed rule describe updates to IPF rates and payment adjustments and the IPF Quality Reporting Program for FY 2024. **The public comment period on the proposed rule ends June 5, 2023.**

This proposed rule would rebase and revise the IPF PPS market basket to reflect a 2021 base year. It also includes a proposal that would make it easier for hospitals to open new excluded psychiatric units paid under the IPF PPS. In addition, this proposed rule includes a request for information (RFI) to inform revisions to the IPF PPS adjustments for FY 2025, as required by the Consolidated Appropriations Act, 2023 (CAA, 2023).

The changes in this proposed rule are effective for IPF discharges occurring October 1, 2023 through September 30, 2024 (FY 2024). Addenda that show payment rates and other relevant information for determination of FY 2024 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 proposed 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 is not proposing any changes to the ECT procedure codes as a result of the update to the ICD-10-PCS code set for FY 2024.

II. Provisions of the FY 2024 IPF PPS Payment Update

A. Rebasing and Revising the IPF Market Basket

1. Rebasing and Revising the IPF Market Basket

Beginning with FY 2024, CMS is proposing to rebase and revise the 2016-based IPF market basket cost weights to a 2021 base year reflecting 2021 Medicare cost report data submitted by both freestanding IPFs and distinct part IPF units within hospitals. CMS believes that 2021 represents the most recent and complete set of Medicare cost report data available for this purpose. The cost reports are for providers with cost reporting periods beginning on or after October 1, 2020 and before October 1, 2021.

Rebasing refers to calculating the weights associated with each component of the market basket. Revising refers to the price proxies that CMS uses to determine the rate of increase for each of those components.

The proposed rule details the methodology used to rebase the market basket, which is generally the same methodology CMS used in creating the current 2016-based IPF market basket. CMS uses Medicare cost report data to calculate weights for seven cost categories: Wages and Salaries; Employee Benefits; Contract Labor; Pharmaceuticals; Professional Liability Insurance; Home Office Contract Labor; and Capital.

A residual category captures all remaining costs. Detailed weights are calculated for 17 categories within this residual by using the 2012 Benchmark Input-Output (I-O) "Use Tables/Before Redefinitions/Purchaser Value" for North American Industry Classification System (NAICS) 622000, Hospitals, published by the Bureau of Economic Analysis (BEA). This data is publicly available at: https://www.bea.gov/industry/input-output-accounts-data.

Table 4, reproduced below, compares the proposed 2021 to the current 2016-based market basket cost weights.

Table 4: IPF Market Basket Cost Weights
Comparison of 2016 to 2021 Based Weights

Cost Category	Proposed 2021-based IPF Market Basket Cost Weight	2016-based IPF Market Basket Cost Weight
Total	**100.0**	**100.0**
Compensation	**66.9**	**66.0**
Wages and Salaries	52.6	52.2
Employee Benefits	14.3	13.8
Utilities	**1.2**	**1.1**
Electricity and Other Non-Fuel Utilities	0.7	0.8
Fuel: Oil and Gas	0.4	0.3
Professional Liability Insurance	**1.0**	**0.9**
All Other Products and Services	**23.8**	**24.9**
All Other Products	**9.1**	**10.7**
Pharmaceuticals	3.6	4.7
Food: Direct Purchases	0.8	0.9
Food: Contract Services	1.0	1.0
Chemicals	0.3	0.3
Medical Instruments	2.0	2.3
Rubber and Plastics	0.3	0.3
Paper and Printing Products	0.5	0.5
Miscellaneous Products	0.6	0.7
All Other Services	14.7	14.2
Labor-Related Services	7.9	7.7
Professional Fees: Labor-related	4.7	4.4
Administrative and Facilities Support Services	0.6	0.6
Installation, Maintenance, and Repair Services	1.2	1.3
All Other: Labor-related Services	1.4	1.4
Nonlabor-Related Services	6.8	6.5
Professional Fees: Nonlabor-related	4.9	4.5
Financial Services	0.7	0.8
Telephone Services	0.2	0.3

Cost Category	Proposed 2021-based IPF Market Basket Cost Weight	2016-based IPF Market Basket Cost Weight
All Other: Nonlabor-related Services	0.9	1.0
Capital-Related Costs	7.2	7.1
Depreciation	4.9	5.3
Building and Fixed Equipment	3.5	3.7
Movable Equipment	1.4	1.5
Interest Costs	1.5	1.2
Government/Nonprofit	1.0	0.9
For Profit	0.5	0.3
Other Capital-Related Costs	0.8	0.7

*Detail may not add to total due to rounding.

The proposed price proxies are the same as used for the 2016-based market basket. CMS is not proposing any changes.

Table 14 reproduced below, compares the percent change in the 2012-based and proposed 2016-based IPF market baskets for FYs 2019 through FY 2026. While there are small differences in a few years, there is no difference on average in the current or rebased IRF PPS market historically. There is only a 0.1 percentage point different in the average market basket estimate for the forecast years.

Table 14

Comparison of Proposed 2021 to 2016-Based IRF Market Basket Percent

	FY	2021-Based	2016-Based
Historical data	FY 2019	2.4	2.5
	FY 2020	2.1	2.2
	FY 2021	2.8	2.9
	FY 2022	5.3	5.3
	Average 2019-2022	**3.2**	**3.2**
Forecast	FY 2023	4.6	4.6
	FY 2024	3.2	3.2
	FY 2025	2.8	2.8
	FY 2026	2.7	2.8
	Average 2023-2026	**3.3**	**3.1**

Note that these market basket percent changes do not include any further adjustments as may be statutorily required.
Source: IHS Global Inc. 4th quarter 2022 forecast.

2. Market Basket Less Total Factor Productivity

For FY 2024, CMS is proposing an inflation update of 3.2 percent less 0.2 percentage points for total factor productivity or 3.0 percent. This proposed update reflects IHS Global Inc.'s 4th quarter 2022 forecast with historical data through the 3rd quarter of 2022. CMS will update this estimate based on later data for the final rule.

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 1.0 percent.

3. 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 2021-based market basket.[1] For FY 2024, CMS is proposing a labor-related share of 75.4 percent, up from 74.2 percent for FY 2023. Table 15 reproduced below shows how rebasing the IPF market basket from FY 2016 to FY 2021 affected the labor-related share:

Table 15: Comparison of Proposed FY 2024 and FY 2023 IPF Labor-Related Shares

	FY 2024 Labor-related Share based on Proposed 2021-based IPF Market Basket[1]	FY 2023 Final Labor-related Share based on 2016-based IPF Market Basket[2]
Wages and Salaries	53.3	53.2
Employee Benefits	14.2	13.5
Professional Fees: Labor-related[3]	4.7	4.3
Administrative and Facilities Support Services	0.6	0.6
Installation, Maintenance and Repair Services	1.2	1.3
All Other: Labor-related Services	1.4	1.5
Subtotal	**75.4**	**74.4**
Labor-related portion of capital (46%)	3.1	3.0
Total LRS	**78.5**	**77.4**

1. IHS Global Inc. 4th quarter 2022 forecast.
2. Based on IHS Global Inc. 2nd quarter 2022 forecast as published in the **Federal Register** (87 FR 46851).
3. Includes all contract advertising and marketing costs and a portion of accounting, architectural, engineering, legal, management consulting, and home office/related organization contract labor costs.

