Medicare Program; Fiscal Year 2024 Inpatient Psychiatric Facilities Prospective Payment System Rate Update Final Rule Summary

The Centers for Medicare & Medicaid Services released the fiscal year (FY) 2024 Inpatient Psychiatric Facilities (IPF) Prospective Payment System (PPS) final rule (CMS-1783-F) on July 27, 2023, which will be published in the *Federal Register* on August 2, 2023. IPFs include psychiatric hospitals and psychiatric units of acute care hospitals or critical access hospitals. The FY 2024 IPF PPS final rule describes updates to IPF rates and payment adjustments and the IPF Quality Reporting Program.

This final rule rebases and revises the IPF PPS market basket to reflect a 2021 base year and makes other changes affecting IPF PPS rates. The final IPF payment rate update for FY 2024 is 3.3 percent compared to 3.0 percent estimate for proposed rule. This rule also finalizes a proposal to make it easier for hospitals to open new excluded psychiatric units paid under the IPF PPS.

These changes 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.

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

CMS continues to use payment adjustment factors for the IPF PPS that were established in 2005 and derived from a regression analysis of the FY 2002 Medicare Provider and Analysis Review (MedPAR) data file (69 FR 66935-66936). The patient-level adjustments address age, Medicare Severity Diagnosis-Related Group (MS-DRG) assignment, and comorbidities; higher per diem costs at the beginning of a patient's stay; and lower costs for later days of the stay.

Facility-level adjustments are for the area wage index, rural location, teaching status, a cost-of-living adjustment for IPFs located in Alaska and Hawaii, and an adjustment for the presence of a qualifying emergency department (ED).

In order to bill for ECT services, IPFs must include a valid procedure code. CMS did not propose any changes to the ECT procedure codes as a result of the update to the ICD-10-PCS code set for FY 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 rebasing and revising the 2016-based IPF market basket[1] 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

[1] CMS uses the term "market basket" (which generally means the mix of goods and services used in providing health care at a given point in time) for purposes of this rule to mean an input price index.

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 rule details the methodology used to rebase the market basket, as proposed, 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)—publicly available at: https://www.bea.gov/industry/input-output-accounts-data.

Table 4, reproduced below, compares the finalized 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	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

Cost Category	2021-based IPF Market Basket Cost Weight	2016-based IPF Market Basket Cost Weight
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
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**

Note: Detail may not add to total due to rounding.

Having received no comments, CMS finalizes its proposal to use the same price proxies in calculating the 2021-based market basket as used in calculating the 2016-based market basket.

Table 14, reproduced below, compares the percent change in the 2021-based and 2016-based IPF market baskets over time. While there are small differences in a few years, there is no difference on average (over 4 years) in the current or rebased IPF PPS market historically. While the proposed rule's forecasted numbers showed a 0.2 percentage point difference for the 4-year average (2023-2026), the more recent projections show no differences.

Table 14: Comparison of Proposed 2021 to 2016-Based IPF 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	4.8	4.8
	FY 2024	3.5	3.5
	FY 2025	3.0	3.0
	FY 2026	2.9	2.9
	Average 2023-2026	**3.6**	**3.6**

Note: These market basket percent changes do not include any further adjustments as may be statutorily required.
Source: IHS Global Inc. 2nd quarter 2023 forecast.

Selected Comment/Response: Several commenters supported rebasing and revising the market basket based on more recent data. A couple others suggested waiting another year or two (for data from FY 2022 or 2023) to reflect less of an impact from the COVID-19 Public Health Emergency (PHE). CMS notes that in last year's proposed rule, many commenters called for updating the IPF market basket due to how costs had changed due to the PHE. Because CMS regularly rebases (every 4 to 5 years), it will use the most recent data available for this rebasing

(2021 cost report data). CMS notes that the 2021-based IPF market basket reflects the higher compensation cost weight as a result of an increase in the contract labor cost weight, relative to 2016, consistent with commenters' observations in response to the FY 2023 IPF proposed rule (87 FR 46849).

2. Market Basket Less Total Factor Productivity

For FY 2024, CMS had proposed an inflation update of 3.2 percent less 0.2 percentage points for total factor productivity, or 3.0 percent, based on IHS Global Inc.'s 4th quarter 2022 forecast with historical data through the 3rd quarter of 2022. Total factor productivity is based on a rolling 10-year average in economy-wide productivity.

CMS finalizes an inflation update of 3.5 percent less 0.2 percentage points for total factor productivity, or 3.3 percent, based on more recent data—that is, IHS Global Inc.'s 2nd quarter 2023 forecast with historical data through the 1st quarter of 2023.

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. For these IPFs, their FY 2024 payment rate update will be 1.3 percent (with other adjustments applied, as described below).

