Medicare Inpatient Psychiatric Facility Prospective Payment System

Final Payment Rule Brief provided by the Wisconsin Hospital Association

Program Year: FFY 2024

Overview and Resources

On July 27, 2023, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2024 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 will be available at https://federalregister.gov/d/2023-16083

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, 2023, unless otherwise noted. CMS estimates the overall economic impact of the finalized payment rate updates to be an increase of $70 million (proposed at $55 million) in aggregate payments to IPFs in FFY 2024 over FFY 2023.

Note: Text in italics is extracted from the August 2, 2023 *Federal Register*.

IPF Payment Rates

Federal Register pages 51,076 – 51,078 and 51,081 – 51,082

The table below lists the IPF federal per diem and the electroconvulsive therapy (ECT) base rates adopted for FFY 2024 compared to the rates currently in effect:

	Final FFY 2023	Final FFY 2024	Percent Change
IPF Per Diem Base Rate	**$865.63**	**$895.63** (proposed at $892.58)	**+3.47%** (proposed at +3.11%)
ECT Base Rate	**$372.67**	**$385.58** (proposed at $384.27)	

The following table provides details of the adopted updates to the IPF payment rates for FFY 2024:

	FFY 2024 IPF Rate Update
Marketbasket Update	**+3.5%** (proposed at +3.2%)
ACA-Mandated Productivity MB Adjustment	**-0.2 percentage points (PPT)** (as proposed)
Wage Index Budget Neutrality Adjustment	**1.0016** (proposed at 1.0011)
Overall Rate Change	***+3.47*** *(proposed at +3.11%)*

Update to the IPF Market Basket Base Year

Federal Register pages 51,057 – 51,078

CMS periodically rebases the market basket to reflect the changes in the goods and services needed to furnish IPF services. CMS will rebase and revise the IPF market basket to reflect a 2021 base year, beginning with FFY 2024, rather than the current 2016 base year for both freestanding and hospital-based IPFs.

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

Federal Register pages 51,078 – 51,081, 51,085 – 51,087, and 51,088 – 51,089

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 2024 to adjust payment rates for labor market differences.

CMS estimates the labor-related portion of the IPF standard rate and also adjusts for differences in area wage levels, using a wage index. Using the adopted 2021-based market basket, CMS is increasing the labor-related share of the IPF per diem base rate and the ECT base rate from 77.4% in FFY 2023 to 78.7% (proposed at 78.5%) for FFY 2024.

A complete list of the finalized IPF wage indexes for payment in FFY 2024 is available on the CMS website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/WageIndex.html.

CMS is adopting wage index a budget neutrality factor of 1.0016 (proposed at 1.0011) for FFY 2024 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.

In the FFY 2023 IPF final rule, CMS finalized a policy to apply a 5% cap on any decrease of the FFY 2023 IPF wage index, and all future IPF wage indexes, 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. Lastly, a new IPF will be 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.

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. Under the IPPS COLA policy, the COLA updates are determined every four years, when the IPPS market basket is rebased. CMS will continue to use the existing IPF PPS COLA factors for FFY 2024 which are shown in Addendum A, as well as in Table 16 on page 51,089 of the *Federal Register* of the final rule.

Adjustments to the IPF Payment Rates

Federal Register pages 51,083 – 51,085 and 51,087 – 51,090

For FFY 2024, CMS will retain the facility and patient-level adjustments currently used for the FFY 2023 IPF PPS. The adjustments are described below in detail.

- Patient Condition Medicare-Severity Diagnosis Related (MS-DRG) Adjustment *(Federal Register pages 51,083 – 51,084):* For FFY 2024, CMS will continue to utilize the MS-DRG system used under the IPPS to classify Medicare patients treated in IPFs.

  As has been the case in prior years, principal diagnoses codes (ICD-10-CM) that group to one of 17 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 would still receive the federal per diem base rate and

all other applicable adjustments, but the payment will not include a DRG adjustment. The following table lists the 17 MS-DRGs that are eligible for a MS-DRG adjustment under the IPF PPS for FFY 2024. These are the same as the adjustment levels currently in place.

