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

On March 31, 2022, the Centers for Medicare & Medicaid Services (CMS) released its proposed update to payment rates under the Inpatient Psychiatric Facilities (IPF) Prospective Payment System (PPS) for fiscal year (FY) 2023 (CMS-1769-P). The proposed rule was published in the April 4, 2022 *Federal Register* (87 FR 19415). IPFs include psychiatric hospitals and psychiatric units of acute care hospitals or critical access hospitals. The FY 2023 IPF PPS proposed rule describe updates to IPF rates and payment adjustments and the IPF Quality Reporting Program. **The public comment period on the proposed rule ends May 31, 2022.**

This proposed rule would also establish a permanent limit on decreases to the IPF wage index of 5 percent annually. There are also requests for information (RFI) on the results of the data analysis of the IPF PPS facility and patient level and adjustments as well as incorporating measures of health equity and disparities across CMS quality programs. The proposed changes in this rule would be effective for IPF discharges occurring during the Fiscal Year (FY) beginning October 1, 2022 through September 30, 2023 (FY 2023).

Tables summarizing the proposed FY 2023 IPF PPS payment rates and adjustments (Addendum A) are available at: Tools and Worksheets | CMS. CMS indicates the complete listing of proposed ICD-10 Clinical Modification (CM) and Procedure Coding System codes (ICD-10-CM/PCS) (Addendum B) is available at the same link but were they not there as of the release of this summary. The FY 2023 wage index tables are available at Wage Index | CMS.

TABLE OF CONTENTS

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 IPFS was put 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 involve 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 Proposed Rule

A. Market Basket Update

For FY 2023, CMS proposes to update the 2016-based IPF market basket to reflect projected price increases according to the IHS Global Inc.'s (IGI) 4th quarter 2021 forecast with historical data through the 3rd quarter of 2021. Using that forecast, the proposed IPF market basket for FY 2023 is 3.1 percent. Using data from the same period, CMS estimates an offset to the IPF market basket for total factor productivity of 0.4 percentage points[1]. Consequently, CMS proposes an IPF PPS update of 2.7 percent for FY 2023. For hospitals that do not successfully submit quality data under the IPFQR program, the update is reduced by 2.0 percentage points to 0.7 percent. CMS will update the proposed update with later data on the market basket and total factor productivity.

[1] The proposed rule indicates that the Bureau of Labor Statistics uses the term total factor productivity in place of multifactor productivity—the term previously used to denote the productivity offset.

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.[2] For FY 2023, CMS proposes a labor-related share of 77.4 percent, up from 77.2 for FY 2022.

C. FY 2023 Payment Rates

CMS determines the FY 2023 payment rates by applying the proposed update factor (2.7 percent), and the wage index budget neutrality adjustment (1.0016, as discussed in section II.E.3 below) to the final FY 2022 rates.

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

	Final FY 2022*	**Proposed FY 2023**
Federal per diem base rate	$832.94	$856.80
Labor share	*$643.03 (77.2%)*	*$663.16 (77.4%)*
Non-labor share	*$189.91 (22.8%)*	*$193.64 (22.6%)*
ECT payment per treatment	$358.60	$368.87
*Rates for IPFs that fail to meet the IPFQR Program requirements***		
Per diem base rate	$832.94	$840.11
Labor share	*$643.03 (77.2%)*	*$ 650.25 (77.4%)*
Non-labor share	*$189.91 (22.8%)*	*$ 189.86 (22.6%)*
ECT payment per treatment	$358.60	$361.69

*The FY 2022 amounts are taken from Addendum A to the FY 2022 IPF PPS final rule, available using the link at the beginning of this summary.
**Note that the FY 2023 rates for hospitals failing to meet the IPFQR Program requirements are calculated by multiplying the full rates for FY 2022 times the reduced update factor and wage index budget neutrality factor.

[2] 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.

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 proposes to continue the existing payment adjustments with some updates, described briefly here.

1. Update to MS-DRG Assignment

For FY 2023, 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, 2022, using the inpatient prospective payment system (IPPS) FY 2022 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 proposed rule had not been released. The existing mappings can be found at: FY 2022 IPPS Final Rule Home Page | CMS

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 proposes to remove 2 codes from the IPF Code First table and add 48 codes (see Addendum B, which is not yet available at the time of this summary).