Selected Comment/Response: Several commenters expressed concern about the productivity adjustment, given the PHE's "unimaginable impacts" on hospital productivity. Some commenters noted that CMS' Office of the Actuary (OACT) had indicated—even before the PHE—that hospital productivity will be less than economy-wide productivity and thus request CMS to work with Congress to eliminate the adjustment. The agency responds noting that, under the statute, it must adjust the IPF market basket for economy-wide productivity..

Commenters said that CMS has underestimated the IPF market basket increase for several years and should utilize its exceptions and adjustments authority to adjust payments prospectively for the understatement of market basket from FYs 2021 through 2023. CMS responds that IPF market basket updates are set prospectively, based on a mix of historical and projected data and can either overestimate or underestimate the actual rate of increase based on later information. CMS analyzed market basket increases from 2012 through 2020 and disagrees with the commenters' assertion that market baskets have underestimated IPFs cost increases. For each of those years, the agency found that the forecasted market basket updates for IPFs were higher than the actual market basket updates.

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, as finalized in this rule.[2] For FY 2024, CMS is finalizing a total labor-related share of 78.7

[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 2021) and FY 2024.

percent—that is, 75.6 percent for the operating costs plus 3.1 percent for the labor-related share of Capital-Related costs. CMS says the FY 2024 labor-related share using the 2021-based IPF market basket is about 1.0 percentage point higher than the FY 2023 labor-related share using the 2016-based IPF market basket, primarily due to the incorporation of the 2021 Medicare cost report data, which increased the Compensation cost weight by 0.9 percentage points compared to the 2016-based IPF market basket. 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 FY 2024 and FY 2023 IPF Labor-Related Shares (LRS)

	FY 2024 Labor-related Share based on 2021-based IPF Market Basket[1]	FY 2023 Labor-related Share based on 2016-based IPF Market Basket[2]
Wages and Salaries	53.4	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	1.5	1.5
Subtotal	**75.6**	**74.4**
Labor-related portion of capital (46%)	3.1	3.0
Total LRS	**78.7**	**77.4**

1. IHS Global Inc. 2nd quarter 2023 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.

Selected Response/Comment: One commenter objected to CMS' policy of excluding non-medical professional services fees from the labor-related share. CMS asserted that these services are purchased on a national market, but the commenter believes they are not so unique they could only be provided by regional or national firms. Similar comments were made about CMS' decision to exclude home office costs from the labor related share of the wage index.

CMS' response agrees with the commenters that these professional services can be provided in a local or national market but indicated there is no reason to believe the wage rates for these services will vary by locality. Further, CMS' allocation of approximately 64 percent of the professional fees cost weight allocated to the labor-related share will reflect that the majority portion of these services are purchased in a local labor market. Similarly, CMS' analysis of hospital cost reports shows that approximately 46 percent of home office costs are in the local labor market while the remainder occur outside of the labor market area where the hospital is located.

B. Update to the FY 2024 IPF Payment Rates

CMS determines the FY 2024 payment rates by applying the finalized update factor of 3.3 percent (1.033) and the wage index budget neutrality adjustment (1.0016, 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 reduced update factor of 1.3 percent (1.013) and the wage index budget neutrality adjustment (1.0016) 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 FY 2024.

	FY 2023	**FY 2024**
Federal per diem base rate	$865.63	$895.63
Labor share	*$670.00 (77.4%)*	*$704.86 (78.7%)*
Non-labor share	*$195.63 (22.6%)*	*$190.77 (21.3%)*
ECT payment per treatment	$372.67	$385.58
Rates for IPFs that fail to meet the IPFQR Program requirements		
Per diem base rate	$848.95	$878.29
Labor share	*$657.09 (77.4%)*	*$691.21 (78.7%)*
Non-labor share	*$191.86 (22.6%)*	*$187.08 (21.3%)*
ECT payment per treatment	$365.49	$378.12

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 finalizes continuing the existing payment adjustments.

1. Update to MS-DRG Assignment

For FY 2024, CMS finalizes continuing the existing payment adjustment for psychiatric diagnoses that group to one of the existing 17 IPF MS-DRGs listed in Addendum A of the rule. 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 final rule had not been released. However, the relevant tables will be found at: https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps. In the list of items on the left-hand side of the page, scroll down to FY 2024 IPPS final 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 did not propose any changes to the Code First table. Addendum B of the rule 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 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 2024, CMS finalizes its proposal, on which it received no comments, to add two ICD-10-CM/PCS codes and remove one ICD-10-CM/PCS code from the Chronic Renal Failure category. Consistent with its longstanding practice and with §412.428(e), CMS is also adopting the following latest ICD-10-CM codes for October 2023, as described in this final rule:

- Adding 2 ICD-10-CM codes to the Chronic Obstructive Pulmonary Disease category, 1 to the Infectious Disease category, 4 to the Poisoning category, and 6 for the Oncology *Treatment* Procedure category.
- For the Oncology Treatment *Diagnosis* Category, adding 12 codes and deleting 2.
- For the Acute Renal Failure Category, adding 1 and deleting 1.

