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Medicare Program; Fiscal Year 2025 Inpatient Psychiatric Facilities Prospective Payment System — Rate Update Proposed Rule Summary

The Centers for Medicare & Medicaid Services (CMS) published the fiscal year (FY) 2025 Inpatient Psychiatric Facilities (IPF) Prospective Payment System (PPS) proposed rule (CMS-1806-P) in the *Federal Register* on April 3, 2024. **The public comment period will end on May 28, 2024**. IPFs include psychiatric hospitals and psychiatric units of acute care hospitals or critical access hospitals.

The FY 2025 IPF PPS proposed rule includes proposals that will:

- Update IPF payment rates and adjustments and update the IPF Quality Reporting Program;
- Revise patient-level adjustment factors as well as increase the per treatment amount for Electroconvulsive Therapy (ECT) for the first time since the IPF was adopted based on an updated regression analysis using 2019-2021 Medicare claims data and cost report data consistent with requirements in the Consolidate Appropriations Act (CAA), 2023;
- Update Core-Based Statistical Areas (CBSA) that are the basis of the labor market areas used for determining the IPF wage index;
- Clarify the eligibility criteria to file an all-inclusive cost report;
- Solicit comments on updated regression analysis that may result in future revisions to facility level adjustments and elements to be included in the IPF patient assessment instrument (PAI) that CMS is required to develop for FY 2028.

These changes are effective for IPF discharges occurring October 1, 2024 through September 30, 2025 (FY 2025). Addenda that show payment rates and other relevant information for determination of FY 2025 IPF PPS rates are available at: https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-psychiatric-facility/tools-and-worksheets. Wage index information is available at: https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-psychiatric-facility/wage-index.

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I. Background

Under the IPF PPS, facilities are paid based on a standardized federal per diem base rate adjusted by a series of patient-level and facility-level adjustments. The 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 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. CMS is proposing to revise these patient level adjustments in this proposed rule based on an updated regression analysis using 2019-2021 data.

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). CMS is not proposing to change the facility level adjustments based on a revised regression analysis in this proposed rule but does request comment on future changes to these adjustments.

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 2025.

II. Provisions of the FY 2025 IPF PPS Payment Update

A. FY 2025 IPF Market Basket and Productivity Adjustment

1. Market Basket Less Total Factor Productivity

For FY 2025, CMS is proposing an inflation update of 3.1 percent less 0.4 percentage points for total factor productivity, or 2.7 percent, based on IHS Global Inc.'s 4th quarter 2023 forecast with historical data through the 3rd quarter of 2023. Total factor productivity is based on a rolling 10-year average in economy-wide productivity.

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 2025 payment rate update will be 0.7 percent (with other adjustments applied, as described below).

2. Labor-Related Share

The area wage index adjustment is applied to the labor-related share of the standardized federal per diem base rate. The labor-related share is the national average portion of costs related to, influenced by, or varying with the local labor market, and is determined by summing the relative importance of labor-related cost categories included in the 2021-based market basket.[1] For FY 2025, CMS is proposing a total labor-related share of 78.8 percent—75.7 percent for the operating costs plus 3.1 percent for the labor-related share of capital-related costs. Table 1 of the proposed rule shows how updated data changes the labor-related share:

Table 1: Comparison of FY 2025 and FY 2024 IPF Labor-Related Shares (LRS)

	FY 2025[1]	**FY 2024**
Wages and Salaries	53.6	53.4
Employee Benefits	14.1	14.2
Professional Fees: Labor-related	4.7	4.7
Administrative and Facilities Support Services	0.6	0.6
Installation, Maintenance and Repair Services	1.2	1.2
All Other: Labor-related Services	1.5	1.5
Subtotal	**75.7**	**76.6**
Labor-related portion of capital (46%)	3.1	3.1
Total LRS	**78.8**	**78.7**

1. IHS Global Inc. 4th quarter 2023 forecast of the 2025-based IPF market basket.

B. Revisions to the IPF PPS Rates for FY 2025

1. Increase in the ECT Payment per Treatment

CMS has been making a per treatment payment for ECT in addition to per diem and outliers since the inception of the IPF PPS in 2005. To establish the ECT per treatment payment, CMS has used the pre-scaled and pre-adjusted median cost for procedure code 90870 developed for the Hospital Outpatient Prospective Payment System (OPPS) because it was unable to separate out the cost of a single ECT treatment in an IPF. Since that time, CMS has updated the ECT payment rate for inflation and budget neutrality but has not recalculated the ECT payment per treatment based on more recent cost data.

[1] The labor-related market basket cost categories are Wages and Salaries; Employee Benefits; Professional Fees: Labor-Related; Administrative and Facilities Support Services; Installation, Maintenance, and Repair; All Other: Labor-Related Services; and a portion (46 percent) of the Capital-Related cost weight. The relative importance reflects the different rates of price change for these cost categories between the base year (FY 2021) and FY 2024.

In the FY 2025 IPF PPS proposed rule, CMS analyzed data in both the IPF PPS and the OPPS and found that there are differences in the per-day cost for stays with and without ECT. CMS found that stays with ECT treatment have an average cost per day of $1,595.76, while stays without ECT treatment have an average cost per day of $1,149.51. Holding all other patient-level and facility-level factors constant, CMS found there is a statistically significant increase in cost per day for IPF stays that include ECT. CMS further analyzed ancillary costs (for example, drugs or laboratory) and found that average ancillary costs per day are three times higher for stays with ECT treatment: $99.36 for stays without ECT treatment versus $301.77 for stays with ECT treatment.

As a result of these findings, CMS is proposing to revise the ECT treatment add-on based on more recent OPPS costs. The original methodology for determining the ECT payment per treatment was based on the median cost for procedure code 90870 developed for the OPPS. Since that time, CMS has used geometric mean costs instead of median costs to develop the OPPS relative weights. For this reason, CMS proposes to develop the ECT payment per treatment add-on under the IPF PPS using the pre-scaled and pre-adjusted 2024 OPPS geometric mean cost (based on 2022 hospital claims) for procedure code 90870 of $675.93. This compares to a rate of $385.58 per ECT treatment that is being used in FY 2024 under the IPF PPS.

After applying the update (1.027), wage index budget neutrality (0.9998 as discussed in section II.D.3 below) and budget neutrality for refinement standardization (0.9514 inclusive of the increase in the ECT per treatment rate), the proposed payment for ECT in FY 2025 will be $660.31. CMS notes that the budget neutrality adjustment for refinement standardization—that accounts for changes to the patient-level adjustment factors and the ED adjustment factor—changes from 0.9536 to 0.9514 as a result of the increase in payment per ECT treatment. That is, there is a slightly larger decrease to IPF PPS payment rates for budget neutrality from this proposal.

Among other comments on its proposal, CMS requests comments that could inform understanding of where ECT costs are allocated in cost reports in order to potentially improve collection of data on ECT treatment costs in the IPF setting. CMS also requests comments on whether to collect additional ECT-specific costs on the hospital cost report. If more data becomes available for the final rule, CMS proposes to update the proposed ECT rate using this additional data.

2. Increase in IPF PPS Payment

CMS determines the FY 2025 proposed payment rates by applying the update factor of 2.7 percent (1.027), the wage index budget neutrality adjustment (0.9998) and the refinement standardization factor (0.9514) to FY 2024 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 1.007 percent (1.0007), the wage index budget neutrality adjustment (0.9998) and the refinement standardization factor (0.9514) to the full unreduced FY 2024 payment rates.

The table below compares the federal per diem base rate and the ECT payments per treatment for FY 2024 (inclusive of the proposed increase to the ECT rate described above) compared to those proposed for FY 2025.