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 and 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 is proposing:

- 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.

CMS will update the ICD-10-CM/PCS codes associated with the existing IPF PPS comorbidity categories, based upon the FY 2023 update to the ICD-10-CM/PCS code set. These updates will include the addition and deletion of codes to the above-described categories. The proposed FY 2023 comorbidity codes are shown in Addenda B, which is not yet available at the time of this summary.

CMS reviewed the FY 2023 ICD-10-CM codes to remove codes that were site "unspecified" where more specific codes are available so specify right or left side of the body. None of the additions to the FY 2022 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 not proposing any changes to the age adjustment factors for FY 2023. 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 2023, CMS is proposing 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.

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.)

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. OMB-designated Micropolitan Statistical Areas[3] are considered to be rural areas. 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, and to provide for a transition policy. 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.

Under the transition policy, a 5 percent cap limited the decrease in any IPF's wage index from FY 2020 to FY 2021. 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 proposes no cap on reductions to the wage index for FY 2022.

The proposed rule includes a lengthy discussion about when CMS has made changes to the wage index over a transitional period. Generally, CMS indicates that transitions are intended to balance between minimizing instability and significant negative payment impacts with payment accuracy that results from new labor market delineations or external factors beyond a provider's control (such as COVID-19). While CMS did not extend the 5 percent cap on reductions in the wage index adopted in FY 2021 to FY 2022, it proposes a permanent cap of 5 percent on reductions to the wage index for any reason. CMS believes providers generally experience fluctuations in the wage index annually of less than 5 percent. Thus, the proposed cap would

[3] OMB defines a Micropolitan Statistical Area as an area associated with at least one urban cluster that has a population of at least 10,000, but less than 50,000.

generally affect few hospitals and minimize the required budget neutrality adjustment while also addressing concerns about instability in payments from year to year.

CMS proposes that the 5 percent cap would apply regardless of the circumstances causing the decline. Under this 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 proposes 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.

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

Changes to the IPF PPS wage index are made budget neutral. CMS proposes a budget neutrality adjustment of 1.0017 associated with revisions the wage index and 0.9999 for the 5 percent cap reductions to the wage index. The net adjustment is 1.0016. To make this calculation, CMS estimates aggregate IPF PPS payments for FY 2022 and FY 2023 using FY 2019 hospital cost report data 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 proposed federal per diem base rate for FY 2023.

4. Teaching Adjustment

For FY 2023, CMS proposes 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).

5. Cost of Living Adjustment for Alaska and Hawaii

CMS is proposing to update the IPF PPS cost of living adjustment (COLA) factors for Alaska and Hawaii in FY 2023. The COLA is applied to the non-labor related share of the IPF standardized amounts. The new COLAs are shown below.

TABLE 2: Cost-of-Living Adjustment 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.

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 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' 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 public health emergency on 2020 utilization, CMS continued to use FY 2019 data to determine the FY 2022 IPF fixed loss threshold.

For FY 2023, CMS is returning to its historical practice of using the latest available data—in this case, FY 2021—to set the fixed loss threshold. Based on an analysis of the December 2021 update of FY 2021 IPF claims and the FY 2022 rate increases, CMS estimates that for FY 2022 IPF outlier payments 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 believes it is necessary to raise the fixed loss threshold to better target 2.0 percent IPF payments as outliers. For FY 2023, CMS proposes to increase the fixed loss threshold from $16,040 in FY 2022 to $24,270 in 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 equal to the 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 proposed national median and ceiling CCRs are:

National Median and Ceiling CCRs, FY 2022		
CCRs	**Rural**	**Urban**
National Median	0.5720	0.4200
National Ceiling	2.0472	1.7279

III. Comment Solicitation on IPF PPS Adjustments

A. Background

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.

B. Update and Comment Solicitation on Analysis of IPF PPS Adjustments

With these more recent data, CMS has undertaken further analysis of more IPF cost and claims information. CMS' contractor report analysis is available at: Technical Report: Medicare Program Inpatient Psychiatric Facilities Prospective Payment System: A Review of the Payment Adjustments (cms.gov). 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 requests 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;
- 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.

