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Medicare Program; FY 2022 Inpatient Psychiatric Facilities Prospective Payment System and Quality Reporting Updates Proposed Rule Summary

On April 7, 2021, the Centers for Medicare & Medicaid Services (CMS) released the proposed rule to update the payment rates under the Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) for fiscal year (FY) 2022. IPFs include psychiatric hospitals and excluded psychiatric units of acute hospitals or critical access hospitals. Updates to the market basket and payment adjustments for the FY 2022 IPF PPS are described as well as any updates to the IPF Quality Reporting (IPFQR) Program. The proposed rule will be published in the April 13, 2021 Federal Register. **The public comment period ends on June 7, 2021**.

Tables summarizing the proposed FY 2022 IPF PPS payment rates and adjustments (Addendum A); the complete listing of ICD-10 Clinical Modification (CM) and Procedure Coding System codes (ICD-10-CM/PCS) (Addendum B) are not included in the proposed rule but are available online at: Tools and Worksheets | CMS. The FY 2022 wage index tables are available at Wage Index | CMS.

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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 as applicable to the IPF stay. The proposed rule reviews in detail the statutory basis and regulatory history of the IPF PPS; the system was implemented in January 2005 and was put on a federal FY updating cycle beginning with FY 2013.

The base payment rate was initially based on the national average daily IPF costs in 2002 updated for inflation and adjusted for budget neutrality. The initial standardized budget-neutral federal per diem base rate established for cost reporting periods beginning on or after January 1, 2005 was $575.95, and has 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 electroconvulsive therapy (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. Facility-level adjustments involve 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).

In order to bill for ECT services IPFs must include a valid procedure code; CMS reports that it is proposing no changes to the ECT procedure codes as a result of the update to the ICD-10-PCS code set for FY 2022. (The ECT procedure codes for FY 2022 are included in Addendum B; link provided on page 1 of this summary.)

Regulations pertaining to the IPF PPS are found in Subpart N of 42 CFR Part 412.

II. Provisions of the FY 2022 IPF PPS Proposed Rule

A. Market Basket Update

For FY 2022, CMS updates the 2016-based IPF market basket to reflect projected price increases according to the IHS Global Inc.'s (IGI) fourth quarter 2020 forecast with historical data through the third quarter of 2020. Using that forecast, the 2016-based IPF market basket increase factor for FY 2022 is 2.3 percent.

Based on IGI's fourth quarter 2020 forecast, the 10-year moving average of multi-factor productivity (MFP) for the period ending FY 2022 is 0.2 percent. CMS proposes to reduce the 2.3 percent IPF market basket update by the 0.2 percentage point productivity adjustment, as required by law, resulting in an estimated FY 2022 IPF PPS payment rate update of 2.1 percent (2.3 – 0.2 = 2.1). If more recent data become available for the final rule, CMS will adjust its estimate of the market basket and productivity adjustment. For facilities that fail to meet requirements of the IPFQR Program for a fiscal year, the statute requires a reduction in the otherwise applicable update factor of 2.0 percentage points. For FY 2022, the proposed update factor for these facilities will be 0.1 percent (2.1– 2.0 = 0.1).

For FY 2022, CMS is proposing one technical change to the price proxies used in calculating the IPF market basket—substituting the iBoxx AAA Corporate Bond Yield index for the Moody's

AAA Corporate Bond Yield index. Effective December, 2020, the Moody's AAA Corporate Bond Yield Index is no longer available to IGI. CMS reports that these two bond yield indices produce similar results with the iBoxx index being approximately 0.1 percentage points higher over a lengthy historical period. However, the impact on the overall index will be negligible because of the low weight of this cost category on the index.

B. 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 2016-based market basket.[1]

For FY 2022, the labor-related share based on IGI's fourth quarter 2020 forecast of the 2016-based IPF PPS market basket is 77.1 percent, a change from 77.3 percent for FY 2021.

C. FY 2022 Payment Rates

CMS determines the FY 2022 proposed payment rates by applying the market basket update factor (2.3 percent), the MFP (0.2 percent), and the wage index budget neutrality adjustment (1.0014, as discussed in section II.E.3 below) to the final FY 2021 rates. As noted above, the update factor will be reduced by 2.0 percentage points for facilities that fail to meet the requirements of the IPFQR Program for FY 2022.

The table below compares the final federal per diem base rate and the ECT payments per treatment for FYs 2021 and 2022.

	Final FY 2021*	**Proposed FY 2022**
Federal per diem base rate	$815.22	$833.50
Labor share	*$630.17 (77.3%)*	*$642.63 (77.1%)*
Non-labor share	*$185.05 (22.7%)*	*$190.87 (22.9%)*
ECT payment per treatment	$350.97	$358.84
*Rates for IPFs that fail to meet the IPFQR Program requirements***		
Per diem base rate	$799.27	$817.18
Labor share	*$617.84 (77.3%)*	*$ 630.04 (77.1%)*
Non-labor share	*$181.43 (22.7%)*	*$ 187.03 (22.9%)*
ECT payment per treatment	$350.97	$351.81

*The 2021 amounts are taken from Addendum A to the FY 2021 IFP PPS final rule, available at: Addendum A FY 2021 Final IPF PPS Rates and Adjustment Factors (cms.gov)
**Note that the FY 2022 rates for hospitals failing to meet the IPFQR Program requirements are calculated by multiplying the full rates for FY 2021 times the reduced update factor and wage index budget neutrality factor.

[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 2016) and FY 2021.

D. Updates to the IPF PPS Patient-Level Adjustment Factors

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 the FY 2022 proposed rule, CMS continues the existing payment adjustments with some updates, described briefly here. The referenced Addendum A and Addendum B are available through the link that appears on page 1 of this summary.