	FY 2024	FY 2025
Federal per diem base rate	$895.63	$874.93
Labor share	*$704.86 (78.7%)*	*$688.57 (78.8%)*
Non-labor share	*$190.77 (21.3%)*	*$186.36 (21.2%)*
ECT payment per treatment	$675.93	$660.30
Rates for IPFs that fail to meet the IPFQR Program requirements		
Per diem base rate	$895.63	$857.89
Labor share	*$704.86 (78.7%)*	*$676.02 (78.8%)*
Non-labor share	*$190.77 (21.3%)*	*$187.87 (21.2%)*
ECT payment per treatment	$675.93	$647.45

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

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 2025, CMS is proposing changes to the patient-level changes based on an updated regression model—the first time CMS has proposed updating these adjustments since the IPF PPS was adopted in 2005.

1. Overview of the IPF PPS Adjustment Factors and Proposed Revisions

The current payment adjustment factors were derived from a regression analysis of 100 percent of the FY 2002 Medicare Provider and Analysis Review (MedPAR) data file, which contained 483,038 cases. Section 1886(s)(5)(D) of the Act, as added by section 4125(a) of the CAA, 2023 requires that the Secretary implement revisions to the methodology for determining the payment rates under the IPF PPS for psychiatric hospitals and psychiatric units, effective for FY 2025.

Consistent with this statutory provision, CMS has developed proposed adjustment factors based on a regression analysis of IPF cost and claims data. The primary sources of this analysis are 2019 through 2021 MedPAR files and FY 2019 through FY 2021 Medicare cost report data (or its most recent cost report going back to FY 2018 if the provider did not have a cost report for any of those years).

2. History of IPF PPS Cost and Claims Analyses

In the FY 2023 IPF PPS proposed rule (87 FR 19428 through 19429), CMS discussed past analyses and areas of interest for future refinement. CMS also posted a technical report on the CMS website[2] summarizing these analyses. In the FY 2024 IPF PPS proposed rule (88 FR 21269

[2] Technical Report: Medicare Program Inpatient Psychiatric Facilities Prospective Payment System: A Review of the Payment Adjustments (cms.gov)

through 21272), CMS requested information to inform revisions to the IPF PPS required by the CAA, 2023.

The primary goal in refining the IPF PPS payment adjustment factors is to pay each IPF an appropriate amount for the efficient delivery of care to Medicare beneficiaries. The system must be able to account adequately for each IPF's case-mix to allow for both fair distribution of Medicare payments and access to adequate care for those beneficiaries who require more costly care.

As required by section 1886(s)(5)(D)(iii) of the Act, as added by section 4125(a) of the CAA, 2023, proposed revisions to the IPF PPS adjustment factors must be budget neutral. As indicated earlier, CMS determined a refinement standardization factor of 0.9514 applied to the proposed IPF PPS payment rates is necessary to maintain budget neutrality for FY 2025.

3. Development of the Proposed Revised Case-Mix Adjustment Regression

The MedPAR data files used for 2019–2021 regression analysis contain a total of 806,611 stays from 1,643 IPFs, which reflect the removal of 41 providers and 304,848 stays with missing or erroneous data. The proposed rule discusses the methodology CMS used in detail including all data sources, data trims and assumptions, calculation of the dependent variable (per diem costs standardized for geographic cost differences) and independent variables (patient and facility level characteristics).

The proposed rule indicates that the regression model can explain approximately 32.3 percent of the variation in per diem cost among IPF stays. Table 2 of the proposed rule shows results that were produced by the regression model for various psychiatric conditions.

4. Sub-Regulatory Process for Publication of Coding Changes

In the FY 2022 IPPS/LTCH PPS final rule (86 FR 44950 through 44956), CMS adopted an April 1 implementation date for ICD–10–CM diagnosis and ICD–10–PCS procedure code updates in addition to the annual October 1 update of ICD–10–CM diagnosis and ICD–10–PCS procedure codes, beginning with April 1, 2022. The intent of the April 1 implementation date is to allow flexibility in the ICD–10 code update process.

To maintain consistency with IPPS policy, CMS is proposing to follow the same process for the IPF PPS beginning in FY 2025. This means that for routine coding updates that incorporate new or revised codes, CMS is proposing to adopt these changes through a sub-regulatory process. Beginning in FY 2025, CMS would operationalize such coding changes in a Transmittal/Change Request, which would align with the way coding changes are announced under the IPPS. These coding updates would take effect April 1, 2025.

In accordance with 42 CFR §412.428(e), CMS would describe these coding changes, along with any coding updates that would be effective for October 1, 2025, in the FY 2026 IPF PPS proposed rule. CMS would summarize and respond to any comments on these April and October coding changes in the FY 2026 IPF PPS final rule. The proposed update aims to allow flexibility

in the ICD–10 code update process for the IPF PPS and reduce the lead time for making routine coding updates to the IPF PPS code first list, comorbidities, and ECT coding categories.

This sub-regulatory process would only apply for routine coding updates. Any future substantive revisions to the IPF PPS DRG adjustments, comorbidities, code first policy, or ECT payment policy would be done through notice and comment rulemaking.

5. Revisions to MS–DRG Adjustment Factors

For FY 2025, CMS is proposing to no longer apply a DRG adjustment for DRGs 080 (Nontraumatic stupor & coma w MCC) and 081 (Nontraumatic stupor & coma w/o MCC) as there were only two cases for these DRGs in the 2019 to 2021 data. Further, CMS is proposing to recognize DRG adjustments for two DRGs associated with poisoning; specifically, DRG 917 (Poisoning and toxic effects of drugs w MCC) and 918 (Poisoning and toxic effects of drugs w/out MCC).

CMS is proposing to revise the adjustment factors for 15 of the existing 17 DRGs that currently receive a DRG adjustment in FY 2024. CMS' analysis found that some of the adjustment factors in the regression model for DRGs that currently receive an adjustment are no longer statistically significant. For DRGs 887 (Other mental health disorder diagnose) and 896 (Alcohol, Drug Abuse or Dependence w/out rehab therapy w MCC), the current adjustment factors (0.92 and 0.88, respectively) do not fall within the confidence interval for each of these DRGs. Therefore, CMS is proposing to apply an adjustment factor of 1.00 for IPF stays assigned to these DRGs.

Table 5 from the proposed rule reproduced below shows the current and proposed revised DRG adjustment factors resulting from the 2019-2021 regression analysis.

Table 5: Proposed Updates to Existing DRG Adjustments

Description	Current Adjustment Factors	# of Stays 2019–2021	% of Stays 2019–2021	Proposed Adjustment Factors
DRG 056-Degenerative nervous system disorders w MCC	1.05	4,287	0.53%	1.13
DRG 057-Degenerative nervous system disorders w/out MCC	1.05	40,584	5.03%	1.11
DRG 876-OR procedure with principal diagnoses of mental illness	1.22	751	0.09%	1.29
DRG 880-Acute adjustment reaction and psychosocial dysfunction	1.05	7,529	0.93%	1.08
DRG 881-Depressive neuroses	0.99	23,566	2.92%	1.06
DRG 882-Neuroses except depressive	1.02	10,143	1.26%	1.02
DRG 883-Disorders of personality and impulse control	1.02	5,804	0.72%	1.17
DRG 884-Organic disturbances and intellectual disabilities	1.03	55,842	6.92%	1.08
DRG 885-Psychoses	1.00	603,280	74.79%	1.00

Description	Current Adjustment Factors	# of Stays 2019–2021	% of Stays 2019–2021	Proposed Adjustment Factors
DRG 886-Behavioral and developmental disorders	0.99	1,582	0.20%	1.07
DRG 887-Other mental disorder diagnoses	0.92	321	0.04%	1.00
DRG 894-Alcohol, Drug Abuse or Dependence, Left AMA	0.97	3,060	0.38%	0.86
DRG 895-Alcohol, Drug Abuse or Dependence w rehab therapy	1.02	12,361	1.53%	0.90
DRG 896-Alcohol, Drug Abuse or Dependence w/out rehab therapy w MCC	0.88	891	0.11%	1.00
DRG 897-Alcohol, Drug Abuse or Dependence w/out rehab therapy w/out MCC	0.88	34,767	4.31%	0.95

6. Revisions to Comorbidity Adjustments

The intent of the comorbidity adjustments is to recognize the increased costs associated with comorbid conditions by providing additional payments for certain existing medical or psychiatric conditions that are expensive to treat. Comorbidities are specific patient conditions that are secondary to the patient's principal diagnosis and that require treatment during the stay. The current comorbidity adjustments were determined based on the regression analysis using the diagnoses reported by IPFs in FY 2002. There are 17 comorbidity categories. For each claim, an IPF may receive only one comorbidity adjustment within a comorbidity category, but it may receive an adjustment for more than one comorbidity category.