IV. Inpatient Psychiatric Facilities Quality Reporting (IPFQR) Program

CMS is not proposing any policy changes for the IPFQR Program for FY 2023 nor any changes to the program's measure set for FY 2023. (See section V.B. of this summary for a table of the measures.) CMS does solicit comments in response to an RFI concerning principles for measuring equity and healthcare quality disparities across the CMS quality enterprise, including the IPFQR Program.

A. Background

CMS established the IPFQR program beginning in FY 2014, as required under Section 1886(s)(4) of the Act as added by the Affordable Care Act. 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. 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. For FY 2022, based upon compliance with the IPFQR program requirements, 1,557 facilities successfully reported and received a full update while 17 failed to report successfully and received a 2.0 percentage point reduction. An additional 29 facilities chose not to participate and were subject to the 2.0 percentage point reduction.

B. IPFQR Program Measure Set for FY 2023

CMS is not proposing any additions, revisions, replacements, or removals be made to the previously finalized IPFQR program's measure set for FY 2023, published as Table 5 in the FY 2022 IPF PPS final rule (shown below, see 86 FR 42653).

IPFQR Program Measure Set for the 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	HBIPS-5	Patients 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
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. 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.

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

CMS notes that significant disparities in healthcare outcomes persist in the United States, especially for individuals belonging to underserved communities. The agency is committed to addressing persistent inequities through improving data collection to better measure and analyze disparities across its quality programs, policies, and measures. Already underway are

confidential reporting to acute care hospitals about readmissions stratified by dual eligibility status and reporting of stratified Health Effectiveness Data Information Set (HEDIS) measure performance data to Medicare Advantage (MA) plans using several demographic and social risk factor variables.

In this RFI, CMS describes key principles and approaches the agency will consider when addressing disparities through quality measure development and stratification. Topics for comment and supporting information provided are grouped around 5 key considerations and 2 potential measures. Highlights from the topics for comment and extensive supporting information provided by CMS are reviewed below; topics for comment appear in bold font. (See section V.A. of the preamble for the entire set of topics and complete background material.) For purposes of this RFI, CMS describes health equity "the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes".

- **Identification of Goals and Approaches for Measuring Healthcare Disparities and Using Measure Stratification Across CMS Quality Reporting Programs**
    - **Within- and between-provider disparity methods to present stratified IPF quality measure results**
    - **Decomposition approaches to explain possible causes of measure performance disparities**
    - **Alternative methods to identify disparities and the drivers of disparities**

CMS notes that the "within-provider" methodological approach to stratified reporting compares a measure's results between subgroups of patients treated by a single provider with or without a given demographic or social risk factor. The "between-provider" approach compares performance across providers on measures for subgroups who all have the factor of interest (e.g., compares providers to a national benchmark). CMS views the two methods as complementary for stratified data reporting.[4]

Another approach, regression decomposition, can facilitate analysis when an identified performance disparity may have multiple contributing factors, allowing estimation of the relative contributions of the factors.[5] CMS walks through a decomposition analysis of hypothetical IPF

[4] 2020 Disparity Methods Updates and Specifications Report, prepared for CMS by the Yale Center for Outcomes Research and Evaluation. Available at https://qualitynet.cms.gov/inpatient/measures/disparity-methods/resources#tab3.

[5] Rahimi E, Hashemi Nazari S. A detailed explanation and graphical representation of the Blinder-Oaxaca decomposition method with its application in health inequalities. Emerg Themes Epidemiol. (2021)18:12. https://doi.org/10.1186/s12982-021-00100-9.

data for the Medicare Spending Per Beneficiary Measure stratified by dual-eligible status, for the factors of health literacy level and Emergency Department service utilization (see section V.A.2.a. of the rule).

