Medicare Inpatient Psychiatric Facility Prospective Payment System

Proposed Payment Rule Brief provided by the Wisconsin Hospital Association
Program Year: FFY 2025

Overview and Resources

On March 28, 2024, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2025 proposed payment rule for the Inpatient Psychiatric Facility (IPF) Prospective Payment System (PPS). The proposed rule reflects the annual update to the Medicare fee-for-service (FFS) IPF payment rates and policies.

A copy of the proposed rule and other resources related to the IPF PPS are available on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS.

An online version of the proposed rule is available at https://federalregister.gov/d/2024-06764.

A brief of the proposed rule, along with page references for additional details, is provided below. Program changes adopted by CMS will be effective for discharges on or after October 1, 2024, unless otherwise noted. CMS estimates the overall economic impact of the proposed payment rate updates to be an increase of $70 million in aggregate payments to IPFs in FFY 2025 over FFY 2024.

Comments on the proposed rule were due to CMS by May 28, 2024.

Note: Text in italics is extracted from the proposed rule found in the April 3, 2024 *Federal Register*.

IPF Payment Rates

Federal Register pages 23149–23150, 23151–23154, and 23194

The table below lists the IPF federal per diem and the electroconvulsive therapy (ECT) base rates proposed for FFY 2025 compared to the rates currently in effect:

	Final FFY 2024	Proposed FFY 2025	Percent Change
IPF Per Diem Base Rate	**$895.63**	**$874.93**	**-2.31%**
ECT Base Rate	**$385.58**	**$660.30**	**+71.25%**
ECT Base Rate (based on OPPS Geometric Mean Cost)	**$675.93**		**-2.31%**

The following table provides details of the proposed updates to the IPF payment rates for FFY 2025:

	Proposed FFY 2025 IPF Base Rate Update
Marketbasket Update	**+3.1%**
ACA-Mandated Productivity MB Adjustment	**-0.4 percentage points (PPT)**
Wage Index Budget Neutrality Adjustment	**0.9998**
Refinement Standardization Factor	**0.9514**
Overall Rate Change	***-2.31%***

For this proposed rule, CMS analyzed the ancillary costs for IPF stays with ECT treatment and found that costs for furnishing ECT have risen by a factor greater than the standard methodology would adjust for. Under the standard methodology, the ECT payment for FFY 2025 would result in a payment of $377.54 per treatment, based on the previous ECT base rate adjusted by the market basket update, wage index budget neutrality, and a refinement standardization factor to account for all other proposed refinements without increasing ECT per treatment. In order to better align IPF PPS payments that include ECT payments with the increased cost of furnishing ECT, CMS analyzed the most recent outpatient PPS (OPPS) cost data to consider changes to the ECT payment for FFY 2025 because CMS believes OPPS ECT payments require comparable resources and are more granular than IPF cost and claims data. Based on this analysis, CMS is proposing to use the calendar year (CY) 2024 OPPS pre-scaled, pre-adjusted geometric mean cost for ECT of $675.93, updated by the proposed FFY 2025 IPF update factors.

The Consolidated Appropriations Act (CAA) of 2023 includes a provision that CMS interprets as any revisions in payment adjustments implemented for the IPF PPS for FFY 2025 and onwards must be budget neutral. As such, CMS proposes to apply a refinement standardization factor for FFY 2025 in order to account for the proposed updates to IPF patient-level adjustment factors, ED adjustments, and ECT per treatment amount. This factor is proposed to be 0.9514 and would be applied to the IPF per diem base rate and the ECT per treatment amount. Applying this adjustment to the proposed base ECT rate results is a ECT payment per treatment of $660.30 for FFY 2025.

Wage Index, Cost-of-Living Adjustment (COLA), Labor-Related Share, and Revised CBSA Delineations

Federal Register pages 23150–23151 and 23172–23190

The labor-related portions of the IPF per diem base rate and the ECT base rate are adjusted for differences in area wage levels using a wage index. CMS proposes to continue to use the current year pre-floor, pre-reclassification inpatient PPS (IPPS) wage index for FFY 2025 to adjust payment rates for labor market differences.

CMS applies the wage index to the estimated labor-related portion of the IPF standard rate to adjust for differences in area wage levels. Using the previously adopted 2021-based marketbasket, CMS is proposing to increase the labor-related share of the IPF per diem base rate and the ECT base rate from 78.7% in FFY 2024 to 78.8% for FFY 2025.

