Medicare Inpatient Psychiatric Facility Prospective Payment System

Final Payment Rule Brief provided by the Wisconsin Hospital Association

Program Year: FFY 2025

Overview and Resources

On July 31, 2024, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2025 final payment rule for the Inpatient Psychiatric Facility (IPF) Prospective Payment System (PPS). The final rule reflects the annual update to the Medicare fee-for-service (FFS) IPF payment rates and policies.

A copy of the final 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 final rule is available at https://www.federalregister.gov/d/2024-16909.

A brief of the final 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 final payment rate updates to be an increase of $65 million in aggregate payments to IPFs in FFY 2025 over FFY 2024.

Note: Text in italics is extracted from the August 7, 2024 *Federal Register*.

IPF Payment Rates

Federal Register pages 64585–64589, 64590–64593, and 64640–64641

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

<table>
<tr><th></th><th>Final
FFY 2024</th><th>Final
FFY 2025</th><th>Percent Change</th></tr>
<tr><td>IPF Per Diem Base Rate</td><td>$895.63</td><td>$876.53
(proposed at $874.93)</td><td>-2.13%
(proposed at -2.31%)</td></tr>
<tr><td>ECT Base Rate</td><td>$385.58</td><td rowspan="2">$661.52
(proposed at $660.30)</td><td>+71.56%
(proposed at +71.25%)</td></tr>
<tr><td>ECT Base Rate (based on OPPS Geometric Mean Cost)</td><td>$675.93</td><td>-2.13%
(proposed at -2.31%)</td></tr>
</table>

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

	Final FFY 2025 IPF Base Rate Update
Market Basket (MB) Update	**+3.3%** (proposed at +3.1%)
ACA-Mandated Productivity MB Adjustment	**-0.5 percentage points (PPTs)** (proposed at -0.4 PPTs)
Wage Index Budget Neutrality Adjustment	**0.9996** (proposed at 0.9998)
Refinement Standardization Factor	**0.9524** (proposed at 0.9514)
Overall Rate Change	***-2.13%*** *(proposed at -2.31%)*

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 $378.23 (proposed at $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 adopted 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 will use the calendar year (CY) 2024 OPPS pre-scaled, pre-adjusted geometric mean cost for ECT of $675.93, updated by the final FFY 2025 IPF update factors. Applying these adjustments FFY 2024 ECT rate results is a ECT payment per treatment of $661.52 (proposed at $660.30) for FFY 2025.

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 will apply a refinement standardization factor for FFY 2025 in order to account for the updates to IPF patient-level adjustment factors, ED adjustments, and ECT per treatment amount. This factor is finalized as 0.9524 (proposed at 0.9514) and will be applied to the IPF per diem base rate and the ECT per treatment amount.

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

Federal Register pages 64589–64590, 64614–64633, and 64635

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 will 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 market basket, CMS will 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% (as proposed) for FFY 2025.

CMS is adopting a wage index budget neutrality factor of 0.9996 (proposed at 0.9998) 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 adopting the newest OMB delineations for the FFY 2025 IPF PPS wage index. Using these new delineations, 54 counties that are currently part of an urban CBSA will be considered located in a rural area (including one urban county in Connecticut that being redesignated to a new rural CBSA), listed in Table 14 on *Federal Register* pages 64619–64620, and 54 counties that are currently located in rural areas will be considered located in urban areas, listed in Table 15 on *Federal Register* pages 64621–64623. 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 ten facilities designated as rural in FFY 2024 will become urban in FFY 2025, resulting in a loss of the 17% rural adjustment. To mitigate the impacts of this loss, these ten IPF providers will be provided with a gradual phase out of their rural adjustment over a three-year period. Specifically, these providers will 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 will receive the full rural adjustment in FFY 2025.

A complete list of the finalized 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 will continue using the existing IPF PPS COLA factors for FFY 2025 which are shown in Addendum A, as well as in Table 18 on *Federal Register* page 64635.

Facility- and Patient-level Adjustments to the IPF Payment Rates

Federal Register pages 64593–64614 and 64632–64636

For FFY 2025, CMS is revising the facility and patient-level adjustments using CY 2019-2021 MedPAR files and FFY 2019-2021 cost report data. For providers that do not have a Medicare cost report for one or more of these 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 adopted adjustments to facility and patient-level adjustments are described below. Details on the regression analysis developed by CMS to revise IPF payments can be found on *Federal Register* pages 64594–64601.

- Patient Condition Medicare-Severity Diagnosis Related (MS-DRG) Adjustment *(Federal Register pages 64602–64606)*: For FFY 2025, CMS will 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 will receive a DRG adjustment. Principal diagnoses that do not group to one of the designated MS-DRGs recognized under the IPF PPS will receive the federal per diem base rate and all other applicable adjustments but will not include a DRG adjustment in the payment.