B. Update to the FY 2024 IPF Payment Rates

CMS determines the FY 2024 payment rates by applying the update factor (3.0 percent), and the wage index budget neutrality adjustment (1.0011, as discussed in section II.D.3 below) to FY 2023 rates. For hospitals that do not report quality data or meet the quality data reporting requirements, CMS determines the FY 2024 payment rate by applying the update factor (1.0 percent) and the wage index budget neutrality adjustment (1.0011) to the full unreduced FY 2023 payment rates.

The table below compares the final federal per diem base rate and the ECT payments per treatment for FY 2023 and proposed for FY 2024.

[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 2021) and FY 2024.

	FY 2023	Proposed FY 2024
Federal per diem base rate	$865.63	$892.58
Labor share	*$670.00 (77.4%)*	$700.68
Non-labor share	*$195.63 (22.6%)*	$191.90
ECT payment per treatment	$372.67	$384.27
Rates for IPFs that fail to meet the IPFQR Program requirements		
Per diem base rate	$848.95	$875.25
Labor share	*$ 657.09 (77.4%)*	$687.07
Non-labor share	*$ 191.86 (22.6%)*	$188.18
ECT payment per treatment	$365.49	$376.81

*Note: The update for FY 2024 for IPFs that do not submit quality data is applied to the full (unreduced) rate for FY 2023, not the actual rate they were paid in FY 2023.

C. Patient-Level Adjustments

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 2024, CMS is proposing to continue the existing payment adjustments.

1. Update to MS-DRG Assignment

For FY 2024, CMS proposes 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.

The diagnoses for each IPF MS-DRG will be updated as of October 1, 2023, using the inpatient prospective payment system (IPPS) FY 2024 ICD-10-CM/PCS code sets. The FY 2024 IPPS rule will include tables of the changes to the ICD-10-CM/PCS code sets, which underlie the FY 2024 IPF MS-DRGs. At the time this summary was prepared, the FY 2024 IPPS proposed 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 2024 IPPS proposed rule home page once the IPPS proposed 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 2024, CMS is not proposing any changes to the Code First table. Addendum B includes the FY 2024 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 2024, CMS proposed to add two ICD-10-CM/PCS codes and remove one ICD-10-CM/PCS code from the Chronic Renal Failure category. The proposed FY 2024 comorbidity codes are shown in Addenda B.

CMS reviewed the FY 2024 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 2024 ICD-10-CM/PCS codes were site "unspecified."

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 is proposing to continue the age adjustment factors for FY 2024 without change. The age adjustments are shown in Addendum A.

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 2024, CMS is proposing to continue the FY 2023 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.D.6 below.

D. Facility-Level Adjustments

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

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. Consistent with past practice, CMS proposes to use the FY 2024 pre-floor, pre-reclassified IPPS hospital wage index for the FY 2024 IPF wage index.

2. Adjustment for Rural Location

CMS proposes 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.

3. Wage Index Budget Neutrality Adjustment

CMS proposes to make changes to the IPF wage index budget neutral. For the proposed rule, CMS estimates aggregate IPF PPS payments for FY 2023 and FY 2024 using FY 2020 cost reports. The ratio of FY 2024 to FY 2023 payments is the budget neutrality adjustment applied to the federal per diem base rate for FY 2024. CMS proposes a budget neutrality adjustment of 1.0011 associated with revisions the wage index.

4. Teaching Adjustment

For FY 2024, CMS is proposing 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 is proposing to continue this policy without change.

5. Cost of Living Adjustment for Alaska and Hawaii

CMS proposes to apply the IPF PPS cost of living adjustment (COLA) factors for Alaska and Hawaii for FY 2024. The COLA is applied to the non-labor related share of the IPF standardized amounts and is updated every 4 years consistent with the timing of when the IPPS labor share is updated.

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 is not proposing any changes to these adjustments.

E. Other Payment Adjustments and Policies

1. Outliers

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 after. The differential in payment between days 1 through 9 and 10 and above is intended to avoid incenting longer lengths of stay.

For FY 2024, CMS is proposing 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' uses data from the 2nd fiscal year that precedes the payment year to simulate payments for setting the fixed loss threshold (e.g., FY 2022 data for setting the FY 2024 outlier threshold). CMS is proposing to use the same methodology to determine the fixed loss threshold for FY 2024 that it has used dating back to FY 2008 except for FY 2023 when it excluded 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 2022 update of FY 2022 IPF claims and the FY 2023 rate increases, CMS estimates that outlier payments for FY 2023 will be 3.0 percent of total payments or 1.0 percentage points higher than the target of 2.0 percent. For this reason, CMS believes it is necessary to propose an increase in the fixed loss threshold to better target 2.0 percent IPF payments as outliers. For FY 2024, CMS proposes to increase the fixed loss threshold from $24,630 in FY 2023 to $34,750 in FY 2024.

For the FY 2023 outlier modeling, CMS observed an overall increase in average cost per day and an overall decrease in the number of covered days that it attributed to some providers having significant increases in their charges, resulting in higher-than-normal estimated costs per day that would skew estimates of outlier payments for FY 2022 and FY 2023. For FY 2023, CMS excluded providers from the outlier model whose change in simulated cost per day is more than 3 standard deviations from the mean.

CMS did not observe this same pattern in the data used for modeling the FY 2024 outlier threshold and is not proposing the same exclusionary criterion. However, CMS **requests comment on whether it should adopt this same exclusionary criterion that would make the proposed FY 2024 outlier threshold closer to $30,000**. **CMS also requested comments on any other ideas that could make the increase in the outlier threshold lower.**

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 proposed FY 2024 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	2.0801	1.7864

2. Allowing Distinct Part Units Mid-Cost Reporting Period

Current regulations at 42 CFR 412.25(c) specify when the status of an excluded inpatient rehabilitation facility (IRF) or IPF unit may be changed from "not excluded from the IPPS" to "excluded from the IPPS" and be paid under the IRF or IPF PPS or vice versa.

- Status of change from not excluded to excluded from the IPPS: May only be done at the start of the cost reporting period. If a unit is added to a hospital after the start of a cost reporting period, it cannot be excluded from the IPPS before the start of a hospital's next cost reporting period.
- Status of change from excluded to not excluded from the IPPS: May be done at any time during a cost reporting period, subject to certain conditions:
    - The hospital must notify the MAC and the CMS Regional Office in writing at least 30 days before the date of the change, and must maintain the information needed to accurately determine costs that are or are not attributable to the excluded unit.
    - A status change from excluded to not excluded that is made during a cost reporting period must remain in effect for the rest of that cost reporting period.

CMS provides background for these policies, which were implemented before the establishment of the IRF PPS and the IPF PPS and were established to address the administrative complexity associated with cost-based reimbursement for excluded IRF and IPF units. Stakeholders have observed that only permitting status changes from not excluded to excluded to be made before the start of a cost reporting period is no longer necessary, creates an unnecessary burden, and does not take into account challenges hospitals face completing construction projects to expand capacity before the start of a cost reporting period.