CMS is proposing a wage index budget neutrality factor of 0.9995 for FFY 2025 to ensure that aggregate payments made under the IPF PPS are not greater or less than would otherwise be made if wage adjustments had not changed. This includes the budget neutrality associated with the 5% wage index cap, described below.

CMS applies a 5% cap on any decrease to the IPF wage index, compared with the previous year's wage index. The cap is applied regardless of the reason for the decrease and implemented in a budget neutral manner. This also means that if an IPF's prior FFY wage index is calculated with the application of the 5% cap, the following year's wage index will not be less than 95% of the IPF's capped wage index in the prior FFY. A new IPF is paid the wage index for the area in which it is geographically located for its first full or partial FFY with no cap applied, because a new IPF would not have a wage index in the prior FFY.

On July 21, 2023, the Office of Management and Budget (OMB) issued OMB Bulletin No. 23-01 (https://www.whitehouse.gov/wp-content/uploads/2023/07/OMB-Bulletin-23-01.pdf) that made a number of significant changes related Core Based Statistical Area (CBSA) delineations. To align with these changes, CMS is proposing to adopt the newest OMB delineations for the FFY 2025 IPF PPS wage index. If CMS adopts this proposal, 54 counties that are currently part of an urban CBSA would be considered located in a rural area (including one urban county in Connecticut that being redesignated to a newly proposed rural CBSA), listed in Table 12 *of Federal Register* pages 23176-23177, and 54 counties that are currently located in rural areas would be considered located in urban areas, listed in Table 13 on *Federal Register* pages 23178-23179. Since CMS already applies a 5% cap on wage index loses from year to year (described above), CMS does not believe any additional transition policies are needed to account for the changes in wage index.

CMS states that 15 facilities designated as rural in FFY 2024 would become urban in FFY 2025 if this proposal is adopted, resulting in a loss of the 17% rural adjustment. To mitigate the impacts of this loss, CMS is proposing that these 15 IPF providers would be provided with a gradual phase out of their rural adjustment over a three-year period. Specifically, these providers would receive two-thirds of the rural adjustment in FFY 2025, one-third of the rural adjustment in FFY 2026, and no rural adjustment in FFY 2027. For the IPF providers changing from urban to rural status, there will be no phase-in; they would receive the full rural adjustment in FFY 2025.

A complete list of the proposed IPF wage indexes used for payment in FFY 2025 is available on the CMS website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/WageIndex.html.

For IPFs in Alaska and Hawaii, the IPF PPS provides a COLA. The COLA is applied by multiplying the non-labor-related portions of the per diem base rate and the ECT base rate by the applicable COLA factor. CMS proposes to continue using the existing IPF PPS COLA factors for FFY 2025 which are shown in Addendum A, as well as in Table 16 on *Federal Register* page 23190.

Adjustments to the IPF Payment Rates

Federal Register pages 23154–23172, 23189–23189, and 23190–23191

For FFY 2025, CMS is proposing to revise the facility and patient-level adjustments using CY 2019-2021 MedPAR files and FFY 2019-2021 cost report data. If a provider does not have a Medicare cost report for one or more years, CMS used the most recent available cost report prior to the year for which the cost report was missing. These revisions consider comments received by CMS in FFY 2024 rulemaking on topics of refining the IPF PPS as required by the CAA of 2023, reporting of ancillary charges on IPF claims, and CMS analysis of social drivers of health. The proposed adjustments to facility and patient-level adjustments are described below in detail. More detail on the regression analysis developed by CMS to revise IPF payments can be found on *Federal Register* pages 28-43.

- Patient Condition Medicare-Severity Diagnosis Related (MS-DRG) Adjustment *(Federal Register pages 23161–23165)*: For FFY 2025, CMS proposes to continue to utilize the MS-DRG system used under the IPPS to classify Medicare patients treated in IPF, with revisions, in a budget neutral manner.

  Similar to prior years, principal diagnoses codes (ICD-10-CM) that group to one of 19 MS-DRGs recognized under the IPF PPS are proposed to receive a DRG adjustment. Principal diagnoses that do not group to one of the designated MS-DRGs recognized under the IPF PPS would receive the federal per diem base rate and all other applicable adjustments but would not include a DRG adjustment in the payment.

