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Regulatory Advisory

April 14, 2023

Inpatient Psychiatric Facility PPS Proposed Rule for FY 2024

The Centers for Medicare & Medicaid Services (CMS) April 4 issued its fiscal year (FY) 2024 proposed rule for the inpatient psychiatric facility (IPF) prospective payment system (PPS).

KEY HIGHLIGHTS

The proposed rule would:

- Update the IPF payment rate by a net 1.9% in FY 2024 as compared to FY 2023;
- Rebase and revise the IPF PPS market basket based on 2021 data;
- Adopt four new quality measures, modify one and remove two.

In addition, the agency:

- Solicits comments to inform the revisions to the IPF PPS required by law;
- Proposes to allow hospitals to open a new IPF unit at any time during the cost reporting period.

WHAT YOU CAN DO

CMS will accept comments on this rule through June 5.

- To submit comments, visit http://www.regulations.gov or send via regular mail to CMS.
- AHA will be submitting comments on the rule and will share these comments with the field prior to the deadline.

PROPOSED IPF PPS PAYMENT PROVISIONS

CMS proposes several updates to IPF payment rates.

- CMS proposes to increase IPF payments by a net 1.9% equivalent to $55 million in FY 2024.
- This 1.9% payment update includes a 3.2% market basket update, a 0.2% productivity cut as required by law and a cut of one percentage point related to outlier payments.
- Under these payment updates, the federal per diem base rate would be $892.58 (an increase from the previous rate of $865.63). The electroconvulsive therapy payment per treatment would be $384.27 (an increase from the previous rate of $372.67).

- The labor-related share for FY 2024 is proposed to be 78.5%, an increase from the FY 2023 labor-related share of 77.4%.
- The fixed dollar loss threshold amount would be $34,750 (an increase from the previous amount of $24,630) to maintain estimated outlier payments at 2% of the total estimated aggregate IPF PPS payments.

Proposal to Rebase and Revise the IPF PPS Market Basket on 2021 Data. CMS rebases and revises the market basket periodically to reflect more recent changes in the mix of goods and services IPFs purchase to furnish care. The agency last rebased and revised the market basket in the FY 2020 IPF PPS final rule, in which CMS used 2016 data. Therefore, CMS proposes to rebase the market basket using 2021 data. The proposed methodology is generally similar to the methodology used for the last revision and rebasing.

Proposed Modification to the Excluded Units Paid Regulation under the IPF PPS. Currently, hospitals may only open a new IPPS-excluded psychiatric unit at the start of a cost reporting period due to complex administrative and regulatory complexities defining these units. In other words, a hospital is limited in when it can designate an existing unit as psychiatric or open a new psychiatric unit that is paid under the IPF PPS. Several stakeholders have suggested that these requirements are unnecessarily restrictive and burdensome; for example, the need to wait until the next cost reporting period may delay hospitals from opening needed psychiatric beds that would be paid under the IPF PPS. In response, CMS proposes to allow a hospital to open a new IPF unit any time within the cost reporting period as long as the hospital notifies the CMS Regional Office and Medicare Administrative Contractor in writing of the change at least 30 days before the date of the change.

REQUESTS FOR INFORMATION

Revisions to the IPF PPS. The Consolidated Appropriations Act of 2023 requires revisions to the IPF PPS beginning in FY 2025. It also requires the secretary to collect data on cost reports beginning Oct. 1, 2023 to inform these revisions. CMS seeks public feedback about specific additional data and information psychiatric hospitals and units might report that could be appropriate and useful to help inform possible revisions to the methodology for payment rates under the IPF PPS. The agency also requests input on potential available data and information sources, including using additional elements of current cost reports and claims.

In addition, CMS is interested in better understanding IPF industry billing practices pertaining to ancillary services. The agency requests information on the reporting of charges for ancillary services such as labs and drugs on IPF claims. CMS states that it is considering whether to require charges for these services to be reported on claims and potentially reject claims with no ancillary services reported as inappropriate or erroneous.

Social Drivers of Health (SDOH). CMS has conducted analysis on the association of ICD-10 codes that indicate certain SDOH with differences in costs. Their findings demonstrate mixed results, but the agency has found that specific codes (specifically particular Z-codes) tend to increase relative costliness of IPF stays. CMS seeks comment on their findings as well as whether it would be appropriate to consider incorporating these codes into the IPF PPS in the future as a patient-level adjustment.

IPF QUALITY REPORTING PROGRAM (IPFQR)

CMS proposes several changes to the IPFQR, including to the measure set used in the program and administrative requirements and policies.

Proposed Adoption of the Facility Commitment to Health Equity Measure. Beginning with the FY 2026 payment determination (data reporting in calendar year (CY) 2025 reflecting performance in CY 2024), CMS proposes to adopt this structural measure that assesses whether an IPF demonstrates certain equity-focused organizational competencies. IPFs would be asked to attest to several statements within five domains, including:

1. Equity is a strategic priority;
2. Data collection;
3. Data analysis;
4. Quality improvement; and
5. Leadership engagement.