- **Guiding Principles for Selecting and Prioritizing Measures for Disparity Reporting**

  Measures to be prioritized could include
  - **Existing, validated, reliable, clinical quality measures for which application of disparities methods and stratified reporting are feasible**
  - **Measures related to treatment or outcomes for which some evidence of disparities has been shown**
  - **Measures for which predetermined standards for statistical reliability and representativeness (e.g., sample size) have been met prior to results reporting**
  - **Measures that offer meaningful, actionable, and valid feedback to providers**

- **Principles for Social Risk Factor and Demographic Data Selection and Use**
  - **Patient-reported data are the gold standard**
  - **Criteria for appropriate use of administrative data, area-based indicators (e.g., Area Deprivation Index) and imputed variables when patient-reported data are unavailable**
  - **Data collection and submission burden (time and costs) imposed on providers**

CMS notes the numerous and diverse demographic and social risk factor variables to be considered during disparities analysis (e.g., gender identity, social isolation). CMS reports early positive experience using the Medicare Bayesian Improved Surname Geocoding (MBISG) to impute missing values for race and ethnicity from administrative data, surname, and residence.[6]

- **Identification of Meaningful Performance Differences**

  Methods for detecting meaningful differences could include
  - **Statistical approaches for reliably grouping results (e.g., confidence intervals, clustering algorithm, cut points based on standard deviations)**
  - **Application of ranked ordering and percentiles to providers based on their disparity measure performances, for beneficiary use in decision making**

[6] Haas A., Elliott M.N., Dembosky J.W., et al. Imputation of race/ethnicity to enable measurement of HEDIS performance by race/ethnicity. *Health Serv Res*, 54(1):13-23. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6338295/pdf/HESR-54-13.pdf

    - **Categorizing different levels of provider performance by applying defined thresholds and fixed intervals to disparity measure results**
    - **National or state-level benchmarking (e.g., mean, median)**
    - **Criteria for when ranking performances is inappropriate (i.e., only measure results should be reported, no comparisons are made)**

CMS states an intention to standardize its analytic approaches wherever possible. However, the agency also states that approaches must be tailored to contextual variations at the program level. Input on the benefits and limitations of the above list of approaches is sought.

- **Guiding Principles for Reporting Disparity Measures**
    - **Confidential reporting to providers for new programs and/or new measures**
    - **Statutory requirements for public reporting**
    - **Special considerations for resource-limited settings (e.g., rural, underserved) to avoid unintended disadvantaging of critical-access providers**
    - **Report overall and stratified results synchronously for maximum value and impact**

CMS believes that varying approaches to results reporting may be useful for driving quality improvement in different contexts and settings. CMS emphasizes that overall improvement without resolution of disparities would be undesirable.

- **Potential Health Equity Measures for the IPFQR Program: Desirable Characteristics**
    - **Actionable for providers**
    - **Assist beneficiary decision making**
    - **Adhere to high scientific acceptability standards (e.g., reliability)**
    - **Avoid creating incentives to lower the quality of care**

Health Equity Summary Score[7]

CMS seeks input about adapting the Health Equity Summary Score (HESS) to the IPFQR Program. The HESS was developed by the CMS Office of Minority Health to assess care provided by MA plans to beneficiaries with social risk factors or high-risk demographics. It is a composite measure that includes multiple measures -- clinical and experience-of-care survey items[8] – and multiple at-risk groups.

---

[7] Agniel D., Martino S.C., Burkhart Q, et al. Incentivizing excellent care to at-risk groups with a health equity summary score. J Gen Intern Med, 2021; 36(7):1847-1857. https://link.springer.com/content/pdf/10.1007/s11606-019-05473-x.pdf.

[8] Clinical measures are from HEDIS (maintained by the National Committee for Quality Assurance); survey items are from the Consumer Assessment of Healthcare Providers and Systems (CAHPS, maintained by the Agency for Healthcare Research and Quality).

Hospital Commitment to Health Equity
CMS seeks input about adopting a structural measure for the IPFQR Program to assess engagement of hospital leadership in collecting health equity performance data. The measure – *Hospital Commitment to Health Equity* – combines attestations from 5 distinct domains of commitment: strategic plan for disparities reduction; demographic and social risk factor data collection; disparities analysis; quality improvement activities; and leadership involvement in reducing disparities. CMS included this measure on the 2021 Measures Under Consideration List; as such, it was reviewed by the NQF-convened Measure Application Partnership (MAP) and received conditional support for rulemaking.[9] CMS also solicits comments on additional relevant domains to capture, facility-level information collection to facilitate health equity measure scoring, and other potential IPFQR Program equity measures.