For FY 2025, CMS is proposing to revise the comorbidity adjustment factors based on the results of the 2019-2021 regression analysis as follows:

a) Gangrene, Severe Protein Malnutrition, Oncology Treatment, Poisoning, and Tracheostomy. For these comorbidity categories, the regression results produced a statistically significant increase in the adjustment factors. CMS proposes an increase in the adjustment for these categories.

b) Coagulation Factor Deficit, Drug/ Alcohol Induced Mental Disorders, and Infectious Diseases. CMS proposes to eliminate the adjustment factor for these categories because the regression factors were not statistically significant, and the current adjustment factors did not fall within the confidence intervals in the 2019 through 2021 regression.

c) Drug/Alcohol Induced Mental Disorders. The current adjustment factor for Drug/Alcohol Induced Mental Disorders is 1.03; however, the adjustment factor derived from CMS' latest regression results was statistically significant at 0.96084, meaning payments would be reduced if CMS applied the regression-derived adjustment factor as a comorbidity

adjustment for this category. A negative payment adjustment would not be consistent with the intent of a comorbidity adjustment, which is intended to provide additional payments to providers to account for the costs of treating patients with comorbid conditions. Therefore, CMS is proposing to remove the Drug/Alcohol Induced Mental Disorders comorbidity category beginning in FY 2025.

d) CMS believes a lack of ancillary charge data may be contributing to the results of its regression analysis as it relates to opioid disorders. Ongoing analysis has found an increase in the number of for-profit freestanding IPFs that are consistently reporting no ancillary charges or very minimal ancillary charges on their cost report. Data that is necessary for accurate Medicare ratesetting is excluded from the information these facilities are reporting. For this reason, CMS is interested in understanding whether commenters believe it may be more appropriate to maintain the existing Drug/Alcohol Induced Mental Disorders comorbidity category adjustment factor of 1.03, given that many providers that treat these patients also report minimal or no ancillary charges on their claims and cost reports.

e) Eating and Conduct Disorders Comorbidity Category. CMS proposes to redesignate the category as being only for Eating Disorders and remove conduct disorders from the conditions eligible for a comorbidity adjustment. The regression results indicate conduct disorders were associated with a negative comorbidity adjustment that was not significant. Eating disorders are associated with an increased level of resource use compared to conduct disorders. Only eating disorders have an increase in resource use at a level that is statistically significant.

f) Chronic Obstructive Pulmonary Disease (COPD) and Obstructive Sleep Apnea (OSA). CMS is proposing to revise COPD category to include OSA because both of these conditions require the patient to use a breathing assist apparatus when sleeping that includes a wire and increases ligature risk (that is, anything that could be used to attach a cord, rope, or other material for the purpose of hanging or strangulation). CMS' 2019-2021 regression model suggest that sleep apnea is associated with an increased level of resource use that would justify its addition to the COPD comorbidity category.

g) Intensive Management for High Risk-Behavior. CMS' regression analysis found that patients presenting with restlessness and agitation, irritability and anger, or anhedonia (inability to feel pleasure) are more costly than patients who do not present these conditions. Therefore, CMS is proposing to add a new comorbidity category recognizing the costs associated with Intensive Management for High-Risk Behavior.

The revised adjustment factors (including those for comorbid conditions being removed or added) are shown in Table 8 below reproduced from the proposed rule.

Table 8
Comparison of FY 2024 and Proposed FY 2025 IPF PPS Comorbidity Category Adjustments

Description	Current Adjustment Factor	Proposed FY 2025 Adjustment Factor
Renal Failure, Acute	1.11	1.06
Artificial Openings - Digestive & Urinary	1.08	1.07
Cardiac Conditions	1.11	1.05
Renal Failure, Chronic	1.11	1.08
Coagulation Factor Deficit	1.13	*N/A*
Chronic Obstructive Pulmonary Disease	1.12	*NIA*
Chronic Obstructive Pulmonary Disease and Sleep Apnea	*N/A*	1.07
Developmental Disabilities	1.04	1.04
Uncontrolled Diabetes	1.05	1.05
Drug/Alcohol Induced Mental Disorders	1.03	*N/A*
Eating and Conduct Disorders	1.12	*N/A*
Eating Disorders	*N/A*	1.09
Gangrene	1.10	1.12
Infectious Diseases	1.07	*N/A*
Severe Protein Malnutrition	1.13	1.17
Oncology Treatment	1.07	1.46
Poisoning	1.11	1.16
Severe Musculoskeletal & Connective Tissue Diseases	1.09	1.05
Tracheostomy	1.06	1.09
Intensive Management for High-Risk Behavior	*N/A*	1.07

7. Revisions to Patient Age Adjustments

In general, CMS has found that the cost per day increases with age. Older age groups are costlier than the under 45 age group. The differences in per diem cost increase for each successive age group and are statistically significant. Based on results of the prior regression model, CMS has adopted an adjustment factor in the IPF PPS for patient age. Using the result of the 2019-2021 regression model, CMS is proposing to revise the patient age adjustments as shown in Table 9 from the proposed rule reproduced below:

Table 9
Proposed Updates to Patient Age Adjustments

Age (in years)	Current Adjustment Factors	# of Stays 2019-2021	% of Stays 2019-2021	Proposed Adjustment Factors
Under 45	1.00	234,270	29.04%	1.00
45 and under 50	1.01			
50 and under 55	1.02			
45 and under 55	*N/A*	121,498	15.06%	1.02

Age (in years)	Current Adjustment Factors	# of Stays 2019-2021	% of Stays 2019-2021	Proposed Adjustment Factors
55 and under 60	1.04	74,512	9.24%	1.05
60 and under 65	1.07	68,136	8.45%	1.07
65 and under 70	1.10	94,473	11.71%	1.09
70 and under 75	1.13			
75 and under 80	1.15			
70 and under 80	*N/A*	126,280	15.66%	1.12
80 and over	1.17	87,442	10.84%	1.13

8. 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. For FY 2025, CMS is proposing to revise the variable per diem adjustments based on the results of its 2019-2021 regression analysis. CMS is proposing to increase the adjustment factors for days 1 through 9. As shown in Table 10 (reproduced below from the proposed rule), the results of the latest regression analysis indicate that there is not a statistically significant decrease in cost per day after day 10; therefore, CMS is proposing that days 10 and above would receive a 1.00 adjustment.

Table 10
Proposed Updates to Variable Per Diem Adjustments

Description	Current Adjustment Factors	# of Stays 2019-2021	% of Stays 2019-2021	Proposed Adjustment Factors
Length of stay - 1 day without ED	1.19	17,141	2.09%	1.27
Length of stay - 1 day *with a qualified ED*	1.31	*N/A*	*N/A*	1.53
Length of stay - 2 days	1.12	28,370	3.52%	1.20
Length of stay - 3 days	1.08	42,298	5.24%	1.15
Length of stay - 4 days	1.05	48,187	5.97%	1.12
Length of stay - 5 days	1.04	54,187	6.72%	1.08
Length of stay - 6 days	1.02	59,215	7.34%	1.06
Length of stay - 7 days	1.01	63,095	7.82%	1.03
Length of stay - 8 days	1.01	51,491	6.38%	1.02
Length of stay - 9 days	1.00	42,855	5.31%	1.01
Length of stay - greater than or equal to 10 days	1.00-0.92	400,022	49.59%	1.00

D. Facility-Level Adjustments

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

1. Wage Index Adjustment

CMS believes that IPFs generally compete in the same labor market as IPPS hospitals, and that the pre-floor, pre-reclassified IPPS hospital wage index is the best available to use as a proxy for an IPF specific wage index. Consistent with past practice, CMS proposes to use the FY 2025 pre-floor, pre-reclassified IPPS hospital wage index for the FY 2025 IPF wage index. 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. As described earlier, the labor-related share of the national rate and ECT payment per treatment will change from 78.7 percent in FY 2024 to 78.8 percent in FY 2025, reflecting the labor-related share of the 2021-based IPF market basket for FY 2025. CMS also applies a cap on reductions to an IPF hospital's wage index of 5 percent from its wage index in a prior year. The 5 percent cap on reductions is applied budget neutral.