MS-DRG	Description	Adjustment Factor
056	Degenerative nervous system disorders w MCC	1.05
057	Degenerative nervous system disorders w/o MCC	1.05
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
880	Acute adjustment reaction & psychosocial dysfunction	1.05
881	Depressive neuroses	0.99
882	Neuroses except depressive	1.02
883	Disorders of personality & impulse control	1.02
884	Organic disturbances & mental retardation	1.03
885	Psychoses	1.00
886	Behavioral & developmental disorders	0.99
887	Other mental disorder diagnoses	0.92
894	Alcohol/drug abuse or dependence, left AMA	0.97
895	Alcohol/drug abuse or dependence w rehabilitation therapy	1.02
896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC	0.88
897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	0.88

- Patient Comorbid Condition Adjustment *(Federal Register page 51,084):* For FFY 2024, CMS will to continue to recognize 17 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. The following table lists the adopted comorbid condition payment adjustments for FFY 2024. These are the same as the adjustment levels currently in place.

Description of Comorbidity	Adjustment Factor
Artificial Openings—Digestive and Urinary	1.08
Cardiac Conditions	1.11
Chronic Obstructive Pulmonary Disease	1.12
Coagulation Factor Deficits	1.13
Developmental Disabilities	1.04
Drug and/or Alcohol Induced Mental Disorders	1.03
Eating and Conduct Disorders	1.12
Gangrene	1.10
Infectious Diseases	1.07
Oncology Treatment	1.07
Poisoning	1.11
Renal Failure, Acute	1.11
Renal Failure, Chronic	1.11
Severe Musculoskeletal and Connective Tissue Diseases	1.09
Severe Protein Calorie Malnutrition	1.13
Tracheostomy	1.06
Uncontrolled Diabetes Mellitus	1.05

Additionally, CMS is finalizing the following changes to the number of ICD-10-CM codes in various comorbidity categories:

- Chronic Renal Failure – adding 2 codes and removing 1 code;
- Chronic Obstructive Pulmonary Disease – adding 2 codes;
- Infectious Disease – adding 1 code;
- Poisoning – adding 4 codes;
- Oncology Treatment Procedure – adding 6 codes
- Oncology Treatment Diagnosis – adding 12 codes and deleting 2 codes; and
- Acute Renal Failure – adding 1 code and deleting 1 code.

- Patient Age Adjustment *(Federal Register page 51,084):* CMS will maintain the patient age adjustment for FFY 2024 as a previous analysis by CMS had shown that IPF per diem costs increase with patient age. The following table lists the patient age adjustments for FFY 2024. These are the same as the adjustment levels currently in place.

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		

- Patient Variable Per Diem Adjustment *(Federal Register page 51,085):* For FFY 2024, CMS 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. The following table lists the adopted variable per diem adjustment factors for FFY 2024. These are the same as the adjustment levels currently in place.

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

- Rural Adjustment *(Federal Register page 51,087):* 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 will continue this adjustment in FFY 2024.

- Teaching Adjustment *(Federal Register page 51,088):* 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 also maintain the teaching adjustment coefficient value at 0.5150 for FFY 2024. 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 51,089 – 51,090):* For FFY 2024, IPFs with a qualifying ED will continue to receive an adjustment factor of 1.31 as the 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. The 1.31 ED adjustment is 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 an ED adjustment factor of 1.19.

Outlier Payments

Federal Register pages 51,090 – 51,092

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 has established a target of 2.0% of total IPF PPS payments to be set aside for high cost outliers. To meet this target for FFY 2024, CMS is updating the outlier threshold to $33,470 (proposed at $34,750), a 35.9% increase over the FFY 2023 threshold of $24,630. To calculate this outlier threshold, CMS used FFY 2022 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 page 51,092

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 will continue to set the national CCR ceilings at 3 standard deviations above the mean CCR, and therefore the national CCR ceiling for FFY 2024 will be 2.1419 (proposed at 2.0801) for rural IPFs and 1.8026 (proposed at 1.7864) for urban IPFs. If an individual IPF's CCR exceeds this ceiling for FFY 2024, the IPF's CCR will be replaced with the appropriate national median CCR, urban or rural. CMS adopted 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 2023.

Modifications to the Regulation for Excluded IPF Units Paid Under the IPF PPS

Federal Register pages 51,092 – 51,095

Currently, to be paid under IPF PPS, and therefore excluded from the IPPS, an IPF unit of a hospital must be paid under the IPF PPS for services provided in an excluded unit at the start of a cost reporting period, and may not attain this payment status in the middle of a cost report period.

