Centers for Medicare & Medicaid Services
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Jill Darling: Thank you very much. Good morning and good afternoon, everyone. My name is Jill Darling, and I am in the CMS Office of Communications. Welcome to today's Hospital Open Door Forum (ODF). Before we begin our agenda, I have a few announcements. For those who need closed captioning I will provide a link in the chat function of the webinar for today. This webinar is being recorded. The recording and transcript will be available on the CMS Open Door Forum podcast and transcript webpage, and I will share a link in the chat for you, and it was also located on the agenda for today. If you are a member of the press, please refrain from asking questions during the webinar. If you do have any questions, please email press@cms.hhs.gov. All participants are muted upon entry.

For today's webinar you see the agenda slide for today's webinar. We will be taking questions at the end of the agenda today. We note that we will be presenting and answering questions on the topics listed on the agenda. We ask that any live questions relate to the topics presented during today's call. If you have any questions unrelated to these agenda items, we may not have the appropriate person on the call to answer your question. As such, we ask that you send any of your unrelated questions to the appropriate policy component, or you can send your email to the ODF resource mailbox that I will provide in the chat for you, and we'll get your question to the appropriate component for a response. You may use the raise hand feature at the bottom of your screen, and we will call on you when it's time for Q&A. Please introduce yourself with your organization or business you're calling from, and when the moderator says your name, please unmute yourself on your end to ask your question and one follow-up question.

Before we get into today's agenda, I just have another announcement. CMS is committed to protecting consumers in the Marketplace from fraud and will ensure that affected consumers get help to minimize impact. Anyone suspecting Marketplace fraud, waste, or abuse should report it to the Marketplace Call Center at 1-800-318-2596. CMS is working closely with state departments of insurance and law enforcement partners to share information and optimize resources to combat unauthorized and fraudulent activity in the Marketplace. Help us spread the word about Marketplace fraud prevention and what consumers can do if they suspect fraud. You can help consumers by sharing these messages: Never give your information to a person or entity you don't know. If you see a health insurance ad on social media or someone reaches out to you offering cash back, gift cards, grocery money, or other perks, it's likely a scam. Information you share could be used without your consent. HealthCare.gov is the official source to find affordable insurance and to enroll in health coverage. Go to HealthCare.gov or call the Marketplace Call

center at 1-800-318-2596 for official information. For free, non-biased personal help, call the Marketplace Call Center 24 hours a day, seven days a week, except holidays, and help is available in other languages. Marketplace call center representatives don't get any incentives for signing you up. Make sure you're on an authorized website before entering any personal or contact information for a health insurance quote. Visit HealthCare.gov/direct-enrollment to check if you are on an authorized website. These are the only websites approved by the Marketplace to provide consumer quotes and help enroll consumers in Marketplace coverage and I will provide some helpful links in the chat for you as well. So, I know that was a lot, and we'll get right into the agenda, but first, I'll hand it off to our chair, Joe Brooks.

Joseph Brooks: All right, thank you, Jill. And hello, everyone, this is Joe Brooks. Thank you for joining us today. As advertised, we'll be providing an overview of the final policies in the fiscal year 2025 IPPS (Inpatient Prospective Payment System) and LTCH PPS (Long-Term Care Hospital Prospective Payment System) final rule, as well as the FY 2025 Inpatient Psychiatric Facilities PPS final rule. Hopefully, you've had a chance to take a look at the documents associated with those final rules, and if not, of course, we have some updates for you, and you should be able to take a look at those at your own leisure. We have several topics to work through today, so to save time for Q&A, I'm going to let us get right to it. And with that I will turn it over to Jim Mildenberger to begin with our update. Jim?