The wage index used for the IPF PPS is calculated using the unadjusted, pre-reclassified and pre-floor IPPS wage index data and is assigned to the IPF based on the labor market area in which the IPF is geographically located. IPF labor market areas are delineated based on the Core-Based Statistical Area (CBSAs) established by the OMB. Generally, OMB issues major revisions to statistical areas every 10 years, based on the results of the decennial census.

On July 21, 2023, OMB issued Bulletin 23–01, which revises the CBSA delineations based on the latest available data from the 2020 census. CMS is proposing to implement the new OMB delineations effective beginning with the FY 2025 IPF PPS wage index. Other policies that CMS is proposing consistent with OMB's revisions to the CBSA delineations include:

a) Rural Adjustment. A total of 54 counties (and county equivalents) and 10 providers are located in areas that were previously considered rural but would now be considered urban under the revised OMB delineations. Table 13 of the proposed rule lists the 54 rural counties that would be urban under the revised OMB delineations. CMS proposes to phase out the rural adjustment for IPFs that are transitioning from rural to urban over 3 years. This policy is further described in section D. 2 below.

b) Micropolitan Statistical Areas. OMB defines a ''Micropolitan Statistical Area'' as a CBSA associated with at least one urban cluster that has a population of at least 10,000, but less than 50,000. CMS has treated micropolitan statistical areas as rural in the past and proposes to continue doing so for FY 2025.

c) Planning Regions. OMB Bulletin No. 23–01 replaced the 8 counties in Connecticut with 9 new ''Planning Regions.'' Planning regions now serve as county-equivalents within the CBSA system. CMS proposes to adopt the planning regions as county equivalents for wage index purposes. Table 11 of the proposed rule provides a crosswalk between the current

Connecticut counties and their respective CBSA to the new proposed Planning Region and respective CBSA.

d) Urban Counties Becoming Rural. A total of 53 counties (and county equivalents) and 15 providers are located in areas that were previously considered part of an urban CBSA but would be considered rural beginning in FY 2025 under the revised OMB delineations. Table 12 lists the 53 urban counties that would be rural under the revised OMB delineations. CMS indicates that the 5 percent cap on reductions in the wage index will apply to hospitals in these counties if CMS finalizes its policy to use the new OMB CBSA delineations. Further, these hospitals will also be eligible for the rural adjustment described in the next section that will mitigate any reduction in payment.

2. Adjustment for Rural Location

Since the inception of the IPF PPS, CMS has provided a 17-percent payment increase for IPFs located in a rural area. This adjustment was based on the regression analysis, which indicated that the per diem cost of rural facilities was 17-percent higher than that of urban facilities after accounting for the influence of the other variables included in the regression.

As discussed in section III. A. 1. below, CMS has completed analysis of more recent cost and claims information to update the rural adjustment. However, in order to minimize the scope of changes that would impact providers in any single year, CMS is proposing to use the existing regression-derived adjustment factor for IPFs located in a rural area for FY 2025.

The proposed rule indicates that prior changes to the CBSA delineations have included a phase-out policy for the rural adjustment for IPFs transitioning from rural to urban status. Consistent with past policy, CMS is proposing a 3- year budget neutral phase-out of the rural adjustment for the 10 IPFs located in rural counties that will become urban under the new OMB delineations to mitigate the steeper and more abrupt reduction in their payments compared to other IPFs.

This policy would allow IPFs located in counties that are classified as rural in FY 2024 becoming urban in FY 2025 to receive two-thirds of the rural adjustment for FY 2025. For FY 2026, these IPFs would receive one-third of the rural adjustment. For FY 2027, these IPFs would not receive a rural adjustment.

3. Wage Index Budget Neutrality Adjustment

CMS proposes to make an FY 2025 IPF wage index budget neutrality adjustment, based on estimated aggregate IPF PPS payments for FY 2024 and FY 2025 using FY 2021 cost reports. The ratio of FY 2025 to FY 2024 payments is the budget neutrality adjustment applied to the federal per diem base rate for FY 2025. CMS proposes a budget neutrality adjustment of 0.9995[3] associated with revisions to the wage index. This proposed budget neutrality adjustment will be revised based on later data in the final rule.

[3] This figure is inconsistent with 6 other instances where the proposed rule indicates the wage index budget neutrality adjustment is 0.9998.

4. Teaching Adjustment

For FY 2025, 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. CMS is not proposing refinements to the facility-level payment adjustments for rural location or teaching status for FY 2025. Given the scope of changes to the wage index and patient-level adjustment factors, CMS believes its proposal will minimize the total impacts to providers in any given year.

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 OPPS 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.

Two public commenters on past rules have indicated that patients transferred to an IPF from an acute care unit or hospital often have higher costs per stay than patients with similar comorbidities admitted from the community. Commenters requested that CMS analyze data related to source of admission and consider a payment adjustment to account for the resources used by these patients.

CMS responded that its regression analysis found that the source of admission was not a statistically significant factor in the cost of care. The results for the two sources of admission variables that indicate higher costs (transfer from hospital inpatient in the same facility and transfer from ambulatory surgical center) are accounted for by the known difference in cost structures between hospital psychiatric units and freestanding psychiatric hospitals. For this reason, CMS is not proposing any changes to when it applies the ED adjustment.

While CMS is not updating facility level adjustments in other circumstances based on the 2019-2021 regression analysis to minimize the number of changes affecting IPFs in a single year, CMS is proposing to update the adjustment factor from 1.31 to 1.53 for IPFs with qualifying EDs for FY 2025. The proposed rule does not further explain why CMS is updating only the facility adjustment for IPFs with an ED.

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 2025, CMS proposes 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 2023 data for setting the FY 2025 outlier threshold). CMS is proposing to use the same methodology to determine the fixed loss threshold for FY 2025 that it has used dating back to FY 2008—except for FY 2022, FY 2023, where specific changes led to changes for those years.

Based on an analysis of the FY 2023 IPF claims and the FY 2024 rate increases, CMS estimates that outlier payments for FY 2024 will be 2.1 percent of total payments or 0.1 percentage points higher than the target of 2.0 percent. For FY 2025, CMS proposes to increase the fixed loss threshold from $33,470 in FY 2024 to $35,590 in FY 2025. CMS will update the proposed outlier threshold in the final rule based on later data.

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 proposed FY 2024 national median and ceiling CCRs are:

National Median and Ceiling CCRs, FY 2025		
CCRs	**Rural**	**Urban**
National Median	0.5720	0.4200
National Ceiling	2.3362	1.8600

3. Requirements for Reporting Ancillary Charges and All-Inclusive Status Eligibility Under the IPF PPS

Currently, IPFs and psychiatric units are required to report ancillary charges on cost reports. However, CMS' ongoing analysis has found a notable increase in the number of IPFs, specifically for-profit freestanding IPFs, appearing to erroneously identify themselves as eligible to file all-inclusive Medicare cost reports on form CMS–2552–10, Worksheet S–2, Part I, line 115. These hospitals identifying themselves as eligible for filing all-inclusive cost reports (indicating that they have one charge covering all services) are consistently reporting no ancillary charges or very minimal ancillary charges and are not using charge information to apportion costs in their cost report.