1. Update to MS-DRG Assignment

For FY 2022, CMS proposes to continue the existing payment adjustment for psychiatric diagnoses that group to one of the existing 17 IPF MS-DRGs listed in Addendum A. Psychiatric principal diagnoses that do not group to one of the 17 designated MS-DRGs will still receive the federal per diem base rate and all other applicable adjustments, but the payment will not include an MS-DRG adjustment.

The diagnoses for each IPF MS-DRG will be updated as of October 1, 2021, using the final inpatient prospective payment system (IPPS) FY 2022 ICD-10-CM/PCS code sets. The FY 2022 IPPS proposed rule will include tables of the proposed changes to the ICD-10-CM/PCS code sets, which underlie the FY 2022 IPF MS-DRGs. However, at the time this summary was prepared, the FY 2022 IPPS proposed rule had not been released.

CMS discusses the Code First policy which follows the ICD–10–CM Official Guidelines for Coding and Reporting. For FY 2022, CMS is proposing to remove 18 codes from the IPF Code First table which is shown in Addendum B (link on page 1 of this summary.) Under the Code First policy, when a primary (psychiatric) diagnosis code has a "code first" note, the provider would follow the instructions in the ICD–10–CM text to determine the proper sequencing of codes.

2. Comorbidity Adjustment

The comorbidity adjustment provides additional payments for certain existing medical or psychiatric conditions that are secondary to the patient's principal diagnosis and are expensive to treat. Diagnoses that relate to an earlier episode of care and have no bearing on the current hospital stay are excluded and must not be reported on IPF claims. Comorbid conditions must exist at the time of admission or develop subsequently, and affect the treatment received, the length of stay, or both.

For FY 2022, CMS proposes to continue the same 17 comorbidity adjustment factors in effect for FY 2021, which are found in Addendum A.

CMS has updated the ICD-10-CM/PCS codes associated with the existing IPF PPS comorbidity categories, based upon the FY 2022 update to the ICD-10-CM/PCS code set. These updates

include the addition and deletion of codes to the poisoning, developmental disabilities and oncology procedures comorbidity categories. These updates are detailed in Addendum B.

Under previously adopted policy, CMS reviewed all new FY 2022 ICD-10-CM codes to remove codes that were site "unspecified" in terms of laterality where more specific codes are available. None of the additions to the FY 2022 ICD-10-CM/PCS codes were site "unspecified" by laterality, therefore none are proposed to be removed.

3. Age Adjustment

The current payment adjustments for age, which provide for increased payments ranging from an adjustment factor of 1.01 for patients age 45 to 50 to 1.17 for patients age 80 and older. CMS proposes no changes to the age adjustment factors for FY 2022. The age adjustments are shown in Addendum A.

4. 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 and are shown in Addendum A. For FY 2022, CMS proposes to continue the FY 2021 variable per diem adjustments. The adjustment is highest on day 1 of the stay and gradually declines through day 22. The day 1 adjustment factor is 1.31 if the IPF has a qualifying ED; otherwise, the adjustment factor is 1.19. For days 22 and later the adjustment is 0.92. The qualifying ED adjustment is discussed in section II.E.6 below.

E. Updates to the IPF PPS Facility-Level Adjustments

Facility-level adjustments provided under the IPF PPS are for the 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

To recognize geographic variation in wages for the IPF PPS, CMS uses the pre-floor, pre-reclassified IPPS hospital wage data to compute the IPF wage index. It believes that IPFs generally compete in the same labor market as IPPS hospitals, and that the pre-floor, pre-reclassified IPPS hospital wage index to be the best available data to use as proxy for an IPF specific wage index. As to the time frame for the wage index data, beginning with FY 2020, CMS uses the IPPS wage index for the concurrent fiscal year. For example, the FY 2020 IPF wage index is based on the FY 2020 pre-floor, pre-reclassified IPPS hospital wage Index. (Previous policy was to use the IPPS wage index data for the prior fiscal year.)

The geographic areas used for the wage index are based on the Office of Management and Budget (OMB) Core Based Statistical Area (CBSA) delineations. These are generally subject to major revisions every 10 years to reflect information from the decennial census, but OMB also issues minor revisions in the intervening years through OMB Bulletins. When OMB changes

delineations that modify the IPPS wage index, these changes are also adopted for purposes of the IPF wage index. For purposes of the IPF wage index, OMB-designated Micropolitan Statistical Areas[2] are considered to be rural areas. The OMB Bulletins are available at https://www.whitehouse.gov/omb/information-for-agencies/bulletins/.

For FY 2021, CMS modified the IPF wage index to reflect changes included in OMB Bulletin No. 18-04, issued on September 14, 2018 and to provide for a transition policy. Adopting the revised delineations included in OMB Bulletin No 18-04 changed 34 urban counties and 5 providers from urban to rural; another 47 counties and 4 providers from rural to urban, and shifts some urban counties between existing and new CBSAs.

Under the transition policy, a 5 percent cap limited the decrease in any IPF's wage index from FY 2020 to FY 2021. It applied regardless of the reason for the wage index decline, that is, whether or not the decline was the result of changes to the wage area delineations. The cap provides for what CMS refers to as a two-year transition to the new wage index areas. CMS proposes no cap on reductions to the wage index for FY 2022.

CMS indicates that OMB published Bulletin 20-01 on March 6, 2020. This bulletin adds one micropolitan area to the CBSA delineations. It will have no effect on the IPF wage index as the new micropolitan area was previously and will continue to be treated as a rural area.

2. Adjustment for Rural Location

CMS proposes to continue the 17 percent adjustment for IPFs located in a rural area that has been part of the IPF PPS since its inception.