Jim Mildenberger: Thanks, Joe. Good afternoon. So, I'll be discussing the payment updates for IPPS and long-term care hospitals. For IPPS hospitals that successfully participate in the Hospital Inpatient Quality Reporting Program and our meaningful electronic health record users, we are increasing operating payment rates by 2.9% for 2025. This 2.9% increase reflects a market basket update of 3.4%, reduced by a 0.5% productivity adjustment. We expect overall IPPS hospital payments to increase by approximately $2.9 billion in 2025. Specifically, we expect the updates to the operating and capital payment rates to increase hospital payments by approximately $3.2 billion. However, we expect uncompensated care payments to disproportionate share hospitals to decrease in 2025 by approximately $0.2 billion. We also want to note that under current law, additional payments for Medicare-dependent hospitals and the temporary change in payments for low-volume hospitals are set to expire at the end of the calendar year. In the past, these payments have been extended by legislation, but if they were both to expire, we estimate the impact on these hospitals would be a decrease in payments of approximately $0.4 billion in 2025.

For long-term care hospitals, we are increasing the standard federal payment rate by 3% in 2025, which reflects a market basket update of 3.5% reduced by 0.5% productivity adjustment. This update reflects the finalization of our proposal to revise the LTCH market basket from a base year of 2017 to a base year of 2022. For 2025, we expect payments to standard payment rate cases to increase approximately 2% or $45 million. This expected increase is primarily due to the market basket update being partially offset by a projected decrease in high-cost outlier payments. As required by law, CMS sets the outlier threshold for standard payment rate cases so that outlier payments are estimated to be 8% of total payments. Our payment model shows that the cost of these cases has risen considerably in recent years and that in 2024, outlier payments will be

approximately 8.8% of total payments, exceeding our target by 0.8%. Therefore, we are increasing the outlier threshold from the 2024 amount of $59,873 to $77,048 in 2025, which our payment model estimates as necessary for returning outlier payments to their target level of 8% in 2025. That is all I have, and I'll turn it over to Michael Treitel to discuss wage index policies.

Michael Treitel: Thank you, Jim. Good afternoon. So, we currently define hospital labor market area. I'll talk about actually the new CBSA (core-based statistical areas) delineations that we're implementing. So, the first thing that we currently define, hospital market labor, labor market areas such as which areas are rural, which areas are urban based on the delineations of statistical areas established by the Office of Management and Budget, also known as OMB. Historically, OMB has issued major revisions to the statistical areas every 10 years based on the results of the decennial census and occasionally issues minor updates and revision statistical errors in the years between the decennial census through OMB bulletins. In the final rule, we finalized to implement the revised OMB delineations as described in the July 21, 2023, OMB bulletin. Using these revised delineations based on the latest OMB bulletin, we believe, increases the integrity of the IPPS wage index system by creating a more accurate representation of current geographic variations in the wage levels.

Also, the final rule discusses the changes under the new delineations to areas going from urban to rural and rural to urban and an area that was subsumed by another area. The final rule also discusses the impacts on hospitals' MGCRB (Medicare Geographic Classification Review Board) reclassification. Probably, they're impacted by these delineations. It's probably a good idea to read the final rule, but one last thing regarding that is important to keep in mind is that since FY 2023, we've applied a 5% cap on any decrease that hospitals may experience in their final wage index from the prior fiscal year. We believe this 5% cap will sufficiently mitigate any significant disruptive financial impacts on hospitals that are negatively affected by the adoption of these revised delineations. And with that, I'll turn it over to Renate Dombrowski to discuss some policies related to GME (Graduate Medical Education). Thank you.

Renate Dombrowski: Thanks, Michael. This is Renate and I have a brief announcement that the fiscal year 2025 IPPS final rule includes the finalized policies for Section 4122 of the CAA (Consolidated Appropriations Act) of 2023. Section 4122 is a one-time distribution of 200 residency positions effective for fiscal year 2026. The slots are effective July 1 of that year. The provision requires the distribution of 200 residency positions to qualifying hospitals. These include hospitals in rural areas are treated as rural, hospitals training over their cap, hospitals and states with new medical schools or branch campuses and hospitals serving geographic HPSAs (Health Professional Shortage Areas). The law also requires that at least half of the slots be distributed to psychiatry programs and subspecialties of psychiatry and that each qualifying hospital receive at least one or a fraction of one slot. To meet the statutory requirement of distributing at least one slot or a fraction of one to each qualifying hospital and also to maintain consistency, when possible, that slot should be focused on underserved populations in areas with the most need. We finalized our proposal to distribute up to one slot to each qualifying hospital. After this, if there are any slots remaining, we would then distribute those remaining slots based on the health professional shortage area, or HPSA, score of the program for which the hospital is

applying. The Section 4122 application process will use the Electronic MEARIS (Medicare Electronic Application Request Information System) Application System. This is the system that's currently used for Section 126 applications, and the application for Section 4122 will open in early 2025. That's all I have, and I'll now turn it over to Ted.