Historically, most hospitals that were approved to file all-inclusive cost reports were Indian Health Services hospitals, government-owned psychiatric and acute care hospitals, and nominal

charge hospitals. The option to elect to file an all-inclusive rate cost report is limited to providers that do not have a charge structure and that, therefore, must use an alternative statistic to apportion costs associated with services rendered to Medicare beneficiaries.

Current cost reporting rules allow hospitals that do not have a charge structure to file an all-inclusive cost report using an alternative cost allocation method. When hospitals identify as all-inclusive, they are excluded from ratesetting because they do not have CCRs but use an alternative basis for apportioning costs. When hospitals erroneously identify as all-inclusive but have a charge structure, data that is necessary for accurate Medicare ratesetting is improperly excluded.

CMS has detailed the efforts it has made to address the increase in the number of hospitals not reporting ancillary charges on their cost reports. Despite these efforts, CMS has continued to identify an increase in the number of IPFs, specifically for-profit freestanding IPFs, that appear to be erroneously identifying on form CMS-2552–10, Worksheet S–2, Part I, line 115, as filing all-inclusive cost reports.

To address this issue, CMS is clarifying the eligibility criteria to be approved to file all-inclusive cost reports. Only government-owned or tribally owned facilities are able to satisfy these criteria, and thus only these facilities will be permitted to file an all-inclusive cost report for cost reporting periods beginning on or after October 1, 2024. In order to be approved to file an all-inclusive cost report, hospitals must either have an all-inclusive rate (one charge covering all services) or a no-charge structure. CMS' policy only allows a hospital to use an all-inclusive rate or no charge structure if it has never had a charge structure in place. Any new IPF would have the ability to have a charge structure under which it could allocate costs and charges and would not be eligible to file an all-inclusive cost report.

For cost reporting periods beginning on or after October 1, 2024, CMS will issue instructions to the MACs and put in place edits to operationalize its longstanding policy that only government-owned or tribally owned IPF hospitals are permitted to file an all-inclusive cost report. All other IPF hospitals must have a charge structure and must report ancillary costs and charges on their cost reports. IPFs that have previously filed an all-inclusive cost report erroneously will no longer be able to do so. To the extent government-owned or tribally owned hospitals can report ancillary charges on their cost reports, CMS strongly encourages them to do so.

CMS believes these operational changes will improve the quality of data reported, which will result in increased accuracy of future payment refinements to the IPF PPS. Furthermore, CMS believes collecting charges of ancillary services from freestanding IPFs supports the directive for competition under the Executive Order on Promoting Competition in the American Economy as it facilitates accurate payment, cost efficiency, and transparency.[4]

[4] Executive Order on Promoting Competition in the American Economy | The White House

III. Request For Information (RFI) Revisions to the IPF PPS Required by the CAA, 2023

CMS is requesting information on two main topics to inform future revisions to the IPF PPS in accordance with the CAA, 2023. First, CMS is requesting information regarding potential revisions to the IPF PPS facility-level adjustments. Second, CMS is requesting information regarding the development of a patient assessment instrument (PAI) under the IPFQR program.

A. Revisions to IPF PPS Facility-Level Adjustments

1. Adjustment for Rural Location

The 2019-2021 MedPAR data set included 101,483 stays, or 12.6 percent of all stays, at rural IPFs. The current adjustment for rural location is 1.17 or a 17 percent increase for inpatient IPF stays in rural psychiatric units or facilities. The 2019-2021 regression model indicates that if the adjustment for rural location were to be revised, the new factor would be 1.16 without any adjustment for IPFs that would meet the Medicare Payment Advisory Commission's (MedPAC) definition of a Medicare Safety Net Index (MSNI) hospital. The MSNI is a methodology developed by the MedPAC for the IPPS that identifies hospitals that may be considered "safety net" providers eligible for additional payment. With an MSNI adjustment, the rural adjustment factor would be 1.19.

2. Teaching Adjustment

The 2019-2021 MedPAR data set included 155,458 stays in teaching facilities, comprising 19.3 percent of IPF stays for the time period. Under the revised regression analysis, the teaching adjustment would increase from the current factor of 0.5150 to 0.7286 without an MSNI adjustment and 0.6955 with an MSNI adjustment. While it does not seem logical that the adjustment would be less with an MSNI adjustment, this apparent anomaly is not explained in the proposed rule.

3. Adjustment for Safety Net Patient Population

In contrast to other Medicare hospital payment systems, the IPF PPS does not have an adjustment that recognizes higher intensity of inpatient services when hospitals serve a disproportionate share (DSH) of low income patients. Section 1886(s) of the Act does not require any specific adjustment of this type, nor does it require the use of any particular methodology. CMS has explored a DSH adjustment for the IPF PPS but prior regression analyses have not supported adopting one, or if CMS did adopt one, it would be negative.

In this proposed rule, CMS explores the adoption of an MSNI adjustment. The MSNI would be calculated as the sum of:

a) The low-income subsidy (LIS) volume ratio, which is the ratio of total stays for low-income beneficiaries to a facility's total stays for Medicare beneficiaries;
b) the proportion of revenue spent on uncompensated care (UCC), defined the same way as it was in the FY 2024 IPPS final rule's discussion of MSNI (88 FR 59306). UCC and total revenue are available data elements from the hospital cost report, but only for the

acute care hospital. These elements are not currently detailed at the level of the IPF unit; and

c) The Medicare dependency ratio, which is a hospital's total covered days for Medicare patients divided by its total patient days.

The final MSNI score is calculated as: LIS Volume Ratio + Proportion of Revenue Spent on UCC ratio + 0.5 * Medicare Dependency Ratio.

The adjusted r-square, a measure of how much of the variation in costs between stays the model can explain, increases by approximately 2.8 percent when the variable for MSNI is added to model. The adjusted r-square for the model without the MSNI variable is 0.32340, while the adjusted r-square for the model with the MSNI variable is 0.33250. The regression analysis indicates an MSNI coefficient of 0.5184, which is statistically significant at the .001 level.

If CMS were to adopt an MSNI adjustment, it would significantly redistribute IPF payments, reducing payments to IPFs with a lower MSNI and increasing payments to IPFs with a higher MSNI. CMS estimates the reduction to the IPF PPS Federal per diem base rate would be $245.

CMS notes data reported by IPFs may be incomplete. First, both UCC amounts and total revenue amounts are reported at the hospital level only. As a result, CMS was only able to calculate a UCC ratio for IPF units based on the overall ratio of the hospital's UCC to its revenues. This assumes that a hospital's overall UCC ratio would be comparable to that of its IPF unit. Further, most freestanding IPF hospitals are not reporting any UCC, which leads to lower MSNI values for these IPFs. The absence of UCC for nonprofit IPFs, may reflect differences in reporting, rather than provision of UCC.

CMS request public comment on eight specific questions that are detailed in the proposed rule on the adoption of an MSNI adjustment for IPFs.

4. Distributional Impacts

CMS modeled the potential distributional impacts of modeling revised adjustments for rural location, teaching status and the adoption of an MSNI adjustment. The distributional impacts could be significant and the results are shown in Table 21 of the proposed rule. CMS indicates that the effect on the IPF PPS Federal per diem base rate would be reduction of nearly 28 percent ($244.81) if CMS were to adopt an MSNI adjustment in concert with an updated rural payment and teaching adjustment but only 0.74 percent from updating only the rural and teaching adjustment ($6.48).

B. Patient Assessment Instrument under IPFQR Program (IPF PAI)

Beginning with FY 2028, IPFs participating in the Inpatient Psychiatric Facilities Quality Reporting (IPFQR) program are statutorily required to collect and submit to the Secretary certain standardized patient assessment data of individuals at the time of admission to and discharge from the IPF (or more frequently if specified by the Secretary) using a standardized patient

assessment instrument (PAI) developed by the Secretary.[5] The standardized PAI must enable comparison of patient assessment data across all IPFs submitting the data and must collect data with respect to each of the following six patient assessment categories specified in statute: (1) functional status; (2) cognitive function and mental status; (3) special services, treatments, and interventions for psychiatric conditions; (4) medical conditions and comorbidities; (5) impairments; and (6) such other categories determined by the Secretary. In this RFI, CMS requests information to assist it in developing an IPF PAI that is consistent with these requirements and achieves the goals of improving the quality of care in IPFs, improving the accuracy of the IPF PPS, and improving health equity.