Noting that cost allocation is no longer used for payment purposes because IRF and IPF units are paid under the IRF PPS and IPF PPS respectively, CMS believes that the restriction that limits an IPF or IRF unit to being excluded from the IPPS only at the start of a cost reporting period is no longer necessary. Thus, it proposes to revise its regulations at §412.25(c)(1) to establish a uniform rule for status changes for IRF and IPF units that would permit the unit's status to be changed from not excluded to excluded (or excluded to not excluded) at any time during a cost reporting period.

The hospital would be required to notify the MAC and the CMS Regional Office in writing of the change at least 30 days before the date of the change, and it would have to maintain the information needed to accurately determine costs that are or are not attributable to the IRF or IPF unit. Additionally, any change in the status of an IRF or IPF unit (i.e., from not excluded to

excluded or vice versa) that is made during a cost reporting period must remain in effect for the rest of that cost reporting period.

While current regulation §412.25(c) applies to both IRFs and IPFs, CMS is proposing discrete regulation text for IRF and IPF unit types in the event public comments raise issues that might affect one hospital unit type and not the other. However, CMS may consider adopting one consolidated regulation text for both IRF and IPF units in either the IRF or IPF final rules for both unit types if it finalizes both of its proposals. **CMS seeks comments on the proposals and also on whether it should finalize a consolidated provision that pertains to both IRF and IPF units**.

III. RFI to Inform Revisions to the IPF PPS Required by the CAA, 2023

A. Changes to IPF PPS in the CAA, 2023

Section 1886(s)(5) of the Act (as added by section 4125 of the CAA, 2023), requires revisions to the methodology for determining the payment rates under the IPF PPS for FY 2025 and future years as the Secretary determines appropriate. Section 1886(s)(5)(A) of the Act requires the Secretary to begin collecting, by not later than October 1, 2023, data and information as appropriate to inform revisions to the IPF PPS. Section 1886(s)(5)(B) of the Act provides examples of the type of data that may be collected:

- Charges, including those related to ancillary services;
- The required intensity of behavioral monitoring, such as cognitive deficit, suicidal ideations, violent behavior, and need for physical restraint; and
- Interventions, such as detoxification services for substance abuse, dependence on respirator, total parenteral nutritional support, dependence on renal dialysis, and burn care.

These data are consistent with the types of data that CMS has been collecting to update the IPF PPS patient level adjustments.

B. Current Data and Information Collection Requirements

The proposed rule reviews how CMS already collects the type of data specified by section 1886(s)(5)(B) of the Act. CMS seeks comment about specific additional data and information psychiatric hospitals and psychiatric units might report that could be appropriate and useful to help inform possible revisions to the methodology for payment rates under the IPF PPS for FY 2025 and future years.

In addition, CMS would expect the nature of IPF services would be associated with laboratory or drug charges. However, CMS' ongoing analysis has found that certain providers, especially for-profit freestanding IPFs, are consistently reporting no ancillary charges or very minimal ancillary charges.

CMS is considering whether to require charges for ancillary services to be reported on claims and potentially reject claims if no ancillary services are reported, and whether to consider

payment for such claims to be inappropriate or erroneous and subject to recoupment. The proposed rule requests comments on these issues.

C. Social Drivers of Health

Social drivers of health (SDOH), also known as social determinants of health, are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. ICD-10 diagnosis codes for SDOH are reported in a low frequency of claims.

In general, CMS' analysis found that claims that included SDOH codes had lower costs than claims that did not include such codes—a counterintuitive finding. However, CMS' analysis also found that certain SDOH diagnosis codes were associated with increased cost for IPF treatment:

- Z559 Problems related to education and literacy, unspecified.
- Z599 Problems related to housing and economic circumstances, unspecified.
- Z600 Problems of adjustment to life-cycle transitions.
- Z634 Disappearance and death of family member.
- Z653 Problems related to other legal circumstances.
- Z659 Problems related to unspecified psychosocial circumstances.

CMS seeks comments on these findings and information about whether it would be appropriate to consider incorporating these codes into the IPF PPS in the future, for example as a patient-level adjustment.

IV. Inpatient Psychiatric Facilities Quality Reporting (IPFQR) Program

CMS proposes to adopt the following 4 new measures:

- The Facility Commitment to Health Equity measure beginning with the FY 2026 payment determination;
- The Screening for Social Drivers of Health measure beginning with voluntary reporting of CY 2024 data and beginning with required reporting of CY 2025 data for the FY 2027 payment determination;
- The Screen Positive Rate for Social Drivers of Health measure beginning with voluntary reporting of CY 2024 data and beginning with required reporting of CY 2025 data for the FY 2027 payment determination; and
- The Psychiatric Inpatient Experience (PIX) survey to measure patient experience of care in the IPF setting beginning with voluntary reporting of CY 2025 data and beginning with required reporting of CY 2026 data for the FY 2028 payment determination.

In addition, CMS proposes to modify the COVID-10 Vaccination Coverage Among Health Care Personnel (HCP) measure beginning with fourth quarter CY 2023 data for FY 2025 payment

determination, and to remove the following 2 existing measures beginning with the FY 2025 payment determination year:

- Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification (HBIPS-5); and
- Tobacco Use Brief Intervention Provided or Offered and Tobacco Use Brief Intervention Provided (TOB-2/2a) measure.

CMS also proposes a data validation pilot program beginning with data submitted in 2025, and to codify procedural requirements related to statutory authority, participation and withdrawal, data submission, quality measure retention and removal, extraordinary circumstances exceptions, and public reporting requirements.

CMS estimates that the overall economic impact of the IPFQR Program proposals in this proposed rule would be a decrease of 505,247 hours in information collection burden resulting in a savings of $12,431,700.

CMS invites public comment on all of the proposals.

A. Background

CMS established the IPFQR program beginning in FY 2014, as required under section 1886(s)(4) of the Act. The IPFQR Program follows many of the policies established for the Hospital Inpatient Quality Reporting Program but has a distinct set of quality measures. Substantive changes to the IPFQR Program are proposed and finalized through rulemaking. 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.

Under the 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 payment determination year is the year in which an IPF would receive the 2 percentage point reduction to the annual update to the standard federal rate. The data submission period is prior to the payment determination year and is the period during which IPFs are required to submit data on the specified quality measures for that determination year. For FY 2023 payment determination, based upon compliance with the IPFQR program requirements, 1,590 facilities successfully reported and received a full update while 2 failed to report successfully and received a 2.0 percentage point reduction. An additional 4 facilities chose not to participate and were subject to the 2.0 percentage point reduction.

B. Covered Entities

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. CMS uses the terms “facility” or IPF to refer to both inpatient psychiatric hospitals and psychiatric units.

C. Previously Finalized Measures

There are 14 finalized measures included in the IPFQR for the FY 2024 payment determination. The measures are shown in Table 5 of the proposed rule and shown in the table under section G below.