The finalized 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" and thus are not being removed.

3. Age Adjustment

The current payment adjustments for age range from 1.00 for patients under age 45 to 1.17 for patients age 80 and older. CMS is finalizing its proposal 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 finalizing its proposal 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 proposed to use the FY 2024 pre-floor, pre-reclassified IPPS hospital wage index for the FY 2024 IPF wage index, which it is finalizing. CMS reiterates that it will apply the IPF wage index adjustment to the labor-related share of the national base rate and ECT payment per treatment such that, as described earlier, the labor-related share of the national rate and ECT payment per treatment will change from 77.4 percent in FY 2023 to 78.7 percent in FY 2024, reflecting the labor-related share of the 2021-based IPF market basket for FY 2024.

Selected Response/Comment: There were several comments that CMS indicated were out-of-scope related to applying the post-reclassified post-rural floor wage index. Another comment indicated that a closed IPPS hospital's wages were aberrantly low for the area and CMS should use the wage index for the nearest area as a substitute so that the IPF wage index for this area is not below what it should otherwise receive.

CMS disagreed, indicating that it is following the longstanding methodology for calculating the wage index. Wage data from the period during which the hospital was open would be comparable to wage data from the same period for hospitals located in other geographic areas. These data would provide an appropriate relative measure of the value of labor in that CBSA's labor market area compared to others. CMS' response indicates that there is only one urban labor market area with no IPPS hospitals in the nation but that area has no IPFs. While that statement is accurate as of the drafting of the proposed rule, there will be an IPF opening in this area that will be affected by a potentially aberrantly low wage index for four years until the closed IPPS hospital's wage data is no longer used for the area wage index.

2. Adjustment for Rural Location

CMS finalizes its proposal 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 finalizes the FY 2024 IPF wage index budget neutrality adjustment, based on estimated 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 proposed a budget neutrality adjustment of 1.0011 associated with revisions the wage index. The final adjustment, based on more recent data, is 1.0016.

4. Teaching Adjustment

For FY 2024, CMS finalizes its proposal 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 finalizes applying 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, reproduced from Table 16 of the final rule.

TABLE 16: 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 proposed no 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 finalizes as proposed to continue to set the fixed loss threshold amount so that outlier payments account for 2 percent of total payments made under the IPF PPS. CMS' 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 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 proposed to increase the fixed loss threshold from $24,630 in FY 2023 to $34,750 in FY 2024. CMS is finalizing the outlier fixed dollar loss threshold amount at $33,470 for FY 2024, based on the latest available data.

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 thus did not propose the same exclusionary criterion but requested comment.

Selected Response/Comment: CMS received 5 comments, including from state-level and national provider associations. One stated that the increase in the outlier threshold amount should be limited to no more than the market basket update for the year but did not provide a rationale. Two commenters recommended CMS mitigate the financial impact that imperfect outlier threshold estimates have on IPFs. Four requested that CMS explain in greater detail the factors driving the increase and that CMS examine its methodology and consider making changes to mitigate increases to the outlier threshold. Commenters also requested information on how the proposed increase would affect the IPF field and its patients.

While CMS did not finalize any alternative methodologies that commenters suggested, the preamble of the final rule provides additional information about the drivers and impact of the increase to the outlier threshold, as commenters requested.

2. Update to IPF Cost-to-Charge Ratio Ceilings

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. Based on the CCRs entered in the latest available IPF PPS PSF, the finalized FY 2024 final national median and ceiling CCRs are:

National Median and Ceiling CCRs, FY 2024		
CCRs	**Rural**	**Urban**
National Median	0.5720	0.4200
National Ceiling	2.1419	1.8026

3. Modification to the Regulation for Excluded Psychiatric Units Paid Under the IPF PPS

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.

These policies were implemented before the establishment of the IPF PPS and the IRF PPS and were established to address the administrative complexity associated with cost-based reimbursement for excluded IPF and IRF units. Stakeholders 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. Cost allocation is no longer used for payment purposes because IPF units are paid under the IPF PPS and IRF units are paid under the IRF PPS. CMS concludes that the restriction limiting 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, CMS finalizes its proposal to establish a uniform rule for status changes for IPF units (at §412.25(c)) which would permit the status of an IPF unit to be changed from not excluded to excluded (or excluded to not excluded) at any time during a cost reporting period. The hospital must 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 must maintain the information needed to accurately determine costs that are or are not attributable to the IPF unit. Additionally, any change in the status of an 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.