1. Framework and General Principles for Development of the IPF PAI

CMS discusses a general set of principles for development of the IPF PAI. The agency describes similarities between the statutory requirements for the IPF PAI and the statutory requirements for certain post-acute care (PAC) providers to submit standardized patient assessment data using PAC PAIs.[6] The agency applies the main considerations it used to develop the PAC PAIs to develop the IPF PAI. That is, CMS assesses for the IPF PAI the following four considerations used by the agency for assessing Standardized Patient Assessment Data Elements (SPADEs) for the PAC PAIs: (1) overall clinical relevance; (2) interoperable exchange to facilitate care coordination during transitions in care; (3) ability to capture medical complexity and risk factors; and (4) scientific reliability and validity.

Overall Clinical Relevance.

CMS is considering ways to ensure the clinical relevance of the IPF PAI. For each of the six patient assessment categories (listed above)[7] CMS seeks to establish SPADEs that IPFs can use to support quality care and outcomes. The agency seeks information on specific instruments and tools used in other settings in each of the areas of assessment that may be applicable in the IPF setting. For example, the agency points to the IRF PAI instrument.[8] CMS is also considering structuring the assessment with conditional questions so that only questions that are relevant to the patient are indicated and providing for certain data elements to be collected at different times during the patient stay.

Interoperability. The agency asks for feedback regarding whether SPADEs already used in the CMS Data Element Library (DEL) are appropriate and clinically relevant for the IPF setting, specifically if they can be used to better support interoperability between IPFs and skilled nursing facilities and inpatient rehabilitation facilities given the number of transfers between these settings.

[5] This requirement is under subparagraph (E) of section 1886(s)(4) of the Act, as added by section 4125(b)(1) of the Consolidated Appropriations Act, 2023 (CAA, 2023).
[6] Section 1899B of the Act requires certain PAC providers to submit standardized patient assessment data through standardized PAI under the respective quality reporting programs of each PAC provider.
[7] Patient assessment categories are: (1) functional status; (2) cognitive function and mental status; (3) special services, treatments, and interventions for psychiatric conditions; (4) medical conditions and comorbidities; (5) impairments; and (6) such other categories determined by the Secretary.
[8] See https://www.cms.gov/files/document/irf-pai-version-40-eff-10012022-final.pdf.

Ability to Capture Medical Complexity and Risk Factors. CMS seeks to better identify patient characteristics to help predict resource use and intends to evaluate SPADEs for their ability to explain medical complexity, the need for special services and treatments, and to measure case-mix differences that impact costs.

Scientific Reliability and Validity. The agency notes that the statutory deadline to implement the IRF PAI beginning for FY 2028 limits its ability to develop and completely test new SPADEs before implementation. CMS believes it will need to incrementally revise the IPF PAI. The agency expects to convene a technical expert panel (TEP) to provide input on new and existing SPADEs. It also notes that when appropriate, using data currently collected by IPFs or SPADEs that have been tested in other clinical settings could reduce the timeframes needed for testing and validity.

Administrative Burden. CMS seeks to minimize additional burden of data collection, including by considering whether data that is currently collected through the IPFQR program measures or on IPF claims could be collected as SPADEs. The agency seeks ways to collect relevant and useful information while minimizing administrative burden.

CMS solicits comment on these principles for selecting and developing SPADES for the IPF PAI, any principles it should eliminate from the selection criteria, and any principles it should add to the selection criteria.

2. Elements of the IPF PAI

CMS reviews each of the six patient assessment categories for which the statute requires SPADEs be collected in the IPF PAI and specifies information sought with respect to each of those categories.[9] The agency solicits comment on PAIs currently available or that could be adapted or developed to assess patients on each of the described assessment categories.

- Functional status – CMS seeks information on standardized elements associated with this category that are relevant to IPFs and on assessments already in use that may be included. Specifically, it solicits information on:
    - The aspects of functions that are most predictive of medical complexity or increased resource needs to treat IPF patients.
    - Which of the SPADEs related to mobility collected by PACs are clinically relevant to IPFs and whether those SPADEs meet the principles for inclusion in the IPF PAI.
- Cognitive function and mental status – CMS seeks feedback on instruments currently used to measure cognitive functions in IPFs and instruments that have clinical relevance for IPFs. Specifically:
    - What aspects of cognitive function and mental status are most predictive of medical complexity or increased resource needs?
    - What components or instruments are used to assess such function and status upon admission? What are the components of mental status assessments at admission and discharge? What are differences between assessments at admission and at discharge?

[9] See section 1886(s)(4)(E)(ii) of the Act, as added by section 4125(b)(1)(C) of the CAA, 2023.

- Special services, treatments, and interventions – CMS notes that these terms are not defined in statute, but points to information already collected in the IPFQR program on the use of restraint and seclusion and states the possibility of this category including high-cost medications, use of chemical restraints, one-to-one observation, and high-cost technologies. The agency seeks comment on these and any other interventions that should be considered. Specifically:
    - What special services, treatments, and interventions are most predictive of increased resource intensity during an IPF stay?
    - Do data collected under the IPFQR program related to this category meet the criteria for inclusion in the IPF PAI?
- Medical conditions and comorbidities – CMS requests feedback on whether existing data elements from PACs would be clinically relevant for this category for the IPF PAI. Specifically:
    - Is the PAC PAIs SPADE regarding pain interference (i.e., effect on sleep, interference with therapy activities, interference with day-to-day activities) clinically relevant in IPFs?
    - Do the medical conditions and comorbidities coded on IPF claims meet criteria for inclusion in the IPF PAI?
- Impairments – CMS inquires whether the SPADEs regarding hearing and vision included in the IRF PAI are appropriate for the IPF PAI and whether additional impairments should be considered, noting the goal to avoid overlap with any other assessment category. Specifically:
    - Are SPADEs related to impairments currently collected in PAC PAIs clinically relevant in the IPF setting and do they meet principles for inclusion in the IPF PAI?
    - What impairments are most predictive of increased resource intensity during an IPF stay?
- Other categories deemed appropriate – CMS is interested in SPADEs that would provide information on demographic factors and social determinants of health (SDOH), such as housing status and food security, associated with underlying inequities as well as on SPADEs that would provide information on special interventions IPFs provide post-discharge. The agency asks if using SDOH data adopted in other PAIs to risk adjust or stratify measures collected for the IPFQR program could make such measures more meaningful. Specifically:
    - What other assessment elements would (i) contribute to the clinical utility of IPF PAI; (ii) best capture medical complexity to improve the IPF PPS; or (iii) inform CMS' understanding of health equity for IPF patients?
    - Are there special interventions provided by IPFs post-discharge which could reduce hospital readmissions for psychiatric conditions? What assessment elements would inform the agency's understanding of these interventions?

3. Implementation

CMS seeks information on tools and methods for submission of data that consider administrative burden and ease of use. Specifically, what operations or practical limitations would be faced by IPFs in making systems changes and training staff to administer the assessment and submit data. What categories of SPADEs would be more or less feasible for IPFs to operationalize? Are there

limitations or impacts based on size or ownership characteristics of IPFs? What forms of training and guidance would be most useful for CMS to provide to IPFs?

4. Relationship to the IPFQR Program

CMS seeks information on the following:

- Whether having some measures that require data submission through the hospital quality reporting (HQR) system and other measures that require data collection and submission through the IPF PAI would increase operational complexity or administrative burden and, if so, how could that be mitigated?
- Which, if any, current chart-abstracted measures would be easier to report through the IPF PAI?
- Would any IPFQR measures be more meaningful if they were stratified or risk-adjusted using data from the above listed required assessment categories or other categories that should be added?
- Are there other new measure concepts that should be considered, which would use data collected through the SPADEs in the IPF PAI?