D. Measure Adoption

CMS describes the IPFQR program as a way to incentivize IPFs to improve quality and value and to provide patients and providers with better decision-making tools. In selecting quality measures, CMS describes the objectives of balancing the need for information and the need to minimize the burden of data collection and reporting. CMS' focus has been on measures that evaluate process of care that impact patient outcomes and support improved quality and efficiency of care.

1. Measure Selection Process

In accordance with the CMS pre-rulemaking process, before being proposed for inclusion in the IPFQR Program, measures are placed on a Measures Under Consideration (MUC) list, which is published annually on behalf of CMS by NQF, the consensus-based entity. Following publication on the MUC list, the Measure Applications Partnership (MAP) reviews the measures under consideration for the IPFQR Program. CMS considers the MAP's recommendations in selecting all measures for the IPFQR Program.

2. Proposal to Adopt the Facility Commitment to Health Equity Measure Beginning with the CY 2024 Reporting Period Reported in CY 2025/FY 2026 Payment Determination

Background: CMS describes significant and persistent disparities in healthcare outcomes, and notes the numerous and diverse demographic and social risk factor variables to be considered during disparities analysis, including gender identity, race, ethnicity, minority groups, religion, geographic location, sexual orientation, and income level. CMS points to studies demonstrating that facility leadership can influence patient outcomes and quality and experience of care, and notes that such leadership can assist in setting goals for assessing progress towards achieving equity goals and ensuring accessibility to high-quality care.

Proposed measure: CMS proposes to adopt an attestation-based structural measure, the Facility Commitment to Health Equity, to address health equity beginning with the CY 2024 reporting period/FY 2026 payment determination. The measure is consistent with the Hospital Inpatient Quality Reporting (IQR) Program's adoption of an attestation-based structural measure in the FY 2023 IPPS/LTCH PPS final rule (87 FR 49191 through 49201).

The measure assesses (and requires facility attestation on) facility commitment to health equity across 5 domains (equity in a strategic priority, data collection, data analysis, quality improvement, and leadership engagement). Some of the domains have multiple elements. A

point is awarded for each domain to which a facility attests affirmatively. For a facility to attest "yes" to a domain and receive credit for that domain, the facility would evaluate and determine whether it engages in each of the elements that comprise that domain. A complete list of domains and elements are described in Table 17 in section V.D.2.b of this proposed rule.

Measure calculation:

- Numerator. Number of domains for which a hospital attests to completing all of the required elements.
- Denominator. Five points (one for each domain available for attestation).

Pre-rulemaking: The measure was included on the MUC List for December 1, 2022. The MAP Review outcome was conditional support for the measure for rulemaking, pending endorsement by NQF, commitment to consideration of equity related outcome measures in the future, more clarity on the measure, and verification of accurate attestation by facilities. Concerns raised included that the measure does not evaluate outcomes and may not directly address health inequities at a systemic level.

The measure is not NQF-endorsed, but CMS proposes to adopt the measure under the exception under section 1886(s)(4)(D)(ii) of the Act, which allows the Secretary to select non-NQF-endorsed measures when the Secretary is unable to identify a suitable NQF-endorsed measure that is available, feasible, and practical.

Data Collection, Submission, and Reporting: IPFs are required to submit information for structural measures once annually using a CMS-approved web-based data collection tool available within the Hospital Quality Reporting (HQR) System. CMS proposes attestation for the measure to begin in 2025, reflecting the 2024 reporting period and affecting the FY 2026 payment determination.

Burden Assessment: CMS estimates that this policy would result in a total annual burden increase of 267 hours across all participating IPFs at a cost of $11,956.63.

3. Screening for Social Drivers of Health

Background: CMS describes the CMMI Accountable Health Communities (AHC) Model, which extensively tested and assessed the relationship between identifying core health-related social needs (HRSNs) and improving healthcare costs, utilization, and outcomes. The 5 core domains[2] to screen for HRSNs that were applied in the AHC Model are used in the Screening for Social Drivers of Health Measure and the Screen Positive Rate for Social Drivers of Health Measure (collectively referred to as the Social Drivers of Health measures). Both Social Drivers of Health measures were adopted into the Hospital IQR Program in the FY 2023 IPPS/LTCH PPS final rule.[3] CMS notes the 2 measures align with efforts included in the CY 2023 Medicare Advantage and Part D final rule, which required Special Needs Plans (SNPs) to include one or more questions on housing stability, food security, and access to transportation in their health risk assessment (HRA), as well as the CY 2023 Physician Fee Schedule (PFS) final rule in which the

[2] The 5 domains are described in detail in Table 18 of the proposed rule.
[3] FY 2023 IPPS/LTCH PPS final rule (87 FR 49191 through 49220).

Screening for Social Drivers of Health measure was added to the Merit-based Incentive Payment System (MIPS) Program.[4]

The proposed Screening for Social Drivers of Health measure (alongside the proposed Screen Positive Rate for Social Drivers of Health measure described in section V.D.4 of this proposed rule) would be the first measurement of social drivers of health in the IPFQR Program. CMS emphasizes the usefulness of this measure with respect to the patient populations of IPFs.

Proposed measure: The Screening for Social Drivers of Health measure assesses the percent of patients admitted to the IPF who are 18 years or older at time of admission and are screened for 5 HRSNs (food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety).

Measure calculation: The measure would be calculated as follows:

- Numerator. Number of patients admitted to an IPF stay who are screened during their IPF stay for all of the five HRSNs.
- Denominator. Number of patients admitted to an IPF stay.
- Exclusions. Patients younger than 18 years of at the time of admission, patients who opt out of screening, and patients who are unable to complete the screening themselves and lack a guardian or caregiver available do so on the patient's behalf.

Pre-Rulemaking: The measure was included on the MUC List for December 1, 2022. The MAP Review resulted in a recommendation to conditionally support for rulemaking pending (1) testing of the measure's reliability and validity; (2) endorsement by NQF; (3) additional details on how potential tools map to the individual HRSNs, as well as best practices; (4) identification of resources that may be available to assist patients with identified HRSNs; and (5) the measure's alignment with data standards. The measure is not NQF-endorsed, but CMS proposes to adopt the measure under the exception under section 1886(s)(4)(D)(ii) of the Act, which allows the Secretary to select non-NQF-endorsed measures when the Secretary is unable to identify a suitable NQF-endorsed measure that is available, feasible, and practical.

Data Collection, Submission, and Reporting: CMS proposes voluntary reporting of this measure beginning with the data collected in 2024, which would be reported to CMS in 2025, followed by required reporting beginning with data collected in 2025, which would be reported to CMS in 2026 for the FY 2027 payment determination.

IPFs would have flexibility with selecting the tool to screen for the 5 HRSNs. CMS describes potential sources of data as including electronic clinical data, standardized patient assessments, administrative claims data, and patient-reported data, and encourages IPFs to use digital standardized screening tools.[5]

[4] 87 FR 70054 through 70055.
[5] CMS references the Social Interventions Research and Evaluation Network (SIREN) website for additional information on resources.

IPFs would report aggregate data on the measure. IPFs are required to submit information for chart-abstracted measures once annually using a CMS-approved web-based data collection tool available within the HQR System.