Noting that §412.25(c) applies to both IPFs and IRFs, CMS finalizes its proposal to make the same change for IRFs in the IRF PPS final rule. Based on stakeholder feedback, CMS adopts a consolidated regulation text that applies to both IPF and IRF units, which is displayed in the IPF PPS final rule. CMS does not anticipate any financial impact for this modification to its regulations.

III. RFI to Inform Revisions to the IPF PPS Required by the Consolidated Appropriations Act, 2023 (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 rule reviews the information already collected by CMS, including the type of data specified by section 1886(s)(5)(B) of the Act. In the proposed rule, CMS sought 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 this final rule, CMS again requests this information.

In addition, CMS would expect the nature of IPF services to result in 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 requested 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 sought 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.

D. Public Comments

CMS received 15 comments in response to the FY 2024 IPF PPS proposed rule pertaining to existing and future data collection to inform revisions to the IPF PPS as required by the CAA, 2023, with various suggestions of patient characteristics and factors for consideration. Commenters included the Medicare Payment Advisory Commission (MedPAC), state-level and national provider and patient advocacy organizations, and health systems. CMS did not respond to comments, except to thank commenters and to say it will consider the comments to potentially inform future rulemaking.

IV. Inpatient Psychiatric Facilities Quality Reporting (IPFQR) Program

CMS finalizes its proposals to:

- Adopt the Facility Commitment to Health Equity measure beginning with the FY 2026 payment determination;
- Adopt both the Screening for Social Drivers of Health measure and 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;
- Adopt the Psychiatric Inpatient Experience (PIX) survey beginning with voluntary reporting of CY 2025 data and beginning with required reporting of CY 2026 data for the FY 2028 payment determination;
- Modify the COVID-19 Vaccination Coverage Among Health Care Personnel (HCP) measure beginning with fourth quarter CY 2023 data for FY 2025 payment determination;
- Remove the Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification (HBIPS-5) measure and the Tobacco Use Brief Intervention Provided or Offered and Tobacco Use Brief Intervention Provided (TOB-2/2a) measure beginning with the FY 2025 payment determination year;
- Adopt a data validation pilot program beginning with data submitted in 2025; and
- Codify procedural requirements related to statutory authority, participation and withdrawal, data submission, quality measure retention and removal, extraordinary circumstances exceptions, and public reporting requirements.

The overall economic impact of the IPFQR Program updates in the final rule is an annual decrease of 380,897 hours in information collection burden resulting in a savings of about $8.2 million. This overall economic impact reflects an estimated decrease of 505,246 hours of facility burden associated with data collection and submission resulting in a savings of about

$10,725,750, and an estimated annual increase in survey burden for patients of 124,349 hours and about $2,575,000.[3]

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.

CMS finalizes its proposal to codify the IPFQR Program requirements for IPF reporting on quality measures at a new §412.433.

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 20 of the final rule and shown in the table under section G below.

D. Measure Adoption

In selecting quality measures, CMS describes the objectives of balancing the need for information to improve quality and value and to provide patients and providers with better decision-making tools, 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.

[3] See Tables 37, 38, and 39 of the rule.

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 the consensus-based entity (CBE). 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. Adoption of the Facility Commitment to Health Equity Measure

CMS finalizes its proposal to adopt an attestation-based structural measure, the Facility Commitment to Health Equity, to address health equity beginning with the CY 2024 reporting period (data submitted in CY 2025) for the 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 will 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 VI.D.2.b. of the final rule.

Measure calculation.

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

The measure is not CBE-endorsed.

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. Attestation for this measure will begin in 2025, reflecting the 2024 reporting period and affecting the FY 2026 payment determination.

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

Selected Comments and Responses. Many commenters supported adoption of this measure. Some commenters recommended testing specific to the IPF setting. Acknowledging that the measure was initially adopted for the acute care setting, CMS believes it is equally applicable to IPFs and will monitor measure implementation and data reporting as part of standard program

and measure review. Many commenters were concerned the measure is not CBE endorsed, but CMS points to the importance of the measure and that there are no CBE-endorsed measures on this topic. Many commenters recommended CMS ensure that the results are publicly reported in a meaningful and understandable way, and the agency responded that it intends to provide educational materials to promote understanding of the publicly reported data. Concern was raised that some IPFs do not have access to certified EHR technology, which will prevent them from reporting on one of the domains of the measure. CMS responds that the IPFQR program is not a pay-for-performance program and therefore IPFs that do not have such technology can attest they satisfy the other domains, receive a score of 0-4 out of 5 and will not be penalized with any payment reduction.