Ted Oja: Thank you, Renate. In the fiscal year 2025 IPPS Long-Term Care Hospital PPS final rule, CMS finalized a separate payment to small independent hospitals of a hundred beds or fewer for the IPPS shares of the additional resource costs of establishing and maintaining a six-month buffer stock of one or more of 86 essential medicines. These costs do not include the cost of the medicine itself. The establishment of these buffer stocks is voluntary. Buffer stocks can be established directly or through contracts with one or more upstream manufacturers, distributors, or intermediaries. To address concerns of hoarding in times of shortage, CMS will not pay for newly established buffer stocks and drugs in shortage but will continue to pay for buffer stocks previously established under the policy that subsequently enter shortage. And now I'll turn things over to Marge Watchorn to discuss social determinants of health diagnosis codes.

Marge Watchorn: Thank you, Ted. My name is Marge Watchorn, and I will be discussing social determinants of health—in particular, resources for treating patients with inadequate housing. IPPS payment is made based on the use of hospital resources in the treatment of an individual based on their severity of illness, complexity of service, and/or consumption of resources. Generally, a diagnosis code with a higher severity level designation would result in a higher payment, which reflects the hospital's increased resource use. After reviewing the impact on resource use, CMS is finalizing its proposal to change the severity designation of the seven ICD-10-CM (International Classification of Diseases, Tenth Revision, Clinical Modification) diagnosis codes that describe inadequate housing and housing instability from non-complication or comorbidity to complication or comorbidity based on the higher average resource costs of cases with these diagnosis codes compared to similar cases without these codes. This builds on our policy from last year for the three diagnosis codes describing homelessness. The finalized policy also more accurately reflects the resource costs associated with each health care encounter when hospitals take care of people who have inadequate housing or have housing instability and will also improve the reliability and validity of the coded data, including in supportive efforts to advance health equity. And now I'll pass it to Allison Pompey.

Allison Pompey: Thanks, Marge. Good afternoon, everyone. The new technology add-on payment program finalized three policies in the final fiscal year 2025 rule—the first ones around gene therapies—and because we believe that gene therapies hold the potential to really significantly improve or even cure certain conditions, we finalized to temporarily increase the NTAP (New Technology Add-On Payment) payment for specific gene therapies indicated and use specifically for the treatment of sickle cell disease from 65% to 75%, and that would conclude at the end of the two- to three-year newness for each such gene therapy. Secondly, we finalized our policy to move the date that we use as a cutoff to determine whether or not a technology gets a third year of NTAP, which we call the newness state. We're moving it from April 1 to October 1. And then, finally, we're no longer considering a whole status to be an ineligible status for the purposes of new technology add-on payment. I will turn it over to Julia.

John Green: Hey, it's John Green. I'm actually going to be covering for Julia today. I will lead discussing the IPPS rule as it applies to quality provisions under the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR), the Hospital Inpatient Quality Reporting (IQR), and Hospital Value-Based Purchasing Programs (HVBP). Firstly, a cross program update to the Hospital Consumer Assessment of Healthcare Providers and Systems, or HCAHPS, surveys. We finalized a proposal to modify the HCAHPS survey across all three of these quality programs as we originally proposed. The update includes adding and modifying questions related to care coordination, the restfulness of the hospital environment, the responsiveness of staff, and information about systems. We proposed a phased implementation timeline in order to build in time to meet the Hospital VBP program statutory requirement that new or substantively modified measures be publicly reported for one year in Hospital IQR prior to moving to the Hospital VBP program. To meet that requirement, we were finalizing the use of the updated survey in both the IQR and PCHQR programs beginning in the calendar year 2025 reporting period, then in the calendar year 2028 reporting period for the Hospital VBP program. In the interim, only the unchanged parts of the HCAHP surveys will be used for calculation in the Hospital VBP program.