Burden assessment:

- CMS estimates that during the voluntary reporting period on 2024 the annual burden of surveying IPF patients would be 16,603.59 hours at a cost of $343,860.29. CMS estimates that during the required reporting period in 2025 the annual burden for surveying would increase an additional annual total of 49,810.41 hours more than during the voluntary period and an additional $1,031,473.65 more than during the voluntary period.
- CMS estimates that during the 2025 reporting period, the annual burden for facility information collection would be a total annual time of 133 hours and total cost of $5,966.38 for all IPFs, and that during the 2026 reporting period the annual burden for facility information collection would a total of an additional (i.e., the incremental increase above the burden amounts for 2025) of 133 hours and total cost of $5,966.38 for all IPFs.

4. Proposal to Adopt the Screen Positive Rate for Social Drivers of Health Measure Beginning with Voluntary Reporting of CY 2024 Data and Followed by Required Reporting Beginning with CY 2025 Data/FY 2027 Payment Determination

Background: CMS describes that the Screening for Social Drivers of Health measure (proposed in section V.D.3.) enables identification of individuals with HRSNs, and the Screen Positive Rate for Social Drivers of Health measure would complement that measure and capture the extent of such needs and estimate the impact of individual-level HRSNs on healthcare utilization. The Hospital IQR Program adopted this proposed measure in the FY 2023 IPPS/LTCH PPS final rule.[6] CMS proposes consistent adoption in the IPFQR Program.

Proposed Measure: CMS proposes adding this process measure to enhance standardized data collection for identifying high-risk individuals who could benefit from connection via the IPF to community-based services relevant to their HRSNs. The measure also could allow impact estimates for the effects of the included HRSN domains on hospitalizations and be valuable during discharge planning. CMS notes that the measure is not intended for comparing IPFs.

The Screen Positive Rate for Social Drivers of Health would provide information on the percent of patients, 18 or older on the date of admission for an IPF stay, who were screened for an HRSN, and who screened positive for at least one of the 5 HRSNs (food insecurity, housing instability, transportation needs, utility difficulties, or interpersonal safety).

Measure calculation:

- Numerator: For each HRSN, the number of patients who screen positive on the date of admission (calculated separately for each of the 5 HRSNs). A patient who screens

[6] 87 FR 49215 through 49220.

positive for more than one HRSN would be included in the numerator for each of such HRSNs.

- Denominator: For each HRSN, the number of patients screened.
- Exclusion: Patients younger than 18 years at the time of admission, patients who opt out of screening, and patients who are unable to complete the screening themselves and lack a guardian or caregiver available do so on the patient's behalf.
- Calculation. A separate rate is calculated for each screening domain, so that five rates are calculated by each hospital for screen-positive patients divided by screened patients.

Pre-Rulemaking: The proposed measure was included on the MUC List for December 1, 2022. The MAP Review resulted in a vote of conditional support for rulemaking, pending endorsement by NQF, attentiveness to how results are shared for public reporting, and examination of any differences in reported rates if IPFs use different reporting processes. The measure is not NQF-endorsed, but CMS proposes to adopt the measure under the exception under section 1886(s)(4)(D)(ii) of the Act, which allows the Secretary to select non-NQF-endorsed measures when the Secretary is unable to identify a suitable NQF-endorsed measure that is available, feasible, and practical.

Data Collection, Submission, and Reporting: CMS proposes voluntary collection of data by IPFs in 2024, for voluntarily reporting the measure to CMS in 2025, and required collection of data by IPFs starting in 2025 for required reporting to CMS of the measure beginning in 2026, which would first affect payment determinations for FY 2027. CMS proposes to adopt this as an aggregate measure, meaning that IPFs would submit only numerator results for each of the 5 screening areas and the number of patients screened for all 5 HRSNs. IPFs are required to submit information for aggregate chart-abstracted measured once annually using a CMS-approved web-based data collection tool available within the HQR System.

Burden Assessment: CMS estimates that during the 2025 reporting period the annual burden for facility information collection would be a total annual time of 133 hours and total cost of $5,966.38 for all IPFs, and that during the 2026 reporting period the annual burden for facility information collection would a total of an additional (i.e. the incremental increase above the burden amounts for 2025) of 133 hours and total cost of $5,966.38 for all IPFs.

5. Proposal to Adopt the Psychiatric Inpatient Experience (PIX) Survey Beginning with Voluntary Reporting of CY 2025 Data and Required Reporting Beginning with CY 2026 Data/FY 2028 Payment Determination

Background: CMS expresses its commitment to adopting an appropriate standardized measure of patient experience of care in the IPFQR Program. The Consolidated Appropriations Act, 2023 amended section 1886(s)(4) of the Act to require that, not later than the FY 2031 payment determination, the IPFQR Program include a quality measure of patients' perspective on care. CMS has identified the Psychiatric Inpatient Experience (PIX) survey as a publicly available patient experience of care instrument developed for, and tested in, the IPF setting. CMS emphasizes that the measure supports the Meaningful Measures 2.0 Framework priorities, supports the Strengthen Equity and Quality in Behavioral Health Care goal of the Behavioral Health Strategy, and supports the Universal Foundation domain of Person-Centered Care.

Proposed Measure: The PIX survey contains 23 items in 4 domains and would be completed prior to discharge. Patients respond to each of the items using a 5-point scale (strongly disagree, somewhat disagree, neutral, somewhat agree, strongly agree) or by choosing the item does not apply. The 4 domains are: (1) Relationship with Treatment Team; (2) Nursing Presence; (3) Treatment Effectiveness; and (4) Healing Environment.[7]

Measure Calculation: The measure includes all patients discharged from an IPF during the reporting period, excluding patients under 13 years of age at the time of discharge and patients unable to complete the survey because of cognitive or intellectual limitations.

The measure would be reported as five separate rates (one for each of the 4 domains) and one overall rate. CMS would report the mean rates for each domain, as well as the overall mean rate, on the Care Compare website. The mean score would be calculated by:

- Assigning a numerical value ranging from 1 (Strongly Disagree) to 5 (Strongly Agree).
- Adding the values of all responses and dividing that value by the number of responses, excluding questions that were omitted or to which the patient selected "Does Not Apply."

Pre-Rulemaking: The proposed measure was included on the MUC List for December 1, 2022. The MAP Review resulted in a vote of conditional support for rulemaking, pending endorsement by NQF, data from testing of the measure in a variety of settings, data regarding survey results depending on administration of the survey pre- versus post-discharge, data regarding patient factors (such as voluntary versus involuntary admissions), and data regarding mode of administration (such as email versus mail) that may affect performance. CMS believes testing has shown the PIX survey is valid and reliable for the IPF setting, but agrees further testing prior to public reporting of the measure data could help better understand measure results, and therefore proposes 2 years of voluntary reporting before beginning mandatory reporting.

The measure is not NQF-endorsed, but the measure developer intends to submit the measure for endorsement following additional testing. CMS proposes to adopt the measure under the exception under section 1886(s)(4)(D)(ii) of the Act.

Data Collection, Submission, and Reporting: CMS proposes voluntary collection of data by IPFs in 2025, for voluntarily reporting the measure to CMS in 2026, and beginning required collection of data by IPFs starting in 2026 for required reporting to CMS of the measure in 2027, which would affect the FY 2028 payment determination.