3. Adoption of the Screening for Social Drivers of Health Measure

CMS finalizes its proposal to adopt the Screening for Social Drivers of Health measure beginning with voluntary reporting of CY 2024 data followed by mandatory reporting beginning with CY 2025 data/FY 2027 payment determination.

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[4] 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.[5] CMS notes the two 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 Screening for Social Drivers of Health measure was added to the Merit-based Incentive Payment System (MIPS) Program.[6]

The Screening for Social Drivers of Health measure (alongside the Screen Positive Rate for Social Drivers of Health measure described in section VI.D.4 of the final rule) will be the first measurements of social drivers of health in the IPFQR Program.

Measure Description. 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). The measure is 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.

[4] The 5 domains are described in detail in Table 18 of the final rule.
[5] FY 2023 IPPS/LTCH PPS final rule (87 FR 49191 through 49220).
[6] 87 FR 70054 through 70055.

- *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.

The measure is not CBE-endorsed.[7]

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

IPFs will have flexibility with selecting the tool to screen for the 5 HRSNs. Potential sources of data include electronic clinical data, standardized patient assessments, administrative claims data, and patient-reported data, and CMS encourages IPFs to use digital standardized screening tools.[8]

Burden assessment. CMS estimates that during the 2025 reporting period, the annual burden for facility information collection will be a total annual time of 133 hours and total annual cost of $5,966 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 $5,978 for all IPFs.

Selected Comments and Responses. Many commenters supported adoption of the measure. Some commenters recommended additional testing specific to the IPF setting. CMS responded that given the urgency of addressing HRSNs and since there are no other measures that address this topic, it is important to implement the measure as soon as feasible. It also believes that the measure is equally applicable to the IPF setting as it is to the general acute care settings in which it was initially developed. Several commenters recommended changes to the measure specifications, particularly with respect to screening for risk of interpersonal violence. CMS responds that the HRSNs were selected based on evidence from the AHC Model and TEP, and it believes IPFs must screen for all domains under the measure. The agency notes that patients should be reminded they may opt out of screening for any reason and that since information provided by patients would be protected health information under HIPAA, IPFs are responsible for adopting safeguards.

[7] The exception under section 1886(s)(4)(D)(ii) of the Act allows the Secretary to select non-CBE-endorsed measures when the Secretary is unable to identify a suitable CBE-endorsed measure that is available, feasible, and practical.

[8] CMS references the Social Interventions Research and Evaluation Network (SIREN) website for additional information on resources.

4. Adoption of the Screen Positive Rate for Social Drivers of Health Measure

CMS finalizes its proposal to adopt the Screen Positive Rate for Social Drivers of Health measure beginning with voluntary reporting of CY 2024 data, followed by required reporting beginning with CY 2025 data/FY 2027 payment determination.

This process measure is a companion measure to the Screening for Social Drivers of Health measure (finalized for adoption in section VI.D.3. of the final rule). While the Screening for Social Drivers of Health measure enables identification of individuals with HRSNs, the Screen Positive Rate for Social Drivers of Health measure captures the extent of such needs and estimates the impact of individual-level HRSNs on healthcare utilization. The Hospital IQR Program adopted this measure in the FY 2023 IPPS/LTCH PPS final rule.[9]

The Screen Positive Rate for Social Drivers of Health provides 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. A separate rate is calculated for each screening domain, so that five rates are calculated by each IPF for screen-positive patients divided by screened patients.

- *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 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*s. 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.

The measure is not CBE-endorsed.

Data Collection, Submission, and Reporting. There will be 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. This is an aggregate measure, meaning that IPFs will 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 measures 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 for all IPFs, and that during the 2026 reporting period the annual burden for facility information collection would be a total of an additional (i.e., the incremental increase above the burden amounts for 2025) of 133 hours and total cost of $5,978 for all IPFs.

[9] 87 FR 49215 through 49220.

Selected Comments and Responses. Many commenters supported adoption of the measure. Some concern was expressed that publicly reporting these data may lead to inaccurate perceptions of the quality of care at IPFs that treat high volumes of patients who screen positive for HRSNs. CMS responds that the measure is not intended to compare IPFs, but is for informing IPFs of the level of unmet need among their patients. Several commenters suggested outcome measures related to the HRSNs be developed and adopted, and CMS noted the SDOH measures finalized in the rule are a first step.

5. Adoption of the Psychiatric Inpatient Experience (PIX) Survey

CMS finalizes its proposal to adopt the PIX survey measure beginning with voluntary reporting of CY 2025 data and required reporting beginning with CY 2026 data/FY 2028 payment determination.