The second cross-program quality proposal was the Patient Safety Structural measure. We are finalizing the patient safety measure in both the PCHQR and IQR programs, however, with a modification to one of the originally proposed attestations to incorporate more flexibility around hospital relationships with patient safety organizations. Hospitals will need to provide their attestation responses in the CDC's NHSN (National Healthcare Safety Network) system for the calendar year 2025 reporting period. In the Hospital IQR program specifically, we finalized the addition of six measures as originally proposed. These include the Age-Friendly Hospital measure beginning with the calendar year 2025 reporting period and fiscal year 2027 payment determination, the CAUTI (Catheter-Associated Urinary Tract Infection) standardized infection ratio stratify for oncology locations beginning in the calendar year 2026 reporting period and fiscal year 2028 payment determination, CLABSI (Central Line-Associated Bloodstream Infection) Standardized Infection Ratio for Oncology Locations beginning with the calendar year 2026 reporting period and fiscal year 2028 payment determination, Hospital Harm—Falls with Injury eCQM (electronic clinical quality measure) beginning with the calendar year 2026 reporting period and fiscal year 2028 payment determination, Hospital Harm—Postoperative Respiratory Failure eCQM also beginning in the calendar year 2026 reporting period and fiscal year 2028 payment determination. Lastly, we have the 30-Day Risk-Standardized Death Rate among Surgical Inpatients measure beginning with the July 1, 2023, to June 30, 2025, reporting period. Excuse me; I believe that's July 1, 2024, to June 30, 2025, reporting period and impacting the fiscal year 2027 payment determinations.

We are finalizing the removal of five measures in the Hospital IQR program. Four of these are condition- and procedures-specific payment measures, and the fifth measure removed is the PSI-04 measure, or the death rate among surgical inpatients. We are finalizing modifications to two measures already in the Hospital IQR program as originally proposed. These include the cross-

program HCAHPS modifications I previously discussed, and we are updating the global malnutrition measure to add patients aged 18 and older.

Additionally, we are finalizing our proposal to begin validating eCQMs for accuracy as we originally proposed. Lastly, we are finalizing the proposed increase in the number of eCQMs required under the Hospital IQR program, however, with a modification to what we originally proposed. After consideration of detailed comments received from interested parties, we extended the time period over which we are increasing the number of ECQMs. We are now finalizing an increase from six to eight eCQMs in the calendar year 2026, then increasing to nine eCQMs in the calendar year 2027, and finally to 11 eCQMs in the calendar year 2028. That concludes my summary of the updates to the Hospital IQR, Hospital VBP, and PCHQR programs. I'd now like to hand things over to my colleague Jessica Warren.

Jessica Warren: Thanks so much, John. Jessica Warren here from the Medicare Promoting Interoperability program. Going over a few highlights from our section of the final rule. First, we finalized increasing the minimum performance-based scoring threshold with a modification from our proposal. So, in calendar year 2025, we would increase our minimum scoring threshold from 60 points to 70 points. And then, in 2026, from 70 points to 80 points. Next, we finalized the separation of the Antimicrobial Use and Resistance (AUR) measure into two measures. So antibiotic use (AU) is one, and antibiotic resistance (AR) is the second. Along with this, the AU and AR measures would then require submission of your level of active engagement, whether you are in option one or option two. Just a reminder that in 2024, this is the first time that the AUR measure was required, which would mean you could select option one as your level of active engagement over 2025 with a separation of AU and AR from AUR. That means you can start over again in option one for each of those. So, you can repeat option one two times.
We have also finalized AU specific and AR specific exclusions. They're essentially mostly the same as they were for the AUR measure, but they're more specific to each of the different components. Not to repeat everything that John just discussed for the IQR program, but to highlight a few updates for eCQMs—two eCQMs available for self-selection under PI (Promoting Interoperability) in alignment with IQR are Hospital Harm—Falls with Injury eCQM, Hospital Harm—Postoperative Respiratory Failure eCQM and then we're also modifying the eCQM, the global malnutrition composite scores to be inclusive of patients 18 and older versus only those age 65 and up. So that concludes the presentation for Medicare promoting interoperability. Next up, we have Lorraine, and she'll be discussing LTCH.