IPFs would collect the data similar to collection of data for chart-abstracted measures or other patient screening measures, and would report to CMS, as described in section V.I.4.

Burden Assessment:

- CMS estimates that during the voluntary reporting period, burden associated with conducting the PIX survey in CY 2025 would be 28,967.4 hours at a cost of $599,914.85. CMS estimates in CY 2026 the annual burden for surveying would increase an additional

[7] For a complete list of survey questions, see the description of the survey in the Journal of Patient Experience: https://journals.sagepub.com/doi/full/10.1177/23743735221105671.

annual total of 28,967.4 hours more than during the voluntary period and an additional $599,914.85 more than during the voluntary period.

- CMS estimates for the reporting period in 2026 facility information collection burden associated with this measure would be an annual total of 59,850 hours (75 hours per facility) at an annual cost of $2,684,871 for all IPFs. For the reporting period in 2027 facility information collection burden would be an additional (i.e., the incremental increase above the burden amounts for 2026) 59,850 hours at an additional cost of $2,684,871.

E. Proposed Modification of COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) Measure

1. Background

The COVID-19 Vaccination Coverage among HCP measure was adopted into the IPFQR measure set in the FY 2022 IPF PPS final rule[8] (and has been adopted in multiple other quality reporting programs, including the Hospital IQR Program). The measure requires each IPF to submit data on the percentage of HCP eligible to work in the IPF for at least one day during the reporting period who have received a complete vaccination course against SARS-CoV-2 (excluding persons with contraindications to the COVID-19 vaccine). CMS describes that since adoption of the measure, the agency continues to believe vaccination is a critical component to effectively countering the spread of COVID-19 and that it's important to incentivize and track HCP vaccination in IPFs. However, CMS states it is important to update the specifications of the HCP COVID-19 Vaccine measure to reflect the most current guidance that specifies for HCP to receive primary series and booster vaccine doses in a timely manner.

2. Overview of Measure and Proposed Modification

The HCP COVID-19 Vaccine measure is a process measure (that is not risk-adjusted) developed by the CDC to track COVID-19 vaccination coverage among HCP in facilities such as IPFs. CMS proposes, beginning with the FY 2025 payment determination (quarter 4 of the 2023reporting period), to modify the HCP COVID-19 Vaccine measure to:

- Replace the term "complete vaccination course" with the term "up to date" in the HCP vaccination definition; and
- Update the numerator to specify the time frames within which an HCP is considered up to date with recommended COVID-19 vaccines, including booster doses.

Pre-rulemaking: The current version of the HCP COVID-19 Vaccine ("Quarterly Reporting of COVID-19 Vaccination Coverage among Healthcare Personnel") measure received endorsement by NQF on July 26, 2022 (NQF #3636), but the measure so endorsed does not capture information about whether HCP are "up to date" with their COVID-19 vaccinations (as proposed in the CMS modifications to the measure). The CDC is pursuing NQF endorsement for the modified version of the measure.

[8] 86 FR 42633 through 42650.

CMS included an updated version of the HCP COVID-19 Vaccine measure on the MUC List for the 2022-2023 pre-rulemaking cycle. Comments by interested parties were mixed and raised the concern about the difficulty of defining "up to date" for purposes of the measure and about data collection burden. The MAP conditionally supported the rulemaking pending testing that indicates the measure is reliable and valid, and pending endorsement by the NQF.

CMS proposes to adopt the measure beginning with the FY 2025 payment determination, consistent with the exception under section 1899B(e)(2)(B) of the Act, having found no currently available, alternative measure that is comparable, NQF-endorsed, feasible, and practical.

Measure Calculation and Specifications: The proposed modification would require IPFs to collect data at least once a week each month for each of the 3 months in a quarter. The modified measure would be calculated as follows:

- Numerator: The number of HCP in the denominator population who are considered up to date[9] with CDC recommended COVID-19 vaccines.
- Denominator: The number of HCP eligible to work in the facility for at least one day during the reporting period, excluding persons with contraindications to COVID-19 vaccination that are described by the CDC. HCPs include employees of the facility, licensed independent practitioners, and adult students/trainees and volunteers. There are no proposed changes to the denominator from that of the current version of the measure.

Burden Assessment: CMS does not believe the proposed modification would affect reporting burden.

3. Data Collection, Submission, and Reporting
    - For FY 2025 payment determination, IPFs would collect the numerator and denominator for the modified measure for at least one self-selected week during each month of the 4th quarter of 2023 reporting period, and submit the data to the CDC's National Health Safety Network (NHSN) Healthcare Personnel Safety (HPS) Component before the quarterly deadline.
    - Each quarter, the CDC would calculate a single quarterly COVID-19 HCP vaccination coverage rate for each IPF, by taking the average of the data from the three weekly rates submitted by the IPF for that quarter.
    - Beginning with the FY 2026 payment determination, IPFs would be required to submit data for the entire calendar year.
    - Public reporting would begin with the October 2024 Care Compare refresh or as soon as technically feasible.

[9] The definition of up to date is as of the first day of the quarter and can be found at https://www.cdc.gov/nhsn/pdfs/hps/covidvax/UpToDateGuidance-508.pdf. HCP would be considered up to date during Q4 of the CY 2022 reporting period if the individual received an updated bivalent booster dose; received their last booster dose less than 2 months ago; or completed their primary series less than 2 months ago.

F. Removal or Retention of IPFQR Measures

1. Background

CMS describes the following 8 factors considered when determining whether to propose a measure for removal from the IPFQR Program:

(1) Measure performance among IPFs is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made ("topped out" measures);
(2) Measure does not align with current clinical guidelines or practice;
(3) Measure can be replaced by a more broadly applicable measure (across setting or populations) or a measure that is more proximal in time to desired patient outcomes for the particular topic;
(4) Measure performance or improvement does not result in better patient outcomes;
(5) Measure can be replaced by a measure more strongly associated with desired patient outcomes for the particular topic;
(6) Measure collection or public reporting leads to negative intended consequences other than patient harm;
(7) Measure is not feasible to implement as specified; and
(8) The costs associated with a measure outweigh the benefit of its continued use in the program.

Even if a measure meets a factor for removal, the following retention factors are considered:

(1) Measure aligns with other CMS and HHS policy goals, such as those delineated in the National Quality Strategy and CMS Quality Strategy;
(2) Measure aligns with other CMS programs, including other QRPs; and
(3) Measure supports efforts to move IPFs towards reporting electronic measures.

Since adoption, no changes have been proposed to these removal and retention policies, and CMS proposes to codify them at 42 CFR §412.433(e).

1. Proposed Measures for Removal

a. Proposed Removal of the Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification (HBIPS-5) (previously endorsed under CBE #0560) Measure Beginning with FY 2025 Payment Determination

Basis for Removal: CMS cites measure removal factor 2 (measure does not align with current clinical guidelines or practice) because of the American Psychiatric Association's (APA's) updated guidelines for patients with schizophrenia. The HBIPS-5 measure had been retained in the IPFQR Program based on prior guidance that the "combinations of antipsychotics... should be justified by strong documentation that the patient is not equally benefited by monotherapy." Revised guidelines no longer contain that recommendation. The MAP recommended the measure be removed from the IPFQR Program since the measure is no longer aligned with current clinical guidelines and practice and the measure lost its NQF endorsement in 2019 due to lack of support by the measure developer (The Joint Commission).