The PIX survey is an anonymous survey that contains 23 items in 4 domains and is to 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.[10]

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 will be reported as five separate rates (one for each of the 4 domains) and one overall rate. CMS will report the mean rates for each domain, as well as the overall mean rate, on the Care Compare website. The mean score is 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."

The measure is not CBE-endorsed.

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

IPFs will collect the data similar to collection of data for chart-abstracted measures or other patient screening measures, and will report to CMS, as described in section VI.I.4 of the rule. IPFs will need to have in place sample plans that ensure they are able to submit data for 300 completed surveys per year.

[10] 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.

Burden Assessment.

- CMS estimates that during the voluntary reporting period, patient survey burden associated with conducting the PIX survey in CY 2025 will be 28,967 hours at a cost of $599,915. CMS estimates in CY 2026 the increase in annual burden for surveying will be about the same as in CY 2025.
- CMS estimates for the reporting period in 2026 facility information collection burden associated with this measure will 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, the increase in annual facility information collection burden will be about the same as in 2026.

Selected Comments and Responses. Many commenters expressed strong support for the survey measure, stating that the measure addresses a measure gap in the IPFQR, was informed by input from individuals with experience in the IPF setting, and acknowledges the importance of patients' experiences. Some commenters raised concerns about the survey being administered 24 hours prior to discharge, giving reasons such as the patient not feeling secure to give honest answers and uncertainty of the discharge time. CMS clarifies that the survey is to be administered beginning 24 hours before discharge so an IPF could permit a patient to mail-back the survey after discharge and could use a vendor to receive paper surveys and report data to CMS on the IPF's behalf, but cautions that relying exclusively on a mail-back option may prevent the IPF from meeting the minimum sampling requirements. Many commenters raised concerns about the burden of transitioning to the PIX survey since they already use other experience of care survey instruments. CMS responds that it considered allowing IPFs to use their own collection instruments, but believe using a single, standardized instrument will better allow for comparability of experience data, and that the PIX survey specifically was developed for the IPF setting with input from patients and their caregivers. Many commenters recommended the survey be administered by a peer or advocate. CMS responded that peer advocates could assist with administering the survey with minimal training and that the measure developer is developing guidelines for survey administration. Several commenters expressed concern regarding the exclusion of patients who are not able to complete the survey because of cognitive or intellectual limitations. CMS responds that all patients must have an opportunity to participate in the survey, that patients who are unable to complete the survey on the basis of disability must be offered reasonable modifications, and that the measure developer is developing guidelines for best practices in survey administration to enhance accessibility of the survey.

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

CMS finalizes its proposal to adopt the modified HCP COVID-19 Vaccine measure beginning with the quarter 4 of the CY 2023 reporting period/FY 2025 payment determination.

Background. The COVID-19 Vaccination Coverage among HCP measure was adopted into the IPFQR measure set in the FY 2022 IPF PPS final rule[11] (and has been adopted in multiple other quality reporting programs, including the Hospital IQR Program). The non-risk-adjusted

[11] 86 FR 42633 through 42650.

process measure was developed by the CDC and 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).

Description of Modified Measure. The modified measure updates the measure specifications to reflect the most current guidance to receive primary series and booster vaccine doses in a timely manner. The modifications:

- 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.

The measure is calculated as follows:

- Numerator: The number of HCP in the denominator population who are considered up to date[12] 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.[13] There are no proposed changes to the denominator from that of the current version of the measure.

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 the CBE on July 26, 2022 (CBE #3636). The CDC is pursuing CBE endorsement for the modified version of the measure.

Data Collection, Submission, and Reporting.

- IPFs will collect data at least once a week each month for each of the 3 months in a quarter, and submit the data to the CDC's National Health Safety Network (NHSN) Healthcare Personnel Safety (HPS) Component before the quarterly deadline. For FY 2025 payment determination, IPFs will collect this data during each month of the 4th quarter of the 2023 reporting period. Beginning with the FY 2026 payment determination, IPFs would be required to submit data for the entire calendar year.
- Each quarter, the CDC will 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.
- Public reporting will begin with the October 2024 Care Compare refresh or as soon as technically feasible.

[12] 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 are considered up to date for the Q2 of the CY 2023 surveillance period if the individual received an updated bivalent booster dose or completed their primary series less than 2 months ago.

[13] IPFs also report a fourth category of HCP, "Other Contract Personnel" to the NHSN, but that category is not included in the measure denominator.