3. Wage Index Budget Neutrality Adjustment

Changes to the IPF PPS wage index are made in a budget neutral manner; CMS estimates the proposed budget neutrality adjustment for FY 2022 to be 1.0014. To make this calculation, CMS estimates aggregate IPF PPS payments for FY 2021 and FY 2022 using FY 2020 IPF PPS claims data and each respective year's labor-related share and wage index values. The ratio of FY 2022 to FY 2021 payments is the budget neutrality adjustment applied to the federal per diem base rate for FY 2022.

4. Teaching Adjustment

CMS proposes to continue for FY 2022 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. The teaching adjustment formula follows, where ADC = average daily census.

$$1 + \left(\frac{Interns\ and\ Residents}{ADC}\right) \text{^}0.5150$$

[2] OMB defines a Micropolitan Statistical Area as an area associated with at least one urban cluster that has a population of at least 10,000, but less than 50,000.

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.

Under current policy, there are provisions of regulations that allow temporary increases to full-time equivalent (FTE) caps on numbers of interns and residents in the above formula when a hospital trains a resident displaced due to another hospital or a teaching program's closure. To qualify for the temporary increase, the resident must be training in the closed hospital or the closed program on the day prior to the hospital or program closing in order. This policy precludes any cap adjustment for residents: 1) displaced residents that found a new training assignment more than one day before the hospital or program closed; 2) residents on rotation at another hospital or on leave on the day prior to the program's closure; and 3) residents that have matched into the closing program but had not yet begun training.

In the FY 2021 IPPS final rule (85 FR 58865 through 58870), CMS addressed all of these issues. To address the first group of residents, CMS changed the requirement from physically training in the hospital on the day the program closed to training in the hospital on the day the program or hospital closure is announced. To address the second and third group of residents, CMS is allowing funding to be transferred temporarily when the residents are not physically at the closing hospital/program, but had intended to train at or return to training at the closing hospital/program.

CMS is proposing to adopt changes for the IPF PPS that parallel those adopted for the IPPS beginning in FY 2022 when a teaching program or hospital closes. To apply for the temporary increase in the FTE resident cap, the receiving IPF would have to submit a letter to its Medicare Administrative Contractor within 60 days of beginning the training of the displaced residents. This letter must identify the residents who have come from the closed IPF or program and have caused the receiving IPF to exceed its cap, and must specify the length of time the adjustment is needed.

The letter from the receiving IPF would have to include: (1) the name of each displaced resident; (2) the last four digits of each displaced resident's social security number; (3) the IPF and program in which each resident was training previously; and (4) the amount of the cap increase needed for each resident (based on how much the receiving IPF is in excess of its cap and the length of time for which the adjustments are needed).

The maximum number of FTE resident cap slots that could be transferred to all receiving IPFs is the number of FTE resident cap slots belonging to the IPF that has the closed program or that is closing. If there are more IPF displaced residents than available cap slots, the slots may be apportioned according to the closing IPF's discretion. Only to the extent a receiving IPF would exceed its FTE cap by training displaced residents would it be eligible for a temporary adjustment to its resident FTE cap.

In the FY 2022 IPF proposed rule, CMS indicates that the resident cap applicable under the IPPS is separate from the resident cap applicable under the IPF PPS and cannot be comingled; moreover, a provider cannot add its IPF resident cap to its IPPS resident cap in order to increase

the number of residents it receives payment for under either payment system. CMS is also proposing that in the future, it would deviate from IPPS teaching policy as it pertains to counting displaced residents for the purposes of the IPF teaching adjustment only when it is necessary and appropriate for the IPF PPS.

5. Cost of Living Adjustment for Alaska and Hawaii

CMS proposes to update the IPF PPS cost of living adjustment (COLA) factors for Alaska and Hawaii in FY 2022. The COLA is applied to the non-labor related share of the IPF standardized amounts. The new COLAs are shown in Addendum A of the proposed rule. The COLA is declining from 1.25 to 1.22 for all urban areas in Alaska. The "Rest of Alaska" COLA is declining from 1.25 to 1.24. Except for the county of Hawaii, the Hawaii COLA is staying at 1.25. For the county of Hawaii, the COLA is increasing from 1.21 to 1.22.

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 with a qualifying ED or an IPPS-excluded psychiatric unit of an IPPS hospital or critical access hospital (CAH), and is intended to account for the costs of maintaining a full-service ED. This includes costs of preadmission services otherwise payable under the Medicare Hospital Outpatient Prospective Payment System 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. CMS is not proposing any changes to these adjustments.

F. Other Payment Adjustments and Policies

The IPF PPS provides for outlier payments 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. 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

thereafter. The differential in payment between days 1 through 9 and 10 and above is intended to avoid incenting longer lengths of stay.

For FY 2022, CMS proposes to continue to set the fixed dollar loss threshold amount at a level such that outlier payments account for 2 percent of total payments made under the IPF PPS. CMS would normally use data from FY 2020 to set the FY 2022 outlier threshold. However, because of impact of the COVID-19 public health emergency on 2020 utilization, CMS determined that FY 2019 data would be the best for estimating IPF PPS payment in FY 2021 and FY 2022 to determine the fixed dollar loss threshold. Based on an analysis of the June 2020 update of FY 2019 IPF claims and the FY 2021 rate increases, CMS estimates that for FY 2021 IPF outlier payments will be 1.8 percent of total payments. Therefore, for FY 2021, CMS proposes to decrease the outlier threshold amount from $14,630 in FY 2021 to $14,030 in order to maintain estimated outlier payments at 2 percent of estimated aggregate IPF PPS payments. If CMS had used FY 2020 data to determine the outlier threshold, CMS estimates it would have been increased to $19,840.