Lorraine Wickiser: Thanks, Jessica. Lorraine with Kaiser and I'm going to go over what we finalized in the fiscal year 2025 rule for the Long-Term Care Hospital Quality Reporting Program (LTCH QRP). So, this year we finalized adding four new items and then modifying one assessment item on the LTCH Continuity Assessment Record and Evaluation Care Data Set, better known as the LCDS. We also have finalized one administrative proposal and then we have two requests for information. So, we finalized the adoption of four new items to collect social determinants of health, or SDOH, information beginning October 1, 2026, for the fiscal year of 2028 LTCH QRP. These assessment items would collect information on living situations, food items, and utilities. We are also finalized to modify the current transportation assessment item

beginning October 1, 2026, for the fiscal year 2028 LTCH QRP. These changes will further enhance our SDOH categories and promote our standardized patient assessment data elements and ensure that we have the necessary national data to conduct these periodic analysis.

Then we also have our administrative proposal that we finalized, which was to revise the LCDS Administration Assessment window from three to four days. So currently, the LCDS Administration Assessment is three days, and in response to the feedback that we had heard from LTCHs that this time frame was difficult due to the medical complexity of some of their patients, we decided to give them an extra day, and this would help significantly reduce their level of burden to get that information in. And then lastly, we had two RFIs (requests for information) in the final rule. One was to get feedback on future measure concepts for the LTCH QRP, and the other was to get feedback on creating an LTCH star rating system. That's it for the LTCH QRP, and I'm going to turn it over to Lauren Blum for the critical access hospital (CAH).

Lauren Blum: Thank you, Lorraine. CMS issued specific reporting requirements for hospitals and CAHs for COVID and flu during the COVID-19 PHE. These requirements expired at the end of April. In close partnership with the CDC and ASPR (Administration for Strategic Preparedness and Response), we are finalizing proposals to continue ongoing, that is, outside of a PHE reporting on data related to influenza, COVID, and RSV to the CDC's NHSN system. The data categories for ongoing reporting include confirmed cases, total bed census and capacity, and certain demographic information. In the final rule, we have revised the frequency of reporting for most data elements for all facilities to report a snapshot of data. That is, data from a single day to be reported once a week, thus removing the burden of data collection for six of seven days per week. However, for data related to newly admitted patients with confirmed infections, we require facilities to report weekly totals, but they no longer are expected to capture and report daily data on a weekly basis.

Likewise, we are finalizing proposals to require additional data reporting requirements that could be activated in the event of a declared PHE. Of note: In response to feedback received during the public comment, we are not finalizing the proposal to also require additional data reporting if the threat of a PHE is significantly likely. Additional data reporting categories that may be activated in the event of a declared PHE include facility structure and infrastructure, operational status, ED (emergency department) diversion status, staffing shortages, supply inventory shortages, and relevant medical countermeasures and therapeutics. The final requirements are effective November 1, 2024, so all hospitals and CAHs have time to adjust and transition to these new reporting requirements. Back to you, Jill.

Jill Darling: Thanks, Lauren, and thanks to everyone. We'll go into the fiscal year 2025 Inpatient Psychiatric Facilities PPS final rule, and I'll hand it to Nick Brock.

Nicolas Brock: All right, thanks, Jill. Yes, so I'll start out with talking about some of the updates to the payment rates. For fiscal year 2025, we are updating the IPF (Inpatient Psychiatric Facility) PPS payment rates by 2.8%. That's based on the 2021 based IPF market basket increase of 3.3%, reduced by 0.5 percentage point productivity adjustment. Additionally, we are updating

the outlier thresholds that estimated outlier payments remain at 2% of total payments, and we estimate that updating the outlier threshold will result in a 0.3% decrease in aggregate payments. Total estimated payments to IPFs are estimated to increase by 2.5%, which is about $65 million in fiscal year 2025 relative to payments in 2024.