  CMS will maintain 15 of the existing 17 IPF MS-DRGs and 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 that are eligible for a MS-DRG adjustment under the IPF PPS for FFY 2025, the updates to the adjustment factor for each MS-DRG, and the MS-DRGs that will no longer be eligible for an add-on adjustment.

MS-DRG	Description	Final FFY 2024 Adjustment Factor	Proposed FFY 2025 Adjustment Factor	Final FFY 2025 Adjustment Factor
056	Degenerative nervous system disorders w MCC	1.05	1.13	1.12
057	Degenerative nervous system disorders w/o MCC	1.05	1.11	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	1.22	1.29	1.29

	illness			
880	Acute adjustment reaction & psychosocial dysfunction	1.05	1.08	1.08
881	Depressive neuroses	0.99	1.06	1.06
882	Neuroses except depressive	1.02	1.02	1.02
883	Disorders of personality & impulse control	1.02	1.17	1.17
884	Organic disturbances & mental retardation	1.03	1.08	1.08
885	Psychoses	1.00	1.00	1.00
886	Behavioral & developmental disorders	0.99	1.07	1.07
887	Other mental disorder diagnoses	0.92	1.00	1.00
894	Alcohol/drug abuse or dependence, left AMA	0.97	0.86	0.86
895	Alcohol/drug abuse or dependence w rehabilitation therapy	1.02	0.90	0.90
896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC	0.88	1.00	1.00
897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	0.88	0.95	0.95
917	Poisoning and toxic effects of drugs w MCC	**	1.19	1.19
918	Poisoning and toxic effects of drugs w/out MCC	**	1.12	1.12
947	Signs and Symptoms w MCC	**	1.13	1.12
948	Signs and Symptoms w/out MCC	**	1.09	1.09

*To be removed for FFY 2025
**To be included for FFY 2025

Additionally, CMS will begin incorporating a sub-regulatory process for handling routine coding updates, which removes 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 64606–64612)*: For FFY 2025, CMS is revising 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 adopting 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 also adding 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 includes the following codes:
    - R451–Restlessness and agitation
    - R454–Irritability and anger
    - R4584–Anhedonia

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

Description of Comorbidity	Final FFY 2024 Adjustment Factor	Proposed FFY 2025 Adjustment Factor	Final FFY 2025 Adjustment Factor
Artificial Openings—Digestive and Urinary	1.08	1.07	1.07
Cardiac Conditions	1.11	1.05	1.04
Chronic Obstructive Pulmonary Disease and Sleep Apnea**	1.12	1.07	1.09
Coagulation Factor Deficits	1.13	*	*
Developmental Disabilities	1.04	1.04	1.04
Drug and/or Alcohol Induced Mental Disorders	1.03	*	*
Eating Disorders**	1.12	1.09	1.09
Gangrene	1.10	1.12	1.12
Infectious Diseases	1.07	*	*
Intensive Management for High-Risk Behavior	***	1.07	1.07
Oncology Treatment	1.07	1.46	1.44
Poisoning	1.11	1.16	1.16
Renal Failure, Acute	1.11	1.06	1.06
Renal Failure, Chronic	1.11	1.08	1.08
Severe Musculoskeletal and Connective Tissue Diseases	1.09	1.05	1.05
Severe Protein Malnutrition	1.13	1.17	1.17
Tracheostomy	1.06	1.09	1.09
Uncontrolled Diabetes	1.05	1.05	1.05

*To be removed for FFY 2025
**Name change due to codes included for FFY 2025
***To be included for FFY 2025

- Patient Age Adjustment *(Federal Register pages 64612–64613):* CMS will continue the patient age adjustment for FFY 2025, which is based on the patient age at the time of admission. 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 adopted patient age adjustments for FFY 2025, which include:
    - 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		

Final FFY 2025 Patient Age Adjustment Factors	
Age	Final Factor
Under 45	1.00 (as proposed)
45 and under 55	1.02 (as proposed)
55 and under 60	1.05 (as proposed)
60 and under 65	1.06 (proposed at 1.07)
65 and under 70	1.09 (as proposed)
70 and under 80	1.11 (proposed at 1.12)
80 and over	1.13 (as proposed)

- Patient Variable Per Diem Adjustment *(Federal Register pages 64613–64614)*: For FFY 2025, will 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 will increase the adjustment factors for days 1-9 and that days 10 and above will receive an adjustment of 1.00. The following table lists the adopted 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