In estimating the total cost of a case for comparison to the outlier threshold amount, CMS multiplies the hospital's charges on the claim by the hospital's cost-to-charge ratio. CMS substitutes the national median urban or rural CCR if the IPF's CCR exceeds a ceiling that is equal to the 3 times the standard deviation from the appropriate (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. CMS proposes to update these amounts for FY 2022 as shown in the table below, which also appears in Addendum A.

National Median and Ceiling Cost-to-Charge Ratios (CCRs)		
CCRs	**Rural**	**Urban**
National Median	0.5720	0.4200
National Ceiling	2.0398	1.6126

III. Inpatient Psychiatric Facilities Quality Reporting (IPFQR) Program

A. Statutory Authority, Covered Entities and Previously Finalized Measures and Administrative Procedures

CMS refers readers to the FY 2019 IPF PPS final rule (83 FR 38589) for a discussion of the background and statutory authority of the IPFQR Program. CMS established the IPFQR program beginning in FY 2014 for IPFs, as required under Section 1886(s)(4) of the Act, as added by the Affordable Care Act. Further developed in subsequent rulemaking, the IPFQR Program follows many of the policies established for the Hospital IQR Program, including the principles for selecting measures and the procedures for hospital participation in the program. Under the statute, an IPF that does not meet the requirements of participation in the IPFQR Program for a rate year is subject to a 2.0 percentage point reduction in the update factor for that year.

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.

Under existing policy, measures adopted to the IRFQR Program remain in the program until they are removed, suspended or replaced. Substantive changes are proposed and finalized through rulemaking.

Two tables at the end of this section (IV.E) display the measures incorporating proposals for new measures and proposals to remove measures for the IPFQR Program for FY 2023 and for FY 2024.

B. Request for Information (RFI) on Closing the Health Equity Gap in CMS Quality Programs

CMS requests public comment on potential changes to the IPFQR Program to facilitate comprehensive and actionable reporting of health disparities:

- By improving demographic data collection as well as collection of social, psychological, and behavioral data elements, including a minimum data set for collection at admission;
- By enabling facility-level reporting of IPFQR program measure data stratified by race, ethnicity, dual eligibility, and disability; and
- By creating a Facility Equity Score to synthesize results across a wide range of social risk factors and disparity measures.

As background for this RFI, CMS provides multiple examples of poor health outcomes that could stem from disparate care across patient populations (e.g., higher COVID-19 complication rates for black, Latino, and Indigenous and Native Americans relative to whites). CMS also provides the following definition of equity for purposes of this RFI from Executive Order 13985 issued on January 21, 2021:

> the consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities that have been denied such treatment, such as Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality.

Further, examples are provided of ongoing efforts by CMS to enhance the transparency of information about healthcare disparities, such as the addition of standardized. patient assessment data elements to several post-acute care quality programs for required reporting of social determinants of health beginning with FY 2020.

CMS specifically seeks information concerning:

- Application of indirect estimates of race and ethnicity to support reporting of stratified data at the facility level, and appropriate privacy safeguards for such reporting;
- Defining and collecting accurate, standardized, self-identified demographic information;
- Other readily available data elements for use in combination with race and ethnicity for measuring disadvantage and discrimination and for stratified data reporting;
- Measure and domain types for stratified reporting by dual eligibility, race, ethnicity, and disability; and
- Methods for using data-driven technologies in a way that does not facilitate exacerbation of health inequities.

To further assist commenters in framing responses, CMS also discusses at length the methods, measures, and indicators of social risk currently used with the CMS Disparity Methods. CMS offers four potential expansions of the CMS Disparity Methods: (1) Stratification of Quality Measure Results – Dual Eligibility; (2) Stratification of Quality Measure Results – Race and Ethnicity; (3) Improving Demographic Data Collection; and (4) Potential Creation of a Facility Equity Score to Synthesize Results Across Multiple Social Risk Factors.

C. New Measures

1. COVID-19 Vaccination Coverage Among Health Care Personnel (HCP)

CMS proposes to add a new process measure to the IPFQR program beginning with FY 2023 to track the percentage of HCP who receive a complete COVID-19 vaccination course, calculated as:

Numerator. The cumulative number of HCP eligible to work in the IPF for at least one day in the reporting period who received a complete vaccination course against SARS-CoV-2.
Denominator. The cumulative number of HCP eligible to work in the IPF for at least one day in the reporting period, excluding persons with contraindications to COVID-19 vaccination as described by the CDC.

Risk adjustment is not required for this process measure. Full specifications are available on the CDC website: https://www.cdc.gov/nhsn/nqf/index.html.

In discussing the proposed measure, CMS reviews the declaration of COVID-19 as a public health emergency, methods of viral transmission, vulnerable patient groups, and guidelines for prioritizing vaccine recipients. Following the usual pre-rulemaking process for stakeholder input, the proposed measure was included on the December 21, 2020 Measures Under Consideration List. The Measure Applications Partnership (MAP) conditionally supported the measure contingent upon clarification of measure specifications, and CMS returned to the MAP with results from further measure testing and updated specifications.

CMS states its intention to seek NQF endorsement of the measure, but proposes to proceed with adopting the measure for FY 2023 given that the COVID-19 PHE is ongoing and having found

no currently available, alternative measure that is comparable, NQF-endorsed, feasible, and practical. The proposed measure could generate actionable quality improvement data on vaccination rates and could be helpful to patients when choosing an IPF.

For the proposed new measure of COVID-19 vaccination coverage among IPF healthcare personnel, CMS proposes an initial data submission period of October 1, 2021 through December 31, 2021 for use in the FY 2023 IPFQR program. For FY 2024 and subsequently, CMS proposes a full calendar year submission period (e.g., all 12 months of CY 2022 data to be reported for use in the FY 2024 IPFQR program). Data would be submitted through the CDC National Health Safety Network (NHSN) web-based surveillance system for at least one week each month and the CDC would report data quarterly to CMS. The IPFQR program previously has included measures for which reporting by providers through the CDC NHSN was required, but does not include any NHSN-based measures for FY 2022.