IV. Inpatient Psychiatric Facilities Quality Reporting (IPFQR) Program

CMS proposes to adopt the 30-Day Risk-Standardized All-Cause Emergency Department (ED) Visit Following an IPF Discharge (IPF ED Visit) measure beginning with the 2025 Performance Period/FY 2027 payment determination. It also proposes quarterly (rather than annual) submission of patient-level data.

CMS estimates that the overall economic impact of the IPFQR Program proposals in this proposed rule would be an increase of 800 hours in information collection burden resulting in a cost increase of $41,696 across all IPFs, attributable to the more frequent data submissions.

CMS invites public comment on these proposals.

A. Background

CMS established the IPFQR program beginning in FY 2014, as required under section 1886(s)(4) of the Act. The IPFQR program follows many of the policies established for the Hospital Inpatient Quality Reporting Program but has a distinct set of quality measures. In addition, as described in section IV.B. of the rule, beginning for FY 2028, IPFs[10] participating in the IPFQR Program must collect and report certain standardized patient assessment data using a standardized patient assessment instrument developed by the Secretary.

Per statute, an IPF that does not meet the requirements of participation in the IPFQR program for a fiscal year is subject to a 2.0 percentage point reduction in the update factor for that year. The

[10] 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.

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. Substantive changes to the IPFQR program are proposed and finalized through rulemaking.

For the FY 2024 payment determination year, based upon compliance with the IPFQR program requirements, of the 1,568 facilities eligible for the IPFQR program, 152 facilities failed to report successfully and received a 2.0 percentage point reduction. An additional 42 facilities chose not to participate and were subject to the 2.0 percentage point reduction.

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.

B. Measure Adoption

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

1. Measure Selection Process

In accordance with the CMS pre-rulemaking process, before being proposed for inclusion in the IPFQR Program, measures are placed on a Measures Under Consideration (MUC) list, which is published annually. Following publication on the MUC list, a multi-stakeholder group, the Partnership for Quality Measurement (PQM) convened by the consensus-based entity (CBE) with a contract with the Secretary reviews the measures under consideration for the IPFQR program. This process is known as the Pre-Rulemaking Measure Review (PRMR). CMS considers the PQM's recommendations in selecting measures for the IPFQR Program.

2. Proposal to Adopt the 30-Day Risk-Standardized All-Cause ED Visit Following an IPF Discharge (IPF ED Visit) Measure Beginning with the 2025 Performance Period/FY 2027 Payment Determination

Background: CMS describes the importance in quality measurement of quantifying post-discharge outcomes and that IPFs can reduce the need for post-discharge acute care, can improve long-term outcomes, and encourage successful reintegration into the community through patient-centered discharge planning, care coordination, and care transition models.

There are currently three measures in the IPFQR Program that assess post-discharge outcomes:

- The Follow-up After Psychiatric Hospitalization (FAPH)[11] measure, which uses Medicare FFS claims to determine the percentage of inpatient IPF discharges for which the patient

[11] The FAPH was adopted in the FY 2022 IPF PPS Final Rule (86 FR 42640-42645).

received a follow-up visit for treatment of mental illness. This measure does not quantify outcomes.

- The Medication Continuation Following Inpatient Psychiatric Discharge[12] measure, which assesses medication continuation, specifically whether patients admitted to IPFs with Major Depressive Disorder, schizophrenia, or bipolar disorder filled at least one evidence-based medication before discharge or during a post-discharge period. This measure does not quantify outcomes regarding post-discharge use of acute care services.
- The thirty Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization (CBE #2860, the IPF Unplanned Readmission) measure,[13] which assesses post-discharge use of acute care by estimating the occurrence of unplanned, all-cause readmissions to IPFs or short-stay acute care hospitals occurring three to thirty days post discharge from an IPF. This measure does not quantify patients 18 and older without a subsequent admission, but with an ED visit within 30 days after IPF discharge.

CMS believes a measure is needed to address the gap in assessing the portion of patients 18 and older who have an ED visit within 30 days after an IPF discharge in order for patients and caregivers to make informed care decisions and for IPFs to compare their performance and identify areas for improving discharge planning and post-discharge care coordination.

Proposed measure: CMS proposes to adopt the claims-based IPF ED Visit measure beginning with the 2025 performance period/FY 2027 payment determination to address the identified gap. The measure would assess the proportion of patients 18 and older who, within 30 days of discharge from an IPF, seek care in an ED, including observation stays, for any cause (but who are not admitted as an inpatient to an acute care hospital or IPF). The measure is designed to complement the IPF Unplanned Readmission measure.

Measure calculation: To calculate the measure, CMS would:

- Identify all IPF admissions during the 1-year performance period.
- Identify eligible index admissions.
- Identify ED visits, including observation stays, within 30 days of discharge from the index admission.
- Identify risk factors in the 12 months prior to and during the index admission.
- Run hierarchical logistic regression to compute a risk-standardized ED visit rate for each IPF, allowing for the results to be comparable across IPFs.

Eligible Index Admission. The measure is based on all eligible index admissions from the focus population of adult Medicare FFS patients with a discharge from an IPF. An eligible index admission is any IPF admission for which the patient meets the following:

- Age 18 older at admission;
- Discharged alive from an IPF;
- Enrolled in Medicare FFS parts A and B during the 12 months before admission, the month of admission, and at least one month after the month of discharge; and

[12] This measure was adopted in the FY 2020 IPF PPS Final Rule (84 FR 38460-38465).
[13] The IPF Unplanned Readmission measure was adopted in the FY 2017 IPPS/LTCH PPS final rule (81 FR 57241-57246).

- Discharged with a principal diagnosis that indicates a psychiatric disorder.

Exclusions. Patients discharged against medical advice; patients with unreliable data on demographics in claims record; patients who died during stay; patients transferred to another care facility; and patients discharged but readmitted within 3 days (i.e., an interrupted stay).

Data sources. Medicare beneficiary and coverage files, Medicare FFS part A records, and Medicare FFS part B records; all of which are available from Medicare administrative records and data submitted through the claims process.

Pre-rulemaking: The IPF ED Visit measure was subject to the pre-rulemaking process required by section 1890A of the Act. The measure was reviewed during the PRMR Hospital Recommendation Group[14] meeting on January 18, 2024. The group by consensus recommended including the measure in the IPFQR program with conditions, including the measure be considered by endorsement by the CBE and further consideration of how the measure addresses 72-hour transfers to the ED because of concerns that interrupted stays could harm IPF performance on the measure if they are not excluded.[15] CMS has submitted the measure to the CBE. CMS addressed the second condition by excluding interrupted stays from the measure.

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

Data Collection, Submission, and Reporting: No additional data collection or submissions by IPFs would be required. CMS proposes a reporting period beginning with data from the 2025 performance period/FY 2027 payment determination.

C. Summary of IPFQR Program Measures

If the proposed IPF ED Visit measure is adopted, the FY 2027 IPFQR Program measure set would include 16 required measures and one voluntary measure, as shown in Table 22 of the rule.

IPFQR Measure Set for FY 2027 Payment Determination
(Reflecting Table 22 in the Proposed Rule)

CBE #	Measure ID	Measure
Required Measures		
0640	HBIPS-2	Hours of Physical Restraint Use
0641	HBIPS-3	Hours of Seclusion Use
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

[14] The PRMR Hospital Recommendation Group was previously the Measure Applications Partnership (MAP) Hospital Workgroup under the pre-rulemaking process followed by the previous CBE.
[15] Details regarding the PRMR voting procedures can be found in Chapter 4 of the PQM Guidebook of Policies and Procedures for Pre-Rulemaking Measure Review and Measure Set Review.