Next, I'll talk a bit about the wage index update, which Michael talked about. It's very, very similar. Update the revised census data for the IPF PPS. So again, we update this wage index annually based on the most recent available acute care hospital wage index, and for fiscal year 2025, we are updating the CBSA labor market areas as defined in the OMB bulletin 23-01. This changes the delineations between urban and rural areas. So, we're implementing a transition period for providers who are transitioning from rural to urban based on the revisions to these CBSAs. The affected providers will receive two-thirds of a rural adjustment in fiscal year 2025, one-third of the rural adjustment in fiscal year 2026, and no rural adjustment in fiscal year 2027. So, phasing that out over a period of three years. This approach is consistent with how we've done this type of policy in the past, and we think this will affect providers and help providers adjust to the loss of the rural payment adjustment over a period of time.

The next thing that I wanted to talk about is the IPF PPS patient level adjustment factors. We're finalizing revisions for fiscal year 2025 to the IPF PPS patient level adjustment factors. Historically, we've used the same patient and facility level adjustment factors that were derived from a regression model that was implemented in 2005. In this final rule, we've updated our regression analysis to determine the IPF PPS payment adjustments to reflect cost and claims data from CY 2019, 2020, and 2021. So blended three years of cost and claims data. Based on our analysis of these more recent updated costs and claims, as well as the public comments that we received in prior rules, we're finalizing changes to the patient level adjustments for which we adjust the IPF PPS per diem payment amount. We're finalizing these revisions in a budget-neutral manner, which means that estimated payments to IPFs for the fiscal year 2025 would be the same in aggregate with or without these finalized revisions. In addition to the patient level adjustment factors, we are also finalizing an increase to the payment per unit for Electroconvulsive Therapy (ECT). In our analysis, we found that the costs associated with providing ECT have increased by more than the updates have been over the course of the intervening year since 2005. And so, for fiscal year 2025, the ECT payment per treatment will be $661.52, which is an increase from the fiscal year 2024 ECT per treatment payment of $385. We believe this increase will help ensure that patients who need access to ECT will have that access.

The next item that I want to talk about here on the agenda is clarification of the requirements for reporting ancillary charges and the use of the all-inclusive status cost reports for IPFs. The Consolidated Appropriations Act of 2023 requires that CMS collect data and information, such as charges related to ancillary services to revise the IPF PPS. Currently, CMS expects that IPFs with a charge structure will report ancillary costs and charges on cost reports. In contrast, those IPFs without a cost structure have the option to use an alternative method of cost reporting by filing all-inclusive cost reports, and all-inclusive cost reporting accommodates the hospitals without the ability to allocate costs and charges and allows them to use an alternative cost allocation method. Historically, there have only been a small number of hospitals that file all-inclusive cost reports,

and these are consistently those that have minimal or ancillary cost data. They've included mostly Indian Health Services hospitals, tribally owned hospitals, and government-owned psychiatric and acute care hospitals. What CMS has noted in recent years is an increase in the number of IPFs that are erroneously filing all-inclusive cost reports. In the final rule, we clarified the eligibility criteria for the option to elect to file an all-inclusive cost report. We are also implementing operational changes to ensure that only government-owned IHS or tribally owned IPF hospitals are permitted to file an all-inclusive cost report for cost reporting periods beginning on or after October 1, 2024. We think that by improving the reporting of ancillary costs and charges, CMS will be able to increase the accuracy of future payment refinements to the IPF PPS, which will further advance behavioral health treatment and support IPFs to provide care to people with more complex and costlier conditions.

I want to note that we do recognize this represents a change for those providers who have been erroneously filing all-inclusive cost reports, and we appreciate that those IPFs with cost reporting dates that start on October 1 are looking to receive timely guidance as soon as possible. That's why CMS is developing guidance to educate providers on how to come into compliance with these clarified cost reporting requirements, including requirements for tracking and reporting ancillary costs and charges. Affected providers should expect to receive outreach from their Medicare Administrative Contractor, and additionally CMS will post guidance on the CMS.gov website and communicate with links to access this guidance through our distribution channels. So be on the lookout for more information about that guidance.