  CMS is proposing to maintain 15 of the existing 17 IPF MS-DRGs and to make the following changes:
    - replace DRGs 080 (Nontraumatic stupor & coma w MCC) and 081 (Nontraumatic stupor & coma w/o MCC) with DRGs 947 (Signs and Symptoms w MCC) and 948 (Signs and Symptoms w/out MCC); and
    - add DRGs 917 (Poisoning and toxic effects of drugs w MCC) and 918 (Poisoning and toxic effects of drugs w/out MCC).

  The following table lists the 19 MS-DRGs proposed to be eligible for a MS-DRG adjustment under the IPF PPS for FFY 2025 and the updates to the adjustment factor for each DRG:

MS-DRG	Description	Final FFY 2024 Adjustment Factor	Proposed FFY 2025 Adjustment Factor
056	Degenerative nervous system disorders w MCC	1.05	1.13
057	Degenerative nervous system disorders w/o MCC	1.05	1.11
080	Non-traumatic stupor & coma w MCC	1.07	*
081	Non-traumatic stupor & coma w/o MCC	1.07	*
876	O.R. procedure w principal diagnoses of mental illness	1.22	1.29
880	Acute adjustment reaction & psychosocial dysfunction	1.05	1.08

881	Depressive neuroses	0.99	1.06
882	Neuroses except depressive	1.02	1.02
883	Disorders of personality & impulse control	1.02	1.17
884	Organic disturbances & mental retardation	1.03	1.08
885	Psychoses	1.00	1.00
886	Behavioral & developmental disorders	0.99	1.07
887	Other mental disorder diagnoses	0.92	1.00
894	Alcohol/drug abuse or dependence, left AMA	0.97	0.86
895	Alcohol/drug abuse or dependence w rehabilitation therapy	1.02	0.90
896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC	0.88	1.00
897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	0.88	0.95
917	Poisoning and toxic effects of drugs w MCC	**	1.19
918	Poisoning and toxic effects of drugs w/out MCC	**	1.12
947	Signs and Symptoms w MCC	**	1.13
948	Signs and Symptoms w/out MCC	**	1.09

*Proposed for removal for FFY 2025
**Proposed to include for FFY 2025

Additionally, CMS is proposing to incorporate a sub-regulatory process for handling routine coding updates, which would remove the requirement to discuss coding updates in the *Federal Register* during regulatory updates prior to implementation. This approach mirrors that of the IPPS.

- Patient Comorbid Condition Adjustment *(Federal Register pages 23165–23170)*: For FFY 2025, CMS is proposing to revise the comorbidity categories for which an adjustment to the per diem rate can be applied. For each claim, an IPF may receive only one comorbidity adjustment per comorbidity category, but it may receive an adjustment for more than one category.

  CMS is proposing the following changes to the number of ICD-10-CM codes in various comorbidity categories:
    - Eating and Conduct Disorders–removing all conduct disorder codes and designate as "Eating Disorders"
    - Chronic Obstructive Pulmonary Disease–adding 4 codes associated with sleep apnea and designate as "Chronic Obstructive Pulmonary Disease and Sleep Apnea"
    - Oncology Treatment–add 2 codes

  CMS is proposing to add a new comorbidity category to address costs of patients exhibiting violent behavior as well as other high-risk, non-violent behaviors. The Intensive Management for High-Rish Behavior category is proposed to include the following codes:
    - R451–Restlessness and agitation
    - R454–Irritability and anger
    - R4584–Anhedonia

  The following table lists all the proposed comorbid condition payment adjustment changes for FFY 2025.

Description of Comorbidity	Final FFY 2024 Adjustment Factor	Proposed FFY 2025 Adjustment Factor
Artificial Openings—Digestive and Urinary	1.08	1.07
Cardiac Conditions	1.11	1.05
Chronic Obstructive Pulmonary Disease and Sleep Apnea**	1.12	1.07
Coagulation Factor Deficits	1.13	*
Developmental Disabilities	1.04	1.04
Drug and/or Alcohol Induced Mental Disorders	1.03	*

Eating Disorders**	1.12	1.09
Gangrene	1.10	1.12
Infectious Diseases	1.07	*
Intensive Management for High-Risk Behavior	***	1.07
Oncology Treatment	1.07	1.46
Poisoning	1.11	1.16
Renal Failure, Acute	1.11	1.06
Renal Failure, Chronic	1.11	1.08
Severe Musculoskeletal and Connective Tissue Diseases	1.09	1.05
Severe Protein Calorie Malnutrition	1.13	1.17
Tracheostomy	1.06	1.09
Uncontrolled Diabetes Mellitus	1.05	1.05

*Proposed for removal for FFY 2025
**Proposed name change due to codes included for FFY 2025
***Proposed to add for FFY 2025

- Patient Age Adjustment *(Federal Register pages 23170–23171):* CMS proposes to continue the patient age adjustment for FFY 2025. However, an analysis by CMS has shown that the IPF per diem costs, which increase with patient age, warrant revision. The following table lists the proposed patient age adjustments for FFY 2025, which includes:
    - merging "45 and under 50" with "50 and under 55" to form the new age group "45 and under 55"; and
    - merging "70 and under 75" with "75 and under 80" to form the new age group "70 and under 80".