2. Follow-Up After Psychiatric Hospitalization (FAPH) for FY 2024 and Subsequent Years

The proposed measure is an expanded and enhanced version of the Follow-Up After Hospitalization for Mental Illness (FUH, NQF #0576) measure. The new measure would assess the follow-up rates for patients hospitalized with mental illness or substance abuse disorder (SUD) and would replace the FUH measure. It improves on the FUH measure by expanding the measure population to include patients hospitalized for drug and alcohol disorders, and would not limit the provider types for the follow-up visit. Two rates would be calculated: a 7-day rate and a 30-day rate. The denominators for both rates include discharges paid under the IPF prospective payment system with a principal diagnosis of mental illness or SUD. The numerator for the 7-day rate is the number of discharges from a psychiatric facility that are followed by an outpatient visit for treatment of mental illness or SUD within 7 days. The numerator for the 30-day rate is the number of discharges from a psychiatric facility that are followed by an outpatient visit for treatment of mental illness or SUD within 30 days.

In discussing the proposed measure, CMS identifies the literature on the clinical benefits of timely follow-up care after hospitalization, describes clinical practice guidelines that stress the importance of continuity of care, and describes the evidence that outpatient follow-up care and interventions are associated with a decreased risk of readmissions for patients with mental illness.

CMS measure development contractors convened a Technical Expert Panel (TEP) for the measure and comments were sought on the CMS quality measures public comment page. A summary report of the comments is available at Follow-Up After Psychiatric Hospitalization Measure (cms.gov). In 2019 CMS tested the measure's reliability and validity and concluded that the measure can reliably distinguish differences in performance between IPFs with a minimum denominator size of 40 discharges. All 13 TEP panel members present agreed that the measure had face validity after reviewing the results of the validity tests.

The measure received conditional support for rulemaking from the NQF-convened Measures Application Partnership (MAP) but was not endorsed by the NQF itself based on concerns raised about the measure's exclusions for patients who died during the 30-day follow up period or who

were transferred, and with combining persons with a diagnosis of SUD and those with a diagnosis of a mental health disorder. However, CMS was unable to identify a comparable feasible and practical NQF-endorsed measure and invokes the Secretary's statutory authority to adopt measures not endorsed by the NQF into the IPAQ Program. CMS proposes including the measure beginning with FY 2024 and for subsequent years.

D. Removal of Measures

CMS does not propose changes to the factors for removing or retaining program measures. It proposes the removal of the following 4 measures beginning with the FY 2024 Payment Determination:

- Alcohol Use Brief Intervention Provided or Offered and Alcohol Use Brief Intervention (SUB-2/2a),
- Tobacco Use Brief Intervention Provided or Offered and Tobacco Use Brief Intervention (TOB-2/2a),
- Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care), and
- Follow-Up After Hospitalization for Mental Illness (FUH, NQF #0576).

As noted above, CMS is proposing to replace FUH with FUPH – a measure it believes is an improvement over the FUH measure. The other three measures are proposed to be removed because the costs associated with the measures outweigh the benefit of their continued use. For the first two measures (SUB-2/2a and TOB-2/2a), CMS indicates that there was substantial improvement in those measures between 2017 and 2019 and there remains little additional room for improvement. With respect to Timely Transmission of Transition Record, CMS states that the benefits of the measure are reduced following a May 2020 update to the Conditions of Participation that newly required facilities that have the ability to generate electronic patient event notifications to send them in the event of a patient's admission, discharge, or transfer. While the new requirement is not identical to the Transition record, it overlaps with it.

CMS expects replacing FUH with FUPH will not have any effect on IPF burden. For the remaining 3 measures, CMS estimates that their removal would reduce burden by 152 hours per facility or almost 248,800 hours across all IPFs. The reduction in cost is estimated to be 18,700 per IPF and $30.6 million across all IPFs.

E. Previously Finalized and Newly Proposed Measures for 2023 and 2024

The following tables show the measures for the FY 2023 and 2024 payment determinations including previously finalized and proposed new and removed measures (Tables 4 and 5 in the public display version of the proposed rule). The measure set for 2023 includes the 14 previously finalized measures for FY 2023 and subsequent years and the one proposed measure for FY 2023 and subsequent years. The measure set for 2024 includes one new measure, one replaced measure, and three dropped measures, resulting in 12 measures as displayed below.

IPFQR Program Measure Set for the FY 2023 Payment Determination and Subsequent Years if Measure Adoption is Finalized as Proposed

NQF #	Measure ID	Measure
0640	HBIPS-2	Hours of Physical Restraint Use
0641	HBIPS-3	Hours of Seclusion Use
0560	HBIPS-5	Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification
0576	FUH	Follow-Up After Hospitalization for Mental Illness
N/A*	SUB-2 and SUB-2a	Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention
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-2 and TOB-2a	Tobacco Use Treatment Provided or Offered and TOB-2a Tobacco Use Treatment
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	Timely Transmission of Transition Record (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
3205	Med Cont	Medication Continuation Following Inpatient Psychiatric Discharge
TBD	COVID HCP	COVID-19 Healthcare Personnel (HCP) Vaccination Measure

* Measure is no longer endorsed by the NQF 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 NQF 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.