Selected Comments and Responses. Several commenters were not supportive of adoption of the modified measure because the COVID-19 PHE has expired and the conditions of participation (COPs) for hospitals no longer require reporting these data. However, CMS clarifies that the COPs for hospitals and the end of the COVID-19 PHE declaration are distinct from the IPFQR reporting requirements. The agency believes this measure is consistent with its approach for other infectious disease prevention (such as for influenza) and that the public health response to protect individuals from COVID-19 continues and is not fully dependent on the PHE declaration. Many commenters did not support the updated measure because of burden associated with the frequency of changes to the CDC's definition of up-to-date. The agency believes the need to update the measure and the definition is necessary as new evidence on COVID-19 arises. In response to comments that recommend reducing the frequency of reporting to quarterly or annually, the agency said that if the COVID-19 vaccination strategy becomes seasonal it intends in future rulemaking to use a similar approach as for the Influenza Vaccination Among HCP measure.

F. Removal or Retention of IPFQR Measures

1. Background.

CMS finalizes its proposal to codify its removal and retention policies at 42 CFR §412.433(e).

The following are the 8 removal 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.

2. Removal of the Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification (HBIPS-5) (previously endorsed under CBE #0560) Measure

CMS finalizes its proposal to remove HBIPS-5 measure beginning with the FY 2025 payment determination.

Basis for Removal. The basis for the measure's removal is 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."[14] 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 CBE endorsement in 2019 due to lack of support by the measure developer (The Joint Commission).

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

3. Removal of the Tobacco Use Brief Intervention Provided or Offered and Tobacco Use Brief Intervention (TOB-2/2a)

CMS finalizes its proposal to remove the TOB-2/2a measure beginning with the FY 2025 payment determination.

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 the stated 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, it is believed that 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, there is more opportunity for improvement on the TOB-3/3a measure, meaning retaining the

[14] https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2020.177901.

TOB-3/3a measure instead of the TOB2/2a measure provides more opportunity to encourage improvement among IPFs.[15]

Basis for Removal. Removal is based on factor 8 - 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 CBE-endorsed due to lack of support by the measure developer (The Joint Commission).

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.

G. Summary of IPFQR Program Measures

No changes were proposed to the 14 measures in the measure set for FY 2024 payment determination. As described above, CMS is finalizing the removal of two measures and modification of one measure beginning for FY 2025 payment determination (resulting in a measure set containing 12 measures). As described, CMS is finalizing the addition of one required measure and two voluntary measures beginning for FY 2026 payment determination (resulting in a measure set containing 13 required measures). Beginning for FY 2027 determination, CMS is finalizing requiring the two FY 2026 voluntary measures and adding one voluntary measure (resulting in a measure set of 15 required measures); and beginning for FY 2028 determination, CMS is finalizing requiring the FY 2027 voluntary measure (resulting in a measure set of 16 required measures).

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

(Combining Tables 20 through 24 in the Final 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 –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 –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

[15] See Table 19 in the final rule for a comparison of national performance on the 2 measures from 2017 to 2021.

CBE #	Measure ID	Measure
n/a*	n/a	Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
n/a	n/a	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)[16]	*n/a*	*COVID-19 Healthcare Personnel (HCP) Vaccination Measure – Modifications beginning for FY 2025 payment determination*
n/a	*Facility Commitment*	*Facility Commitment to Health Equity – Adoption beginning for FY 2026 payment determination*
n/a	*Screening for SDOH*	*Screening for Social Drivers of Health – 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 – Voluntary reporting for FY 2026 payment determination and required beginning for FY 2027 payment determination*
n/a	*PIX*	*Psychiatric Inpatient Experience Survey – Voluntary reporting for FY 2027 payment determination and required beginning for FY 2028 payment determination*

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

H. Public Display and Review Requirements

CMS finalizes its proposal to codify at §412.433(g) its procedural requirements for public reporting, 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.[17]

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

Codification of procedural requirements. CMS finalizes its proposal to codify at 42 CFR §412.433(b) through (d) its procedural requirements 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. All references to "QualityNet" are replaced with references to "CMS-designated information system".

Modified HCP Measure. No changes were 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.

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

[17] Section 1886(s)(4)(E) of the Act requires that the Secretary 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.

Screening for Social Drivers of Health measure and Screen Positive Rate for Social Drivers of Health measure. CMS finalizes its proposal to apply 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) 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 IPFQR Program and required reporting beginning for the FY 2027 IPFQR Program's payment determination.

Psychiatric Inpatient Experience (PIX) measure. CMS finalizes its proposal that for voluntary reporting in the FY 2027 program year and required reporting beginning with the FY 2028 payment determination facilities are to report the data on the PIX survey measure using the patient-level data reporting described in the FY 2022 IPF PPS final rule (86 FR 42658 through 42661).