CMS proposes removal of the measures beginning with FY 2025 payment determination.

Burden Assessment: CMS calculates a reduction of a total of 248,776.5 hours annually for all IPFs (152.25 hours per facility) and of a total reduction of $10,199,836.50 annually for all IPFs.

b. Proposed Removal of the Tobacco Use Brief Intervention Provided or Offered and Tobacco Use Brief Intervention (TOB-2/2a) for FY 2025 and Subsequent Years

Background: The TOB-2/2a measure was adopted in the FY 2015 IPF PPS final rule to address the comorbidity of tobacco use among IPF patients. At the time of adoption, the benefits of the measure had been high because there were no other measures addressing provision of tobacco use cessation counseling or treatment. Subsequently, the Tobacco Use Treatment Provided or Offered at Discharge and Tobacco Use Treatment at Discharge (TOB-3/3a) measure was adopted in the FY 2016 IPF PPS final rule (80 FR 46696 through 46699). The TOB2/2a measure captures whether the tobacco cessation counseling and FDA-approved tobacco cessation medications were offered or refused during the inpatient stay, and the TOB-3/3a measure captures whether a referral to outpatient tobacco cessation counseling and FDA-approved tobacco cessation medications were offered or refused at the time of the patient's discharge.

CMS proposed removal of the TOB-2/2a measure in the FY 2022 IPF PPS proposed rule, citing costs of maintaining the measure and oversight of the measure as high, but removal was not finalized because of cited benefits of IPFs continuing to improve performance on the measure, the importance of tobacco use intervention during the COVID-19 pandemic, and potential influence on other quality improvement activities. However, with continued evaluation, CMS believes having 2 measures addressing tobacco use (both having high information collection burden) leads to overall program costs outweighing the benefits. Since national performance on the TOB-2/2a measure is relatively high compared to the TOB-3/3a measure, CMS believes there is more opportunity for improvement on the TOB-3/3a measure, meaning retaining the TOB-3/3a measure instead of the TOB2/2a measure would provide more opportunity to encourage improvement among IPFs.[10]

Basis for Removal: CMS cites removal factor 8 as the basis for removal (the costs associated with the TOB-2/2a measure outweigh the benefit of its continued use in the IPFQR Program). The MAP recommended removal of the measure from the IFPQR because the measure is high cost and no longer NQF-endorsed due to lack of support by the measure developer (The Joint Commission).

CMS proposes removal of the measures beginning with FY 2025 payment determination.

Burden Assessment: CMS calculates a reduction of a total of 248,776.5 hours annually for all IPFs (152.25 hours per facility) and of a total reduction of $10,199,836.50 annually for all IPFs.

[10] See Table 19 in the Proposed Rule for a comparison of national performance on the 2 measures from 2017 to 2022.

G. Summary of IPFQR Program Measures

No changes are proposed to the 14 measures in the measure set for FY 2024 payment determination. As described above, CMS proposes the removal of 2 measures and modification of 1 measure beginning for FY 2025 payment determination (resulting in a measure set containing 12 measures). As described, CMS proposes the addition of one required measure and 2 voluntary measures beginning for FY 2026 payment determination (resulting in a measure set containing 13 required measures). Beginning for FY 2027 determination, CMS proposes to require the 2 FY 2026 voluntary measures and add one voluntary measure (resulting in a measure set of 15 required measures); and beginning for FY 2028 determination, CMS proposes to require the FY 2027 voluntary measure (resulting in a measure set of 16 required measures).

IPFQR Measure Set for FY 2024 Payment Determination with Proposed Changes for FY 2025 through 2028 Payment Determination Shown in Italics

(Combining Tables 20 through 24 in the Proposed Rule)

CBE #	Measure ID	Measure
0640	HBIPS-2	Hours of Physical Restraint Use
0641	HBIPS-3	Hours of Seclusion Use
*0560**	*HBIPS-5*	*Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification – Proposed Removal beginning for FY 2025 payment determination*
n/a	FAPH	Follow-Up After Psychiatric Hospitalization
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 – Proposed Removal beginning for FY 2025 payment determination*
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
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	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
(3636)[11]	*n/a*	*COVID-19 Healthcare Personnel (HCP) Vaccination Measure – Proposed modifications beginning for FY 2025 payment determination*
n/a	*Facility Commitment*	*Facility Commitment to Health Equity – Proposed adoption beginning for FY 2026 payment determination*

[11] Modifications are proposed to the HCP measure beginning for FY 2025 determination. The modified version is not NQF-endorsed.

n/a	*Screening for SDOH*	*Screening for Social Drivers of Health – Proposed voluntary reporting for FY 2026 payment determination and required beginning for FY 2027 payment determination*
n/a	*Screen Positive*	*Screen Positive Rate for Social Drivers of Health – Proposed voluntary reporting for FY 2026 payment determination and required beginning for FY 2027 payment determination*
n/a	*PIX*	*Psychiatric Inpatient Experience Survey – Proposed voluntary reporting for FY 2027 payment determination and required beginning for FY 2028 payment determination*

* Measure is no longer endorsed by the NQF but was endorsed at time of adoption. Section 1886(s)(4)(D)(ii) of the Act authorizes the Secretary to specify a measure that is not endorsed by the NQF as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary. CMS attempted to find available measures for each of these clinical topics that have been endorsed or adopted by a consensus organization and found no other feasible and practical measures on the topics for the IPF setting.

H. Public Display and Review Requirements

The Secretary must establish procedures for making the IPFQR Program data available to the public after IPFs have the opportunity to review data specific to the IPF involved, in accordance with section 1886(s)(4)(E) of the Act. CMS proposes to codify at 42 CFR §412.433(g) for public reporting in the IPFQR Program procedural requirements adopted in the FY 2014 IPPS/LTCH PPS[12] and the FY 2017 IPPS/LTCH PPS[13] final rules, which provide IPFs a 30-day period to review their data and submit corrections to errors resulting from CMS calculations, prior to public display on a CMS website.

I. Form, Manner, and Timing of IPFQR Data Submission for the FY 2024 Payment Determination and Subsequent Years

Codification of procedural requirements: No changes are proposed to procedural requirements previously finalized for participation in, and withdrawal from, the IPFQR Program, as well as data submission requirements. CMS proposes to codify the procedural requirements at 42 CFR §412.433(b) through (d) for an IPF to register for, or withdraw from, participation in the IPFQR Program and to submit the required data on measures in a form and manner and time specified by CMS.

Modified HCP Measure: No changes are proposed to the form, manner, and timing of data submission for the modified COVID-19 Vaccination Coverage Among HCP measure from that required for the current version of the HCP measure. See the FY 2022 IPF PPS final rule (86 FR 42657) for the current policies applicable to the current version of the measure.