IPFQR Program Measure Set for the FY 2024 Payment Determination and Subsequent Years if Adoptions and Removals are Finalized as Proposed

NQF #	Measure ID	Measure
0640	HBIPS-2	Hours of Physical Restraint Use
0641	HBIPS-3	Hours of Seclusion Use
0560	HBIPS-5	Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification
N/A	FAPH	Follow-Up After Psychiatric Hospitalization
1659	IMM-2	Influenza Immunization
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
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
3205	Med Cont	Medication Continuation Following Inpatient Psychiatric Discharge
TBD	COVID HCP	COVID-19 Healthcare Personnel (HCP) Vaccination Measure

* Measure is no longer endorsed by the NQF 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 NQF 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.

F. Considerations for Future Measure Topics

CMS seeks comment on the following potential measures and concepts under consideration for future years:

- Patient Experience of Care Data Collection Instrument. In the FY 2020 IPF PPS proposed rule (84 FR 16986 through 16987), CMS solicited input on how providers implemented the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey in their facilities and whether there are other potential surveys that would be appropriate to adopt for the IPFQR Program. Commenters responded that there is not one survey used predominantly across IPFs (84 FR 38467) and some expressed concerns that the HCAHPS survey may not be appropriate for the IPF setting because it does not include some of the unique aspects of inpatient psychiatric care including group therapy, non-physician providers, and involuntary admissions. **CMS continues to seek to identify a minimally burdensome patient experience of care instrument that would be appropriate for the IPF setting and seeks comment on instruments currently in use in the IPF setting, whether the HCAHPS survey is appropriate for this setting, and information on how facilities that currently use the HCAHPS survey have addressed challenges with using this survey.**
- Functional Outcomes Instrument for Use in a Patient Reported Outcomes Measure. CMS has identified functional outcomes as a potential gap area in the IPFQR Program's measure set. It is evaluating whether a patient reported outcomes measure that assesses functional outcomes, such as global functioning, interpersonal problems, psychotic

symptoms, alcohol or drug use, emotional lability, and self-harm, would be an appropriate measure to include in the IPFQR Program measure set. CMS states that if it were to develop such a measure, the measure would compare a patient's responses to a standardized functional outcomes assessment instrument at admission with the same assessment at discharge. **CMS seeks comment on the value of such a measure, what would be an appropriate functional outcome assessment instrument to use in the potential development of such a measure, and any additional topics or concepts stakeholders believe should be considered for patient reported outcomes measures.**

- Measures for Electronic Data Reporting. CMS seeks to improve digital data measurement and is considering measures for the IPFQR Program measure set that would be appropriate for digital data collection. **It has identified the Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) measure as a potential option for digital data collection and seeks input on the current data collection burden associated with this measure, concerns regarding potential electronic specification and data collection for the measure, and other measures that may be appropriate for electronic data collection, including those currently in the IPFQR Program measure set, or for future adoption.**

G. Form, Manner, and Timing of Quality Data Submission for 2022 and Subsequent Years

1. QualityNet System Changes

CMS proposes to replace the term "QualityNet system administrator" with the term "QualityNet security official" in section 412.434(b)(3) and to no longer require an active QualityNet security official account in order to meet IPFQR program requirements. The change in terminology aligns with that of the Hospital Outpatient Quality Reporting program and other programs.

2. Data Submission Requirements

CMS proposes the following data submission requirements for the two proposed quality measures.

- For the COVID-19 HCP-Vaccination measure (for FY 2023 and subsequent years) facilities would be required to report data on the number of HCP who have completed vaccination for COVID-19 through the CDC's National Healthcare Safety Network. Specific details for the measure can be found at https://www.cdc.gov/nhsn/PDFs/slides/NHSN-Overview-HPS_Aug2012.pdf. Facilities would report the numerator and denominator for the COVID-19 HCP vaccination measure to the NHSN for at least one week each month, beginning in October 2021 for the October 2021 through December 31, 2021 reporting period affecting the FY 2023 payment determination.
- For the FAPH measure (for FY 2024 and subsequent years) no additional data submission requirements are necessary.

3. Proposal to Adopt Patient-Level Reporting for Chart Abstracted Measures

In the 2019 IPF PPS final rule, CMS raised the concern that reporting of aggregate measure data raises the potential for human error that cannot be detected by CMS and sought comment on requiring patient-level data reporting of IPFQR measure data in the future. Some commenters supported patient-level reporting to improve the accuracy of submitted data. Others recommended CMS use a system that has already been used and tested to avoid additional burden.

CMS is proposing to incrementally begin requiring reporting of patient-level information for numerators and denominators for 9 chart-abstracted IPFQR Program measures:

- Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification (NQF #0560);
- Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention;
- Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge,
- Tobacco Use Treatment Provided or Offered and TOB-2a Tobacco Use Treatment;
- Tobacco Use Treatment Provided or Offered at Discharge and TOB-3a Tobacco Use Treatment at Discharge;
- Influenza Immunization (NQF #1659);
- Transition Record with Specified Elements Received by Discharged Patients (discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care);
- Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or any Other Site of Care); and
- Screening for Metabolic Disorders.

For two measures, only the numerators of the measures will be required for reporting on the patient-level as their denominators are 1,000 hours:

- Hours of physical restraint use, and
- Hours of seclusion use.

Data would be submitted using the CMS Abstraction & Reporting Tool (CART) with which many facilities are already familiar. Facilities would still manually abstract the medical record using either a vendor abstraction tool or an abstraction tool provided by CMS. The tool would then produce an individual XML file for each of the cases. The facility would then log into the Hospital Quality Reporting system and upload batches of the XML files and CMS would calculate the aggregate measures/rates.

For the FY 2023 payment determination (data submitted during 2022), CMS will permit voluntary patient-level data submission. For the FY 2024 payment determination, facilities will be required to submit the patient-level data for all of the chart abstracted measures.
CMS does not expect that requiring patient-level data submission to increase burden for IPFs as they must already abstract patient-level data in order to calculate and submit the measure performance information presently required.