CBE #	Measure ID	Measure
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-3 and TOB-3a	Tobacco Use Treatment Provided or Offered at Discharge and TOB-3a Tobacco Use Treatment at Discharge
1659	IMM-2	Influenza Immunization
n/a*	n/a	Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
n/a	n/a	Screening for Metabolic Disorders
2860	n/a	Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility
n/a	*n/a*	*Thirty-Day Risk-Standardized All-Cause ED Visit Following an IPF Discharge – Proposed in Rule*
3205*	Med Cont.	Medication Continuation Following Inpatient Psychiatric Discharge
n/a	n/a	Modified COVID-19 Healthcare Personnel (HCP) Vaccination
n/a	Facility Commitment	Facility Commitment to Health Equity
n/a	Screening for SDOH	Screening for Social Drivers of Health**
n/a	Screen Positive	Screen Positive Rate for Social Drivers of Health**
Voluntary Measure		
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. Section 1886(s)(4)(D)(ii) of the Act authorizes the Secretary to specify a measure that is not endorsed by the CBE 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.
** Screen Positive and Screening for SDOH are voluntary for FY 2026 payment determination but will be required beginning for FY 2027 payment determination.

D. Proposal to Modify Data Submission Requirements

The FY 2022 IPF PPS Final Rule (86 FR 42658 through 42661) finalized voluntary patient-level data reporting for the FY 2023 payment determination and mandatory patient-level data reporting for chart-abstracted measures beginning with FY 2024 payment determination.[16] CMS observed the large volumes of patient data that were required to be stored because of the required annual data submission periods. It is concerned that the volume of data from all IPFs reporting

[16] Current IPFQR measures requiring patient-level data submission include: (1) Hours of Physical Restraint Use (numerator only); (2) Hours of Seclusion Use (numerator only); (3) Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention; (4) Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge; (5) Tobacco Use Treatment Provided or Offered at Discharge and TOB-3a Tobacco Use Treatment at Discharge; (6) Influenza Immunization; (7) Transition Record with Specified Elements Received by Discharged Patients; and (8) Screening for Metabolic Disorders.

the full year of data during a data submission period may lead to risks that systems will be unable to handle the large volumes of data.

CMS therefore proposes to require quarterly (instead of annual) data submission to address these concerns. Quarterly submission of patient-level data would be consistent with the frequency of submissions of such data required under the Hospital Inpatient Quality Reporting Program and the Hospital Outpatient Quality Reporting Program. Data submission for each calendar quarter would be required during a period of at least 45 days beginning three months after the end of the calendar quarter.[17] In addition, CMS proposes that all other data that would still be reported on an annual basis (non-measure data, aggregate measures, and attestations) would be reported concurrently with the patient-level data from the fourth quarter of the applicable year. For example, annual data submissions would be required by the Q4 2025 submission deadline (May 15, 2026), as shown in the below table.

Proposed Patient-Level Data Quarterly Submission Deadlines for 2025 and 2026 Performance Periods
(As Shown in Table 24 of the Rule)

Performance Period		Submission Deadline
January 1, 2025-March 31, 2025	(Q1 2025)	November 15, 2025
April 1, 2025-June 30, 2025	(Q2 2025)	November 15, 2025
July 1, 2025-September 30, 2025	(Q3 2025)	February 15, 2026
October 1, 2025-December 31, 2025	(Q4 2025)	May 15, 2026
January 1, 2026-March 31, 2026	(Q1 2026)	August 15, 2026
April 1, 2026-June 30, 2026	(Q2 2026)	November 15, 2026
July 1, 2026-September 30, 2026	(Q3 2026)	February 15, 2027
October 1, 2026-December 31, 2026	(Q4 2026)	May 15, 2027

V. Regulatory Impact Analysis

CMS estimates that payments to IPF providers for FY 2025 will increase by $70 million due to:

- $75 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
- -$5 million due to outliers decreasing from 2.1 percent in FY 2024 to 2.0 percent of IPF PPS payments in FY 2025.

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.

[17] The FY 2018 IPF FFS final rule (82 FR 38472 through 38473) updated the submission period for data (July 1 through August 15 of the calendar year preceding the payment determination year involved) to be a 45-day period beginning at least 30 days after the end of the data collection period.

Table 29 in the proposed rule, reproduced below, shows the estimated effects of the IPF PPS proposed rule policies by type of IPF using the December 2023 update of FY 2023 MedPAR claims data.

TABLE 29: FY 2025 IPF PPS Payment Impacts

Facility by Type[1]	Number of Facilities	Outlier	Refinement of Patient-Level Adjustments and ECT	Wage Index FY25, LRS, and 5% Cap	Total Percent Change[2]
All Facilities	1,430	-0.1	0.0	0.0	2.6
Total Urban	1,171	-0.1	0.0	-0.2	2.4
Urban unit	655	-0.1	0.4	-0.5	2.5
Urban hospital	516	0.0	-0.5	0.2	2.3
Total Rural	259	0.0	0.0	1.3	4.0
Rural unit	199	0.0	0.3	1.1	4.1
Rural hospital	60	0.0	-0.7	1.7	3.7
By Type of Ownership:					
Freestanding IPFs					
Urban Psychiatric Hospitals					
Government	117	-0.1	1.0	-0.6	2.9
Non-Profit	98	0.0	-0.2	-0.1	2.4
For-Profit	301	0.0	-0.9	0.4	2.2
Rural Psychiatric Hospitals					
Government	30	-0.1	1.5	0.0	4.2
Non-Profit	12	-0.1	-1.5	-0.1	1.0
For-Profit	18	0.0	-1.4	2.9	4.1
IPF Units					
Urban					
Government		-0.2	0.7	-0.3	2.9
Non-Profit	436	-0.1	0.6	-0.8	2.4
For-Profit	124	0.0	-0.5	0.2	2.4
Rural					
Government		0.0	0.0	0.9	3.6
Non-Profit	114	-0.1	0.5	1.2	4.4
For-Profit	40	0.0	0.2	1.2	4.1
By Teaching Status:					
Non-teaching	1,230	-0.1	-0.2	0.3	2.7
Less than 10% interns and residents to beds	104	-0.1	0.6	-0.9	2.3

Facility by Type[1]	Number of Facilities	Outlier	Refinement of Patient-Level Adjustments and ECT	Wage Index FY25, LRS, and 5% Cap	Total Percent Change[2]
10%to 30% interns and residents to beds	71	-0.1	1.1	-1.2	2.4
More than 30% interns and residents to beds	25	-0.2	1.0	-1.1	2.4
Bv Region:					
New England	102	-0.1	0.8	-1.3	2.1
Mid-Atlantic	193	-0.1	0.2	-1.5	1.2
South Atlantic	226	0.0	0.4	0.9	4.0
East North Central	228	0.0	0.0	0.2	2.9
East South Central	140	0.0	-0.1	2.5	5.0
West North Central	99	-0.1	1.1	0.3	3.9
West South Central	214	0.0	-1.0	1.7	3.3
Mountain	102	0.0	-0.4	1.1	3.4
Pacific	126	-0.1	-0.5	-1.6	0.5
By Bed Size:					
Psychiatric Hospitals					
Beds: 0-24	87	0.0	-0.8	0.6	2.5
Beds: 25-49	87	0.0	-1.1	1.0	2.6
Beds: 50-75	92	0.0	-0.4	0.8	3.1
Beds: 76 +	310	0.0	-0.4	0.0	2.2
Psychiatric Units					
Beds: 0-24	450	-0.1	0.2	0.4	3.2
Beds: 25-49	234	-0.1	0.5	-0.7	2.4
Beds: 50-75	98	-0.1	0.7	0.2	3.5
Beds: 76 +	72	-0.2	0.5	-1.1	1.9

[1] Providers in this table are classified as urban or rural based on the current CBSA delineations for FY 2024.

[2] This column includes the impact of the updates in columns (3) through (6) above, and of the proposed IPF market basket percentage increase for FY 2025 of 3.1 percent, reduced by O.4 percentage point for the productivity adjustment as required by section 1886(s)(2)(A)(i) of the Act.