Screening for Social Drivers of Health measure and Screen Positive Rate for Social Drivers of Health measure: CMS proposes the previously finalized data submission requirements for aggregate data reporting described in the FY 2018 IPPS/LTCH PPS final rule (82 FR 38472 through 38473) would apply to the Screening for Social Drivers of Health measure and Screen Positive Rate for Social Drivers of Health measure for voluntary reporting for the FY 2026

[12] 78 FR 50897 through 50898.
[13] 81 FR 57248 through 57249.

IPFQR Program and required reporting beginning for the FY 2027 IPFQR Program's payment determination.

Psychiatric Inpatient Experience (PIX) measure: For voluntary reporting in the FY 2027 program year and required reporting beginning with the FY 2028 payment determination, CMS proposes that facilities would report these data using the patient-level data reporting described in the FY 2022 IPF PPS final rule (86 FR 42658 through 42661).

Proposed Data Validation Pilot: CMS proposes a voluntary data validation pilot beginning with data submitted in 2024 (reflecting care provided during 2023). After reviewing validation policies of other pay-for-reporting quality programs, CMS is proposing to randomly select on an annual basis up to 100 IPFs and request each selected IPF to provide to CMS eight charts per quarter, a total of 32 charts per year, used to calculate all chart-based measures beginning with data submitted in CY 2025. CMS would reimburse IPFs for the cost of submitting charts for validation at a rate of $3.00 per chart (consistent with the Hospital IQR Program).

Quality Measure Sampling Requirements: Generally, CMS applies its sampling procedures to chart-abstracted measures.[14] CMS outlines previously finalized sampling policies would not apply to (1) the Facility Commitment to Health Equity measure proposed in section V.D.2 (since it is a structural attestation measure); (2) the Screening for Social Drivers of Health measure (described in section V.D.3 of this proposed rule) since it would apply to all patients; (3) the Screen Positive Rate for Social Drivers of Health measure (described in section V.D.4 of this proposed rule) since it would apply to all patients who had been screened for health-related social needs (HRSNs); or (4) the COVID-19 Vaccination Coverage Among Healthcare Personnel measure because the denominator is all healthcare personnel.

The PIX survey measure (described in section V.D.5 of this proposed rule) is a patient-reported measure and would be eligible for sampling, but CMS is proposing not to include it in the global sample. Instead, CMS would require IPFs to develop sampling plans that ensure that IPFs are able to submit data for 300 completed PIX surveys per year. IPFs that are unable to reach 300 completed surveys through sampling would be required to submit data on survey results for all eligible patient discharges.

Non-measure data collection and DACA requirements: No changes are proposed to non-measure data collection policies or to accuracy and completeness acknowledgement (DACA) requirements.

J. Reconsideration and Appeals Procedures

No changes are proposed to the IPFQR Program's reconsideration and appeals procedures.

[14] IPFs can choose from options to sample quality measures: (1) Sampling and population requirements as specified by the appropriate measure steward; or (2) a uniform sampling methodology (that is, The Joint Commission/CMS Global Initial Patient Population methodology). See FY 2019 IPF PPS final rule (83 FR 38607 through 38608) for a discussion of previously finalized sampling policies.

K. Extraordinary Circumstances Exceptions (ECE) Policy

No changes are proposed, and CMS proposes to codify the ECE policies at 42 CFR §412.433(f), specifying that CMS may grant an exception to data submission deadlines and requirements in the event of extraordinary circumstances beyond the control of the IPF either in response to a request by the IPF or at CMS' discretion if CMS determines an extraordinary circumstance occurred.

V. Regulatory Impact Analysis

In the proposed rule, CMS estimates that payments to IPF providers for FY 2024 will increase by $55 million due to:

- $85 million for the market basket update to IPF rates ($90 million) net of total factor productivity ($5 million), and
- -$30 million due to outliers decreasing from 3.0 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 proposed rule, reproduced below, shows the estimated effects of the IPF PPS final rule policies by type of IPF using the December 2022 update of FY 2022 MedPAR claims data.

TABLE 39: FY 2024 IPF PPS Proposed Rule Payment Impacts
Percent Change

Facility by Type	Number of Facilities	Outlier	Wage Index FY24, LRS, and 5% Cap	Total Percent Change[1]
(1)	(2)	(3)	(4)	(5)
All Facilities	1,481	-1.0	0.0	1.9
Total Urban	1,209	-1.1	0.1	2.0
Urban unit	695	-1.6	0.2	1.6
Urban hospital	514	-0.5	0.0	2.5
Total Rural	272	-0.6	-0.8	1.5
Rural unit	211	-0.6	-0.8	1.6
Rural hospital	61	-0.7	-0.9	1.3
By Type of Ownership:				
Freestanding IPFs				
Urban Psychiatric Hospitals				
Government	117	-1.8	0.1	1.2
Non-Profit	98	-0.5	0.5	3.0
For-Profit	299	-0.3	-0.2	2.5
Rural Psychiatric Hospitals				
Government	31	-1.3	-0.6	1.1
Non-Profit	13	-2.4	-0.2	0.3
For-Profit	17	0.0	-1.3	1.6
IPF Units				

Facility by Type	Number of Facilities	Outlier	Wage Index FY24, LRS, and 5% Cap	Total Percent Change[1]
Urban				
Government	100	-2.9	0.6	0.6
Non-Profit	455	-1.5	0.4	1.9
For-Profit	140	-0.7	-0.6	1.6
Rural				
Government	51	-0.4	-0.7	1.9
Non-Profit	118	-0.7	-0.7	1.6
For-Profit	42	-0.4	-1.1	1.4
By Teaching Status:				
Non-teaching	1,283	-0.8	-0.2	2.0
Less than 10% interns and residents to beds	101	-1.8	0.9	2.1
10% to 30% interns and residents to beds	67	-2.4	0.4	1.0
More than 30% interns and residents to beds	30	-2.1	0.5	1.4
By Region:				
New England	105	-1.4	-0.7	0.9
Mid-Atlantic	204	-1.7	1.1	2.4
South Atlantic	228	-0.6	0.1	2.5
East North Central	243	-0.6	-0.3	2.1
East South Central	149	-0.7	-0.8	1.4
West North Central	105	-1.9	-0.3	0.7
West South Central	215	-0.6	-0.1	2.3
Mountain	106	-0.6	-0.9	1.4
Pacific	126	-1.3	0.4	2.1
By Bed Size:				
Psychiatric Hospitals				
Beds: 0-24	92	-0.8	-0.4	1.7
Beds: 25-49	84	-0.2	-0.8	2.1
Beds: 50-75	86	-0.1	-0.2	2.7
Beds: 76+	313	-0.6	0.1	2.5
Psychiatric Units				
Beds: 0-24	487	-1.1	-0.3	1.6
Beds: 25-49	241	-1.2	0.3	2.1
Beds: 50-75	106	-1.8	0.0	1.1
Beds: 76+	72	-2.2	0.7	1.5

[1] This column includes the impact of the updates in columns (3) through (4) above, and of the proposed IPF market basket update factor for FY 2024 (3.2 percent), reduced by 0.2 percentage point for the productivity