4. Data Validation Pilot

CMS seeks comment on elements of a potential data validation pilot including suggestions for the number of measures to validate, the number of participating facilities, whether the pilot should be mandatory or voluntary, threshold for determining measure accuracy, or any other policies CMS should include.

CMS does not propose changes for reporting requirements for the FY 2022 payment determination, quality measure sampling requirements, non-measure data collection policies, data accuracy and completeness acknowledgment, reconsideration and appeals policies, nor to extraordinary circumstances exceptions policies.

5. Total Burden Summary for IPFQR Program Changes

CMS provides the following estimates of the burden associated with the IPFQR Program changes as proposed. (Table 15 in the public display version.)

Total Estimated IPFQR Program Burden

Measure/Response Description	Estimated Responses per Facility	Time per Response (hours)	Annual Time per Facility (hours)	Total Annual Time (hours)	Total Annual Cost ($)
Hours of Physical Restraint Use	1,346	0.25	336.50	549,841	22,543,481
Hours of Seclusion Use	1,346	0.25	336.50	549,841	22,543,481
Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification	609*	0.25	152.25	248,776.5	10,199,836.50
Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and Alcohol and Other Drug Use Disorder Treatment at Discharge	609*	0.25	152.25	248,776.5	10,199,836.50
Tobacco Use Treatment Provided or Offered at Discharge and Tobacco Use Treatment at Discharge	609*	0.25	152.25	248,776.5	10,199,836.50
Influenza Immunization	609*	0.25	152.25	248,776.5	10,199,836.50
Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	609*	0.25	152.25	248,776.5	10,199,836.50
Screening for Metabolic Disorders	609*	0.25	152.25	248,776.5	10,199,836.50
Thirty-day all-cause unplanned readmission following psychiatric hospitalization in an IPF	0**	0	0	0	0
Medication Continuation Following Inpatient Psychiatric Discharge	0**	0	0	0	0
COVID-19 Vaccination Rate Among Healthcare Personnel	0***	0	0	0	0

Measure/Response Description	Estimated Responses per Facility	Time per Response (hours)	Annual Time per Facility (hours)	Total Annual Time (hours)	Total Annual Cost ($)
Follow-Up After Psychiatric Hospitalization	0**	0	0	0	0
Non-Measure Data Collection and Reporting	4	0.5	2.0	3,268	133,988
TOTAL	6,346	N/A	1,588.5	2,595,609	$106,419,969

* Under previously finalized ''global sample'' (80 FR 46717 through 46718) CMS allows facilities to apply the same sampling methodology to all measures eligible for sampling. In the FY 2016 IPF PPS final rule (80 FR 46718), CMS finalized that facilities with between 609 and 3,056 cases that choose to participate in the global sample would be required to report data for 609 cases. Because facilities are only required to submit data on a number specified by the global sampling methodology, rather than abstracting data for all patients or applying measure specific sampling methodologies, CMS believes that the number of cases under the global sample is a good approximation of facility burden associated with these measures. Therefore, for the average IPF discharge rate of 1,346 discharges versus the previously estimated 1,283, the global sample continues to require abstraction of 609 records.
** CMS will collect these data using Medicare Part A and Part B claims; therefore, these measures will not require facilities to submit data on any cases.
*** The COVID-19 HCP measure will be calculated using data submitted to the CDC under a separate OMB Control Number (0920-1317).

IV. Regulatory Impact Analysis

In the proposed rule, CMS estimates that payments to IPF providers for FY 2022 will increase by $90 million. This reflects a net increase of $80 million for the IFP update (+$90 million increase from the 2.3 percent from the market basket update less $10 million for the multifactor productivity adjustment) and a $10 million increase as a result of the updated outlier threshold amount. As discussed above, outlier payments are estimated to change from 1.8 percent in FY 2021 to 2.0 percent of total estimated IPF payments in FY 2022. 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.

Table 17 in the proposed rule, reproduced below, shows the estimated effects of the IPF PPS final rule policies by type of IPF. Unlike prior impact analyses, CMS presents the impact of each provision using FY 2019 data and FY 2020 data. While the FY 2020 is the latest data available for simulating the impacts of the change to the outlier threshold, wage index, labor-related share and COLA, the FY 2020 data is atypical as a result of the impact of the COVID-19 public health emergency on the IPF utilization. For this reason, CMS is simulating impact using more typical and complete FY 2019 data and also illustrating how those impact would appear using FY 2020 utilization data.

TABLE 17: FY 2022 IPF PPS Proposed Rule Payment Impacts
Percent Change in Columns 3 through 5