Data Validation Pilot. CMS finalizes its proposal for a voluntary data validation pilot beginning with data submitted in 2025. The pilot is based on the agency's review of validation policies of other pay-for-reporting quality programs. Under the pilot, CMS will randomly select on an annual basis up to 100 IPFs and request each selected IPF to provide to it eight charts per quarter, a total of 32 charts per year, used to calculate all chart-based measures. 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. CMS outlines these previously finalized sampling policies will not apply to the following measures being added to the IPFQR program: (1) the Facility Commitment to Health Equity measure because it is a structural attestation measure; (2) the Screening for Social Drivers of Health measure because it will apply to all patients; (3) the Screen Positive Rate for Social Drivers of Health measure because it will apply to all patients who had been screened for health-related social needs (HRSNs); and (4) the COVID-19 Vaccination Coverage Among Healthcare Personnel measure because the denominator is all healthcare personnel.

The PIX survey measure being added is a patient-reported measure and is eligible for sampling, but CMS finalizes its proposal not to include it in the global sample. Instead, CMS will 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 will be required to submit data on survey results for all eligible patient discharges.

J. Reconsideration and Appeals Procedures

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

K. Extraordinary Circumstances Exceptions (ECE) Policy

CMS finalizes its proposal to codify the ECE policies at §412.433(f), which specify that it 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 the agency determines an extraordinary circumstance occurred.

V. Regulatory Impact Analysis

CMS estimates that payments to IPF providers for FY 2024 will increase by $70 million due to:

- $95 million from the update to the payment rates,
  - $100 million for the market basket update to IPF rates (3.5 percent),
  - Minus $5 million for the productivity adjustment (0.2 percent), and
- -$25 million due to outliers decreasing from 2.9 percent in FY 2023 to 2.0 percent of IPF PPS payments in FY 2024.

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 40 in the final rule, reproduced below, shows the estimated effects of the IPF PPS final rule policies by type of IPF using the March 2023 update of FY 2022 MedPAR claims data.

TABLE 40: FY 2024 IPF PPS Payment Impacts
(Percent change in columns 3 through 5)

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	1,479	-0.9	0.0	2.3
Total Urban	1,204	-1.0	0.1	2.4
Urban unit	687	-1.5	0.2	2.0
Urban hospital	517	-0.4	0.0	2.9
Total Rural	275	-0.6	-0.7	2.0
Rural unit	214	-0.6	-0.7	2.0
Rural hospital	61	-0.5	-0.8	1.9
By Type of Ownership:				
Freestanding IPFs				
Urban Psychiatric Hospitals				
Government	119	-1.4	0.1	2.0
Non-Profit	98	-0.5	0.5	3.4
For-Profit	300	-0.2	-0.2	2.9
Rural Psychiatric Hospitals				
Government	31	-0.7	-0.3	2.3
Non-Profit	13	-2.1	-0.1	0.9
For-Profit	17	0.0	-1.3	2.0
IPF Units				
Urban				
Government	99	-2.6	0.7	1.3
Non-Profit	449	-1.4	0.3	2.1
For-Profit	139	-0.6	-0.5	2.2
Rural				
Government	51	-0.4	-0.6	2.2

Facility by Type	Number of Facilities	Outlier	Wage Index FY24, LRS, and 5% Cap	Total Percent Change[1]
Non-Profit	120	-0.7	-0.6	1.9
For-Profit	43	-0.4	-0.9	2.0
By Teaching Status:				
Non-teaching	1,282	-0.7	-0.2	2.4
Less than 10% interns and residents to beds	97	-1.7	0.9	2.5
10% to 30% interns and residents to beds	70	-1.9	0.3	1.7
More than 30% interns and residents to beds	30	-2.0	0.7	2.0
By Region:				
New England	105	-1.3	-0.6	1.4
Mid-Atlantic	202	-1.5	1.1	2.9
South Atlantic	229	-0.5	0.2	3.0
East North Central	240	-0.6	-0.7	2.0
East South Central	149	-0.6	-0.7	1.9
West North Central	105	-1.8	0.0	1.4
West South Central	215	-0.6	0.0	2.7
Mountain	106	-0.7	-1.0	1.6
Pacific	128	-1.1	0.4	2.7
By Bed Size:				
Psychiatric Hospitals				
Beds: 0-24	91	-0.8	-0.3	2.2
Beds: 25-49	84	-0.1	-0.7	2.4
Beds: 50-75	87	-0.1	-0.2	3.0
Beds: 76+	316	-0.5	0.2	3.0
Psychiatric Units				
Beds: 0-24	484	-1.0	-0.4	1.9
Beds: 25-49	240	-1.2	0.1	2.3
Beds: 50-75	105	-1.4	0.0	1.8
Beds: 76+	72	-2.1	0.8	1.9

[1] This column includes the impact of the updates in columns (3) through (4) above, and of the IPF market basket update factor for FY 2024 of 3.5 percent, reduced by 0.2 percentage point for the productivity adjustment.