Final FFY 2024 Patient Age Adjustment Factors			
Age	**Adjustment Factor**	**Age**	**Adjustment Factor**
Under 45	1.00	65 and under 70	1.10
45 and under 50	1.01	70 and under 75	1.13
50 and under 55	1.02	75 and under 80	1.15
55 and under 60	1.04	80 and over	1.17
60 and under 65	1.07		

Proposed FFY 2025 Patient Age Adjustment Factors			
Age	**Adjustment Factor**	**Age**	**Adjustment Factor**
Under 45	1.00	65 and under 70	1.09
45 and under 55	1.02	70 and under 80	1.12
55 and under 60	1.05	80 and over	1.13
60 and under 65	1.07		

- Patient Variable Per Diem Adjustment *(Federal Register pages 23171–23172):* For FFY 2025, CMS proposes to continue the per diem rate adjustment, which is based on patient length-of-stay (LOS) using a variable per diem adjustment factor. An analysis by CMS has shown that per diem costs decline as the LOS increases. Currently, variable per diem adjustments begin on day 1 (adjustment of 1.19 or 1.31 depending on the presence of an Emergency Department (ED)) and gradually decline until day 21 of a patient's stay. For day 22 and onwards, the variable per diem adjustment remains the same for the remainder of the stay.

  A more recent analysis by CMS has shown that there is not a statistically significant decrease in cost per day after day 10. As such, CMS proposes to increase the adjustment factors for days 1-9 and that days 10 and above would receive an adjustment of 1.00. The following table lists the proposed variable per diem adjustment factors for FFY 2025.

Final FFY 2024 Patient Variable Per Diem Adjustment			
Day-of-Stay	**Adjustment Factor**	**Day-of-Stay**	**Adjustment Factor**
Day 1	1.19 (w/o ED) or 1.31 (w/ED)	Day 12	0.99
Day 2	1.12	Day 13	0.99
Day 3	1.08	Day 14	0.99
Day 4	1.05	Day 15	0.98
Day 5	1.04	Day 16	0.97
Day 6	1.02	Day 17	0.97
Day 7	1.01	Day 18	0.96
Day 8	1.01	Day 19	0.95
Day 9	1.00	Day 20	0.95
Day 10	1.00	Day 21	0.95
Day 11	0.99	After Day 21	0.92

Proposed FFY 2025 Patient Variable Per Diem Adjustment	
Day-of-Stay	**Adjustment Factor**
Day 1	1.27 (w/o ED) or 1.53 (w/ED)
Day 2	1.10
Day 3	1.15
Day 4	1.12
Day 5	1.08
Day 6	1.06
Day 7	1.03
Day 8	1.02
Day 9	1.01
Day 10+	1.00

- Rural Adjustment *(Federal Register page 23172)*: IPFs located in rural areas receive an adjustment to the per diem rate of 1.17. This adjustment is provided because an analysis by CMS determined that the per diem cost of rural IPFs was 17% higher than that of urban IPFs. CMS proposes to continue this adjustment in FFY 2025 without any revisions.

- Teaching Adjustment *(Federal Register pages 23172 and 23189–23189)*: CMS is proposing that IPFs with teaching programs continue to receive an adjustment to the per diem rate to account for the higher indirect operating costs experienced by hospitals that participate in graduate medical education programs. CMS also proposes to maintain the teaching adjustment coefficient value at 0.5150 for FFY 2025. The teaching adjustment is based on the number of full-time equivalent interns and residents training in the IPF and the IPF's average daily census.