The next thing I wanted to talk about was the request for information about the facility level adjustment factors under the IPF PPS. In addition to analysis about the patient level adjustment factors, which we, as I mentioned earlier, are finalizing changes to, we also undertook analysis of the adjustment factors for facility level characteristics. We solicited comments on the results of that analysis, including a potential adjustment based on the Medicare Safety Net Index (MSNI), which was developed by MedPAC as a recommended alternative to the current statutorily required methodology for disproportionate share payments to IPPS hospitals. So, the common solicitation, their request for information, was with respect to that MSNI in the IPF PPS setting. While we discussed considerations related to applicability and modeling and we received a number of very helpful comments, we'll take these comments into consideration for future rulemaking. We also had another request for information in the proposed rule regarding the IPF PPS patient assessment instrument, which is required by the Consolidated Appropriations Act (CAA) of 2023. The CAA 2023 requires IPFs to collect and submit standardized patient assessment data on specified categories. The data will enable CMS to propose future revisions to the IPF PPS that would more accurately pay for care, monitor quality, and assess for disparities in behavioral health care. So, we included an RFI in the proposed rule to solicit comments with the goal of engaging the public to identify meaningful data elements for collection that are appropriate for the acute inpatient psychiatric care setting and potential criteria for the development and implementation of the instrument. In response to this RFI, we received again a number of comments that were very helpful. We summarized the comments that we received on this RFI in the final rule, and we will take these comments into consideration to potentially

inform future rulemaking for the development of the IPF PAI (Patient Assessment Instrument). So, on that, I'll hand it over to Kaleigh Emerson to talk about IPF Quality Reporting updates.

Kaleigh Emerson: Thank you. This is Kaleigh Emerson with the Inpatient Psychiatric Facility Quality Reporting, IPFQR program, and I'll be going over the updates to the IPFQR program in the fiscal year 2025 final rule. We finalized our proposal to adopt the 30-Day Risk Standardized All-Cause Emergency Department Visit Following an IPF Discharge measure, also called the IPF ED Visit measure. This measure complements the 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization and IPF measure, which is already in the program. And it provides information on the percent of patients discharged from the IPF who visit an emergency department within 30 days of their discharge without a subsequent readmission. Including both measures in the IPFQR program will provide a more complete assessment of post-discharge acute care. We believe the measure will provide meaningful information about the quality of care in IPFs and will encourage IPFs to improve discharge planning, care coordination, and follow-up after discharge.

We also had one administrative proposal related to our data reporting requirements. The existing requirement was that IPFs submit all patient level data for measures in the IPFQR program once per year, and we proposed to change that requirement to have IPFs submit data instead on a quarterly basis, and we believed that this proposal would reduce operational burden for IPFs. In response to our proposal, many interested parties express concern that IPFs would not be able to update processes and systems in time for data submission in November of 2025. Due to concern regarding these operational challenges, we did not finalize the proposal in this final rule. IPFs will continue reporting patient level data on an annual basis. Thank you, and that concludes the information for the IPFQR program.

Jill Darling: Great, thank you, Kaleigh. And thank you to all of our speakers today. I know that was much information, so we do have some time for Q&A. So, if you do have a question or comment, please use the raise hand feature at the bottom of your screen. Have one question and one follow-up, please, and we'll just give it a moment to see any raised hands. OK, currently I'm not seeing any questions. I did provide the Hospital ODF email in the chat for everyone in case you do have something to email us. So please feel free to use that, and I'll pass it back to Joe for closing remarks.

Joseph Brooks: OK, great. Thank you, Jill. I appreciate it. And thank you to your staff for helping us provide this Open Door Forum. We really appreciate it and thank you to the presenters as well. We really appreciate all of your time with your presentations and the information you provided the public today. Again, if you didn't get a chance to ask your question, please go ahead and get that to us via email hospital_odf@cms.hhs.gov. We'd be happy to take a look and get an answer back to you. Thank you to everyone for joining. One last check at hands raised or questions. I don't see anything in there. Please cut me off, Jill, if you see something I'm not seeing. I think that will do it for today. Thanks again, everyone. Have a great rest of your afternoon and week. Thank you all for joining us today.