Final FFY 2025 Patient Variable Per Diem Adjustment	
Day-of-Stay	**Adjustment Factor**
Day 1	1.28 (w/o ED) (proposed at 1.27) 1.54 (w/ED) (proposed at 1.53)
Day 2	1.20 (proposed at 1.10)
Day 3	1.15 (as proposed)
Day 4	1.12 (as proposed)
Day 5	1.08 (as proposed)
Day 6	1.06 (as proposed)
Day 7	1.03 (as proposed)
Day 8	1.02 (as proposed)
Day 9	1.01 (as proposed)
Day 10+	1.00 (as proposed)

- Rural Adjustment *(Federal Register pages 64632–64633)*: IPFs located in rural areas receive an adjustment to the per diem rate of 1.17. This adjustment is provided because an analysis previous done by CMS determined that the per diem cost of rural IPFs was 17% higher than that of urban IPFs. CMS will continue this adjustment in FFY 2025 without any revisions.

- Teaching Adjustment *(Federal Register pages 64634–64635)*: IPFs with teaching programs will 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 will maintain the teaching adjustment coefficient value at 0.5150 for FFY 2025. This 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.

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- <u>ED Adjustment</u> *<u>(Federal Register pages 64635–64636)</u>:* For FFY 2025, CMS will continue the policy where IPFs with a qualifying ED will receive a variable per diem adjustment for day one 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 will increase from 1.31 in FFY 2024 to 1.54 in FFY 2025 (proposed at 1.53) and will not be 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 an adjustment factor of 1.28 (proposed at 1.27) for FFY 2025, an increase from the adjustment factor of 1.19 from FFY 2024.

Outlier Payments

Federal Register pages 64636–64637

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 will 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 will update the outlier threshold to $38,110 (proposed at $35,590), a 13.9% increase over the FFY 2024 threshold of $33,470. To calculate this outlier threshold, CMS used FFY 2023 claims updated as of March 2024, excluding providers if their change in estimated average cost per day is outside three standard deviations from the mean.

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

Federal Register pages 64637–64638

CMS applies a ceiling to IPFs' 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 three 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 will continue to set the national CCR ceilings at three standard deviations above the mean CCR, and therefore the national CCR ceiling for FFY 2025 will be 2.3181 (proposed at 2.3362) for rural IPFs and 1.8287 (proposed at 1.8600) for urban IPFs. If an individual IPF's CCR exceeds this ceiling for FFY 2025, the IPF's CCR will be replaced with the appropriate national median CCR, urban or rural. CMS is adopting a national median CCR of 0.5720 (as proposed) for rural IPFs and 0.4200 (as proposed) for urban IPFs, with both values being the same as were adopted for FFY 2024. Calculations of both the final 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 64638–64640

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 64642–64663

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 15 measures for the FFY 2025 payment determination and for subsequent years. CMS is adopting its proposal 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. All IPFQR measures, and their associated payment determination FFY, are listed in the table below.

Measure	NQF #	Payment Determination Year
Required Measures		
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+
30-Day Risk-Standardized All-Cause ED Visit Following an IPF Discharge	N/A	FFY 2027+

Voluntary Measures		
Psychiatric Inpatient Experience (PIX) Survey	N/A	Voluntary FFY 2025-2027 Required FFY 2028+

Based on comments received, CMS is not adopting the proposal that IPFQR data be submitted quarterly rather than yearly, beginning with the FFY 2027 payment determination. CMS agreed with commenters that moving to quarterly reporting for the CY 2025 performance period would not allow enough time for new and existing IPF providers to update processes and systems that to meet the initial submission deadline. If CMS proposes this policy in the future, it will consider recommendations received for future proposals regarding quarterly data submission, a transition time required for IPFs to update their submissions, evaluation of the timing of the CMS Specifications Manual with respect to reporting deadlines, and policies to ensure that new certified IPFs are able to participate in the IPFQR Program.

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

Federal Register pages 64642–64649

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 sought comment each of the following topics:

- The framework for development of the IPF-PAI (*Federal Register* pages 64642–64644);
- 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 64644–64645);
- Potential approaches to collect patient assessment data (*Federal Register* page 64645); and
- Selecting Patient Assessment Data Elements to be collected on the IPF-PAI and the implementation process (*Federal Register* pages 64645–64649).

Responses to comments received can be found on the page numbers referenced above.

Request for Information: Informing Future Revisions to the IPF PPS

Federal Register pages 64641–64642

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. In the FFY 2025 IPF proposed rule, CMS sought comments on their analysis of the following topics:

- Calculation of the rural location adjustment to include control variables
- Inclusion of occupancy control variables in the determination of teaching
- Using the Medicare Safety Net Index developed by MedPAC to adjust IPF payments

A brief discussion on comments received by CMS can be found on *Federal Register* pages 64641–64642

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