Several domains comprise multiple attestation statements; to receive credit for the domain, an IPF would have to attest affirmatively to each statement within that domain (in other words, there is no partial credit). Performance would be scored out of five points. The measure was adopted for the IQR in the FY 2023 Inpatient Prospective Payment System (IPPS) final rule. The measure is not endorsed by a consensus-based entity (CBE), and CMS has not submitted it for endorsement.

Proposed Adoption of the Screening for Social Drivers of Health Measure. Beginning with voluntary reporting in CY 2025 of data collected in CY 2024 and required reporting in CY 2026 of data collected in CY 2025 data (to inform the FY 2027 payment determination), CMS proposes to adopt this structural measure that evaluates whether IPFs are screening patients for certain health-related social needs (HRSNs). CMS explains that IPFs could use a self-selected screening tool to collect data on HRSNs including:

- Food insecurity;
- Housing instability;
- Transportation needs;
- Utility difficulties; and
- ~~Interpersonal safety.~~

IPFs would report the number of inpatients admitted to the facility who are 18 years or older at the time of admission who were screened for all five HRSNs. The measure was adopted for the IQR in the FY 2023 IPPS Final Rule. The measure is not endorsed by a CBE, and CMS has not submitted it for endorsement.

Proposed Adoption of the Screen Positive Rate for Social Drivers of Health Measure. Beginning with voluntary reporting in CY 2025 of data collected in CY 2024 and required reporting in CY 2026 of data collected in CY 2025 data (to inform the FY 2027 payment determination), CMS proposes to adopt this measure that assesses the percent of patients admitted to the IPF who were screened for the HRSNs listed above who screen positive for one or more. IPFs would report five separate rates (one for each need). The measure is intended to provide information to IPFs on the level of unmet HRSNs among patients served, "and not for comparison between IPFs." The measure was adopted for the IQR in the FY 2023 IPPS final rule. The measure is not endorsed by a CBE, and CMS has not submitted it for endorsement.

Proposed Adoption of the Psychiatric Inpatient Experience (PIX) Survey. Beginning with voluntary reporting in CY 2026 and mandatory reporting in CY 2027, CMS proposes to adopt a specific patient experience of care instrument, the PIX survey, and a measure based on patient responses on a 5-point Likert scale to survey items. The survey comprises 23 items across four domains, including:

- Relationship with treatment team;
- Nursing presence;
- Treatment effectiveness; and
- Healing environment.

The measure would be reported as five separate rates: one for each of these four domains and one overall rate. Mean rates would be publicly reported on Care Compare.

The survey is distributed to patients, on paper or on a table computer, by administrative staff at a time beginning 24 hours prior to planned discharge. Patients would be excluded from the measure if they are younger than 13 years old at discharge or unable to complete the survey due to cognitive or intellectual limitations.

CMS acknowledges that IPFs already administer different patient experience of care survey instruments to their patients and would thus need to transition to the PIX survey. Because of this, the agency proposes a voluntary reporting period during which IPFs would be able to begin administering the PIX survey and collecting survey data in CY 2025 to report on a voluntary basis in CY 2026, and would be required to administer the survey and collect data during CY 2026 to report during CY 2027; this would affect the FY 2028 payment determination.

Proposed Modification of the COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) Measure. Beginning with the FY 2025 IPFQR, CMS would modify the current HCP COVID-19 vaccination measure used in the program. The current measure

assesses the number of HCP who have received a complete vaccination course against COVID-19; in this rule, CMS proposes to replace the definition of "complete vaccination course" with a definition of "up to date" with CDC recommended COVID-19 vaccines. The agency proposes this modification to incorporate new CDC guidance related to booster doses and their associated timeframes.

CMS does not propose any changes to the data submission or reporting processes for this measure. Compliance for the FY 2025 payment determination would be based on reporting of individuals who are up to date beginning in quarter four of CY 2023.

Proposed Measure Removals. Beginning with the FY 2025 payment determination, CMS would remove the following measures from the IPFQR:

- Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification (HBIPS-5): The agency believes that this measure is no longer aligned with current clinical guidelines and practice.
- Tobacco Use Brief Intervention Provided or Offered and Tobacco Use Brief Intervention Provided (TOB-2/2a): The agency believes that the costs associated with this measure outweigh its benefits; in addition, the agency would retain a related measure, Tobacco Use Treatment Provided or Offered at Discharge and Tobacco Use Treatment at Discharge (TOB-3/3a), which it believes would better drive improvement in patient outcomes.

Proposed Data Validation Pilot Program. In the FY 2022 IPF PPS final rule, CMS adopted required patient-level data reporting beginning with data submitted in CY 2023, affecting the FY 2024 payment determination. In this rule, CMS proposes to begin validating this data in a pilot program beginning with data submitted in CY 2024, affecting the FY 2025 payment determination. Specifically, CMS proposes to request eight charts per quarter from each of 100 randomly selected IPFs. The agency notes that it would reimburse IPFs for the cost of submitting charts for validation at a rate of $3.00 per chart. The pilot would be voluntary.

FURTHER QUESTIONS

If you have questions, please contact Caitlin Gillooley, AHA's director for quality and behavioral health policy, at 202-626-2267 or cgillooley@aha.org.