(1)	(2)		(3)		(4)		(5)	
Facility by Type	**Number of Facilities**		**Outlier**		**Wage Index FY22, LRS, and COLA**		**Total Percent Change[1]**	
	FY 2019 Claims	**FY 2020 Claims**	**FY 2019 Claims**	**FY 2020 Claims**	**FY 2019 Claims**	**FY 2020 Claims**	**FY 2019 Claims**	**FY 2020 Claims**
All Facilities	1,526	1,536	0.2	-0.7	0.0	0.0	2.3	1.4
Total Urban	1,226	1,238	0.2	-0.7	0.0	0.0	2.3	1.3
Urban unit	742	738	0.3	-1.1	-0.1	-0.1	2.3	0.9
Urban hospital	484	500	0.1	-0.2	0.0	0.0	2.2	1.9
Total Rural	300	298	0.1	-0.5	0.1	0.1	2.4	1.8
Rural unit	240	237	0.1	-0.6	0.0	0.0	2.2	1.5
Rural hospital	60	61	0.1	-0.2	0.5	0.5	2.7	2.4
By Type of Ownership:								
Freestanding IPFs								
Urban Psychiatric Hospitals								
Government	117	123	0.3	-1.1	-0.2	-0.2	2.2	0.7
Non-Profit	93	95	0.1	-0.3	-0.3	-0.2	1.9	1.6
For-Profit	274	282	0.0	-0.1	0.1	0.2	2.3	2.2
Rural Psychiatric Hospitals								
Government	31	32	0.1	-0.4	0.5	0.6	2.8	2.2
Non-Profit	12	12	0.2	-0.7	0.0	0.1	2.3	1.5
For-Profit	17	17	0.0	0.0	0.6	0.6	2.7	2.7
IPF Units								
Urban								
Government	109	108	0.4	-2.1	0.1	0.1	2.7	0.0
Non-Profit	482	480	0.3	-1.1	-0.1	-0.1	2.3	0.9
For-Profit	151	150	0.1	-0.5	-0.1	-0.1	2.2	1.5
Rural								
Government	58	57	0.1	-0.2	0.3	0.2	2.5	2.1
Non-Profit	133	130	0.2	-0.8	0.0	0.0	2.2	1.2
For-Profit	49	50	0.1	-0.4	-0.2	-0.2	2.0	1.4
By Teaching Status:								
Non-teaching	1,329	1,339	0.1	-0.6	0.0	0.0	2.2	1.5

(1)	(2)		(3)		(4)		(5)	
Facility by Type	Number of Facilities		Outlier		Wage Index FY22, LRS, and COLA		Total Percent Change[1]	
	FY 2019 Claims	FY 2020 Claims	FY 2019 Claims	FY 2020 Claims	FY 2019 Claims	FY 2020 Claims	FY 2019 Claims	FY 2020 Claims
Less than 10% interns and residents to beds	106	106	0.3	-1.2	0.0	0.0	2.4	0.9
10% to 30% interns and residents to beds	70	70	0.4	-1.6	0.0	0.0	2.4	0.5
More than 30% interns and residents to beds	21	21	0.4	-1.9	-0.1	-0.1	2.4	0.1
By Region:								
New England	106	106	0.2	-0.8	-0.3	-0.4	2.0	1.0
Mid-Atlantic	215	217	0.3	-1.3	-0.2	-0.2	2.1	0.5
South Atlantic	241	243	0.1	-0.5	0.7	0.7	2.9	2.3
East North Central	245	245	0.1	-0.4	-0.1	-0.1	2.2	1.5
East South Central	152	155	0.1	-0.5	-0.7	-0.7	1.5	0.8
West North Central	110	110	0.2	-0.9	0.2	0.2	2.6	1.4
West South Central	225	227	0.1	-0.4	-0.3	-0.3	1.9	1.4
Mountain	103	102	0.1	-0.4	0.1	0.1	2.3	1.8
Pacific	129	131	0.2	-0.9	0.4	0.5	2.8	1.6
By Bed Size:								
Psychiatric Hospitals								
Beds: 0-24	85	90	0.1	-0.3	0.1	0.1	2.3	1.9
Beds: 25-49	79	83	0.1	-0.2	-0.5	-0.4	1.7	1.4
Beds: 50-75	84	87	0.0	-0.1	0.1	0.3	2.3	2.3
Beds: 76 +	296	301	0.1	-0.3	0.1	0.1	2.3	2.0
Psychiatric Units								
Beds: 0-24	540	531	0.2	-0.8	0.0	-0.1	2.3	1.2
Beds: 25-49	258	259	0.2	-0.9	0.0	0.0	2.4	1.2
Beds: 50-75	115	115	0.3	-1.1	-0.2	-0.3	2.2	0.7
Beds: 76 +	69	70	0.3	-1.6	0.0	0.0	2.4	0.4

[1]This column includes the impact of the updates in column (3) and (4) above, and of the proposed IPF market basket increase factor for FY 2022 (2.3 percent), reduced by 0.2 percentage point for the productivity adjustmentas required by section 1886(s)(2)(A)(i) of the Act. Note, the products of these impacts may be different from thepercentage changes shown here due to rounding effects.

Except for outliers, the impacts using 2019 and 2020 utilization appear similar. For this reason, CMS examined why it obtained such a different result in the calculation and impact of the outlier threshold using 2019 and 2020 utilization. CMS found that estimated outlier payments using the FY 2020 claims dataset are 26 percent higher than the estimated outlier payments using the FY 2019 claims dataset, due to estimated costs per stay that were relatively higher than estimated

Federal per diem payment amounts per stay. Estimated total payments using the FY 2020 claims dataset are 14 percent lower than the estimated total payments using the FY 2019 claims dataset.

CMS found both declines in covered IPF days and covered stays during the pandemic that is 2-3 times greater than occurred in recent years. However, CMS correlates these declines with the pandemic and does not expect them to continue. CMS' analysis indicates while both covered stays and covered days both declined, the average length of stay generally stayed the same between the 2019 and the 2020 utilization data. However, average IPF payments declined more than IPF costs between these years suggesting more outlier payments as a percent of total payments in FY 2021 using the FY 2020 utilization data than the FY 2019 utilization data. Further analysis suggests that covered laboratory costs increased substantially during months that are correlated with the pandemic. This result is consistent with doing more laboratory tests to screen patients for potential COVID infection.

From this analysis, CMS concluded that it would be preferable to use FY 2019 utilization rather than FY 2020 utilization to set the outlier threshold as FY 2020 is an unusual year due to the pandemic. This decision will benefit IPF hospitals by producing a lower fixed loss threshold that is more consistent with the historical threshold than the much higher threshold that would result from setting it with FY 2020 utilization. **CMS requests public comment on its proposal and analysis.**