CMS believes that this requirement is burdensome for hospitals as it is often difficult to predict the exact timing of the end of a construction project for a new unit, and therefore the hospital cannot always guarantee the

completion at the start of a cost reporting period. This can lead to significant revenue loss if the hospital is unable to be paid under the IRF PPS until the start of the next cost reporting period. CMS also believes there is an increase in mental health needs and the need for availability of inpatient psychiatric beds.

Separately, the current requirements were established when excluded IPF units were paid at cost-based reimbursement and not PPS, and therefore the restriction that limits an IPF unit to gaining excluded-unit status to the start of a cost reporting period is no longer necessary.

Since advancements in technology have simplified the cost reporting process and have enhanced communication between providers, CMS is finalizing greater flexibility for hospitals to open excluded units. Specifically, CMS will allow a hospital to open a new IPF unit anytime within the cost reporting year, as long as the hospital provides notification in writing of the change to both CMS and their Medicare Administrative Contractor at least 30 days before the date of the change. Additionally, a unit becomes IPPS-excluded during a cost reporting year, this change will remain in effect for the rest of that cost reporting year.

IPF Quality Reporting (IPFQR) Program

Federal Register pages 51,098 – 51,145

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 14 measures for the FFY 2024 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+
HBIPS-5—Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification	#0560	FFY 2015+ ***(finalized removal for FFY 2025+)***
IMM-2—Influenza Immunization	#1659	FFY 2017+
TOB-2/2a—Tobacco Use Treatment Provided or Offered and Tobacco Use Treatment	N/A	FFY 2017+ ***(finalized removal for FFY 2025+)***
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+
COVID-19 Healthcare Personnel (HCP) Vaccination Measure	TBD	FFY 2023+
Follow-Up After Psychiatric Hospitalization (FAPH)	N/A	FFY 2024+

CMS is adopting four new measures for the IPF QRP:

- Facility Commitment to Health Equity (attestation in calendar year (CY) 2024 reporting period for CY 2025/FFY 2026 payment determination);
- Screening for Social Drivers of Heath (SDOH) (voluntary reporting CY 2024 followed by required reporting CY 2025/FFY 2027 payment determination);
- Screen Positive Rate for SDOH (voluntary reporting CY 2024 followed by required reporting CY 2025/FFY 2027 payment determination); and
- Psychiatric Inpatient Experience (PIX) Survey (voluntary reporting CY 2025 followed by required reporting CY 2026/FFY 2028 payment determination).

Separately, CMS is removing two measures beginning with the FFY 2025 IPF QRP:

- Patents Discharged on Multiple Antipsychotic Medications with Appropriate Justification (HBIPS-5); and
- Tobacco Use Brief Intervention Provided or Offered and Tobacco Use Brief Intervention (TOB-2/2a).

Beginning with 4th quarter CY 2023 reporting period/FFY 2025 payment determination, CMS will modify the "COVID-19 Vaccination Coverage among Healthcare Personnel" measure to replace the term "complete vaccination course" with the term "up to date" in the healthcare personnel vaccination definition. CMS will also update the numerator to specify the time frames within which a healthcare personnel is considered up to date with recommended COVID-19 vaccines.

Lastly, CMS is implementing voluntary data validation pilot program beginning with data submitted in CY 2025 (reflecting care provided during CY 2024). CMS is requesting 8 charts per quarter (32 charts per year) and will randomly select up to 100 IPFs on an annual basis to provide those charts to CMS. CMS will specify the timeline and mechanism for submitting those charts to the individual IPFs that have been chosen. CMS will also reimburse IPFs at a rate of $3.00 per chart submitted for validation.

Request for Information: Inform Revisions to the IPF PPS

Federal Register pages 51,095 – 51,098

The Consolidated Appropriations Act 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, 2023. Data collection may include, but is not limited to:

- *"Charges, including those related to ancillary services;*
- *The required intensity of behavioral monitoring, such as cognitive deficit, suicidal ideations, violent behavior, and need for physical restraint; and*
- *Interventions, such as detoxification services for substance abuse, dependence on respirator, total parenteral nutritional support, dependence on renal dialysis, and burn care."*

With regards to collection of data and information, CMS is sought comment on several topics listed on *Federal Register* page 51,097. CMS solicited comment on requiring charges for ancillary services to be reported on claims, with specific questions listed on *Federal Register* page 51,098. Lastly, CMS sought comment on SDOH ICD-10 codes that are considered statistically significant and whether they should be incorporated into IPF PPS.

CMS did not respond to comments submitted in this final rule.

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