- ED Adjustment *(Federal Register pages 23190–23191)*: For FFY 2025, CMS is proposing to continue the policy where IPFs with a qualifying ED would receive a variable per diem adjustment for day 1 of each stay. This adjustment is intended to account for the costs associated with maintaining a full-service ED. The ED adjustment applies to all IPF admissions, regardless of whether a patient receives preadmission services in the hospital's ED. This adjustment is proposed to increase from 1.31 in FFY 2024 to 1.53 in FFY 2025 and would not made when a patient is discharged from an acute care hospital or Critical Access Hospital (CAH) and admitted to the same hospital or CAH's psychiatric unit. In such cases, the IPF receives a proposed ED adjustment factor of 1.27 for FFY 2025, an increase from the adjustment factor of 1.19 from FFY 2024.

Outlier Payments

Federal Register page 23191

Outlier payments were established under the IPF PPS to provide additional payments for extremely costly cases. Outlier payments are made when an IPF's estimated total cost for a case exceeds a fixed dollar loss threshold amount (multiplied by the IPF's facility-level adjustments) plus the federal per diem payment amount for the case. Costs are determined by multiplying the facility's overall cost-to-charge ratio (CCR) by the allowable charges for the case. When a case qualifies for an outlier payment, CMS pays 80% of the difference between the estimated cost for the case and the adjusted threshold amount for the first through ninth day of the stay, and then 60% of the difference for the tenth day onwards. The varying 80% and 60% "loss sharing ratios" were established to discourage IPFs from increasing patient LOS in order to receive outlier payments.

CMS proposes to continue to use the established target of 2.0% of total IPF PPS payments to be set aside for high-cost outliers. To meet this target for FFY 2025, CMS proposes to update the outlier threshold to $35,590, a 6.3% increase over the FFY 2024 threshold of $33,470. To calculate this outlier threshold, CMS used FFY 2023 claims, excluding providers if their change in estimated average cost per day is outside 3 standard deviations from the mean.

Updates to the IPF Cost-to-Charge Ratio (CCR) Ceiling

Federal Register pages 23191–23192

CMS applies a ceiling to IPF's CCRs. If an individual IPF's CCR exceeds the appropriate urban or rural ceiling, the IPF's CCR is replaced with the appropriate national median CCR for that FFY, either urban or rural. The national urban and rural CCRs and the national urban and rural CCR ceilings for IPFs are updated annually, based on analysis of the most recent data that is available. The national median CCR is applied when:

- New IPFs have not yet submitted their first Medicare cost report;
- IPFs' overall CCR is in excess of 3 standard deviations above the corresponding national CCR ceiling for the current FFY; and/or
- Accurate data to calculate an overall CCR are not available for IPFs.

CMS proposes to continue to set the national CCR ceilings at 3 standard deviations above the mean CCR, and therefore the national CCR ceiling for FFY 2025 is proposed to be 2.3362 for rural IPFs and 1.8600 for urban IPFs. If an individual IPF's CCR exceeds this ceiling for FFY 2025, the IPF's CCR would be replaced with the appropriate national median CCR, urban or rural. CMS proposes a national median CCR of 0.5720 for rural IPFs and 0.4200 for urban IPFs, with both values being the same as were adopted for FFY 2024. Calculations of both the proposed national CCR ceiling and national median CCR are based on current (FFY 2024) CBSA-based geographic designations.

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

Federal Register pages 23192–23194

Currently, IPFs and psychiatric units are required to report ancillary charges on cost reports. However, analysis by CMS has found a notable increase in IPFs erroneously identifying as eligible for filing all-inclusive cost reports (indicating that they have one charge covering all services, listed on Worksheet S-2, Part 1, line 115). These providers are consistently reporting no or very minimal ancillary charges where CMS would otherwise expect to see ancillary services and correlated charges. The CAA of 2023 authorizes CMS to collect data and information on charges related to ancillary services to inform revisions to the IPF PPS. In the FFY 2024 proposed rule, CMS included a request for information related to reporting of charges for these services.

Based on comments received in prior rulemaking, CMS is clarifying the eligibility criteria to be approved to file all-inclusive cost reports. For cost report periods beginning on or after October 1, 2024, only government-owned or

tribally owned facilities will satisfy these criteria, and these will be the only facilities permitted the option to file an all-inclusive cost report.

IPF Quality Reporting (IPFQR) Program

Federal Register pages 23153–23154 and 23200–23213

IPFs that do not successfully participate in the IPFQR Program are subject to a 2.0 percentage point reduction to the market basket update for the applicable year.

CMS had previously finalized 16 measures for the FFY 2025 payment determination and for subsequent years, listed below.