CMS concludes by stating that the agency will not be responding in the FY 2023 IPF PPS final rule to specific comments submitted about this RFI but that all input received will be considered during future policy development. Additions or changes to IPFQR Program requirements will be proposed through rulemaking.

V. Regulatory Impact Analysis

In the proposed rule, CMS estimates that payments to IPF providers for FY 2023 will increase by $50 million. This reflects a net increase of $90 million for the IPF update (+$105 million for the market basket less $15 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 proposed rule, reproduced below, shows the estimated effects of the IPF PPS final rule policies by type of IPF using the December update of FY 2021 MedPAR claims data.

[9] The MAP conditionally supported this measure, but prior to adoption in rulemaking recommended that: the measure be submitted for NQF endorsement; verification of the attestations should be required; and additional data be presented to evaluate its impact on quality of care (i.e., linking elements of the measure to clinical outcomes or process improvements). https://www.qualityforum.org/Publications/2022/03/MAP_2021-2022_Considerations_for_Implementing_Measures_Final_Report_-_Clinicians,_Hospitals,_and_PAC-LTC.aspx

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

Facility by Type	Number of Facilities	Outliers	Wage Index	Total Percent Change[1]
All Facilities	1,418	-1.2	0.0	1.5
Total Urban	1,148	-1.3	0.0	1.4
Urban unit	677	-1.9	0.0	0.7
Urban hospital	471	-0.4	0.1	2.4
Total Rural	270	-0.8	-0.2	1.7
Rural unit	213	-0.9	-0.2	1.6
Rural hospital	57	-0.4	-0.3	2.0
By Type of Ownership:				
Freestanding IPFs				
Urban Psychiatric Hospitals				
Government	119	-1.8	0.1	0.9
Non-Profit	88	-0.7	0.3	2.3
For-Profit	264	-0.1	0.0	2.7
Rural Psychiatric Hospitals				
Government	30	-0.7	-0.3	1.7
Non-Profit	12	-1.5	-0.1	1.1
For-Profit	15	-0.1	-0.3	2.3
IPF Units				
Urban				
Government	92	-2.4	0.0	0.3
Non-Profit	450	-2.2	-0.1	0.4
For-Profit	135	-1.0	0.1	1.8
Rural				
Government	48	-0.8	0.0	1.9
Non-Profit	123	-0.9	-0.2	1.5
For-Profit	42	-1.0	-0.2	1.4
By Teaching Status:				
Non-teaching	1,234	-0.9	0.1	1.8
Less than 10% interns and residents to beds	99	-1.6	-0.2	0.8
10% to 30% interns and residents to beds	61	-2.9	-0.4	-0.7
More than 30% interns and residents to beds	24	-3.7	0.2	-0.9
By Region:				
New England	102	-1.8	-0.5	0.4
Mid-Atlantic	181	-1.6	-0.1	1.0
South Atlantic	219	-0.7	-0.1	1.9
East North Central	233	-1.0	-0.2	1.4
East South Central	143	-1.0	-0.3	1.4
West North Central	102	-1.7	-0.3	0.7

Facility by Type	Number of Facilities	Outliers	Wage Index	Total Percent Change[1]
West South Central	211	-0.5	0.3	2.5
Mountain	99	-0.7	0.1	2.0
Pacific	128	-1.7	0.9	1.8
By Bed Size:				
Psychiatric Hospitals				
Beds: 0-24	82	-0.5	0.2	2.4
Beds: 25-49	73	-0.1	0.1	2.7
Beds: 50-75	78	-0.1	-0.1	2.5
Beds: 76 +	295	-0.5	0.1	2.2
Psychiatric Units				
Beds: 0-24	486	-1.5	0.0	1.2
Beds: 25-49	240	-1.7	-0.1	0.9
Beds: 50-75	100	-2.2	-0.1	0.3
Beds: 76 +	64	-2.1	-0.1	0.5

[1] This column includes the impact of the updates in columns (3) through (5) above, and of the proposed IPF market basket update factor for FY 2023 (3.1 percent), reduced by 0.4 percentage point for the proposed productivity adjustment as required by section 1886(s)(2)(A)(i) of the Act.