Measure	NQF #	Payment Determination Year
HBIPS-2—Hours of Physical Restraint Use	#0640	FFY 2015+
HBIPS-3—Hours of Seclusion Use	#0641	FFY 2015+
IMM-2—Influenza Immunization	#1659	FFY 2017+
TOB-3/3a Tobacco Use Treatment Provided or Offered at Discharge and Tobacco Use Treatment at Discharge	N/A	FFY 2018+
SUB-2/2a Alcohol Use Brief Intervention Provided or Offered and Alcohol Use Brief Intervention	N/A	FFY 2018+
Transition record with specified elements received by discharged patients	N/A	FFY 2018+
Screening for Metabolic Disorders Measure	N/A	FFY 2018+
SUB-3/3a Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and Alcohol and Other Drug Use Disorder Treatment at Discharge	N/A	FFY 2019+
30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Facility	#2860	FFY 2019+
Medication Continuation Following Inpatient Psychiatric Discharge	#3205	FFY 2021+
Modified COVID-19 Healthcare Personnel (HCP) Vaccination Measure	N/A	FFY 2025+
Follow-Up After Psychiatric Hospitalization (FAPH)	N/A	FFY 2024+
Facility Commitment to Health Equity	N/A	FFY 2026+
Screening for Social Drivers of Health	N/A	FFY 2027+
Screen Positive Rate for Social Drivers of Health	N/A	FFY 2027+
Psychiatric Inpatient Experience (PIX) Survey	N/A	Voluntary FFY 2025-2027 Required FFY 2028+

CMS is proposing to include the *30-Day Risk-Standardized All-Cause ED Visit Following an IPF Discharge* Measure (reporting CY 2025 performance period/FFY 2027 payment determination) in the IPFQR.

For the FFY 2027 payment determination, and subsequent years, CMS is proposing that IPFQR data be submitted quarterly rather than yearly. If finalized, 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. Additionally, all data which continue to be reported on an annual basis (non-measure data, aggregate measures, and attestations) is proposed to be reported concurrently with the data from the fourth quarter of the applicable year. The below table shows the proposed quarterly submission deadlines for the CY 2025 and CY 2026 performance periods.

Performance Period	Submission Deadline
January 1, 2025–March 31, 2025	November 15, 2025
April 1, 2025–June 30, 2025	November 15, 2025

July 1, 2025–September 30, 2025	February 15, 2026
October 1, 2025–December 31, 202	May 15, 2026
January 1, 2026–March 31, 2026	August 15, 2026
April 1, 2026–June 30, 2026	November 15, 2026
July 1, 2026–September 30, 2026	February 15, 2027
October 1, 2026–December 31, 2026	May 15, 2027

Request for Information– Patient Assessment Instrument under IPFQR Program (IPF-PAI) to Improve the Accuracy of the PPS

Federal Register pages 23200–23204

The CAA of 2023 requires IPFs participating in the IPFQR program to collect and submit certain standardized assessment data using a standardized PAI for FFY 2028 and subsequent years. As CMS develops the IPF-PAI, CMS seeks to collect information to achieve the following goals:

- improve quality of care in IPFs;
- improve accuracy of the IPF PPS in accordance with the provisions included in the CAA of 2023; and
- improve health equity.

Specifically, CMS is seeking comment each of the following topics:

- The framework for development of the IPF-PAI (*Federal Register* pages 23201–23202);
- Potential approaches that could be used to develop data elements that make up the PAI, including data elements used in PAIs for other healthcare setting that could be adapted for use in the IPF-PAI (*Federal Register* pages 23202–23203);
- Potential approaches to collect patient assessment data (*Federal Register* page 23203);
- Selecting Patient Assessment Data Elements to be collected on the IPF-PAI (*Federal Register* pages 23203–23204);
- Implementation (*Federal Register* page 23204); and
- Relationship to the IPFQR program (*Federal Register* page 23204).

Request for Information: Informing Future Revisions to the IPF PPS

Federal Register pages 23194–23200

The CAA of 2023 requires revisions to the methodology for determining the payment rates under the IPF PPS for FFY 2025 and future years, if appropriate. This includes collecting data and information to revise payments, beginning no later than October 1, 2024. CMS seeks comments on their analysis of the following topics:

- Calculation of the rural location adjustment to include control variables (*Federal Register* page 23195)
- Inclusion of occupancy control variables in the determination of teaching adjustments (*Federal Register* pages 23195–23196)
- Using the Medicare Safety Net Index developed by MedPAC to adjust IPF payments (*Federal Register* pages 23196–23200)

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