



**WISCONSIN HOSPITAL
ASSOCIATION**

**SUMMARY OF THE
RATE YEAR 2009
UPDATE NOTICE
FOR THE MEDICARE
INPATIENT PSYCHIATRIC FACILITY
PROSPECTIVE PAYMENT SYSTEM**

May 2008

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Summary of the Rate Year (RY) 2009 Update Notice for the Medicare Inpatient Psychiatric Facility Prospective Payment System

I. OVERVIEW

The Centers for Medicare and Medicaid Services (CMS) published an update notice for the Medicare Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) in the May 7 *Federal Register*. Changes are effective for discharges beginning on or after July 1, 2008. The notice provides updates to the rates for Medicare payment of inpatient services furnished in psychiatric hospitals and distinct part psychiatric units of acute care hospitals and Critical Access Hospitals (CAHs).

Specifically, CMS will:

- increase the per diem rate from \$614.99 in RY 2008 to \$637.78 for RY 2009;
- decrease the outlier fixed-dollar loss threshold from \$6,488 in RY 2008 to \$6,113 for RY 2009; and
- increase the payment for electroconvulsive therapy (ECT) treatment from \$264.77 in RY 2008 to \$274.58.

CMS normally provides a period of public comment before provisions in a notice take effect. However, this notice does not enact any policy changes within the IPF PPS. The notice only reflects the application of previously established methodologies that already have been subject to public comment, therefore, CMS has waived a public comment period for this notice.

Note: Text in italics is extracted from the May 7, 2008 *Federal Register*.

II. BACKGROUND

The IPF PPS covers inpatient psychiatric services that are furnished in specialized hospitals, psychiatric distinct part or exempt units located in hospitals, and beds located in acute care hospitals that are in a separately certified exempt unit. Before 2005, psychiatric services in these hospitals and units were reimbursed for the “reasonable costs” of providing service to Medicare beneficiaries, subject to a limit on allowable costs. The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 governed this reasonable cost-based system.

The IPF PPS bases payments on a national per diem rate with wage index and teaching adjustments and an add-on for rural facilities. The payment for an individual patient is further adjusted for factors such as the Diagnosis Related Group (DRG) classification, age, length of stay, and the presence of specified comorbidities. Additional payments are provided for cost outlier cases and electroconvulsive therapy treatments.

III. TRANSITION PERIOD

Federal Register pages 25710 - 25711

Background: CMS provided a three-year transition period beginning January 1, 2005, to help relieve those facilities that may have experienced a financial hardship under the new IPF PPS compared to

payments under TEFRA. Changes to the blended percentages occurred at the start of an IPF's cost report period and hospitals received a blended payment of the PPS per diem amount and a hospital-specific amount based on the IPF's TEFRA payment. More specifically, the transition provided a blended rate as follows: Year 1 – 75% hospital-specific TEFRA payment amount and 25% IPF PPS per diem; Year 2 – 50% TEFRA and 50% IPF PPS; and Year 3 – 25% TEFRA and 75% IPF PPS.

CMS Final Rule: For RY 2009, “. . .the transition period established in the November 2004 IPF PPS final rule will no longer be applied.”

“IPFs with cost reporting periods beginning January 1, 2008 will have completed the transition period and will receive 100 percent IPF PPS payments. Other IPFs with cost reporting periods beginning after January 1, 2008, during 2008, will also begin to receive 100 percent IPF PPS payments.”

IV. STOP-LOSS PROVISION

Federal Register pages 25723 - 25724

Background: In addition to providing a transition period, CMS also added a stop-loss provision during the transition period to ensure that an IPF's total PPS payments were no less than a minimum percentage of their TEFRA payment, had the IPF PPS never been implemented. The stop-loss provision guaranteed that each facility's IPF PPS payments were at least 70% of the payments that would have been received under TEFRA. The transition period is due to end with cost report periods beginning on or after January 1, 2008.

CMS Final Rule: For RY 2009, “. . .the transition will be completed . . . , for cost reporting periods beginning on or after January 1, 2008, IPFs will be paid 100 percent PPS and, therefore, the stop loss provision will no longer be applicable.”

V. IPF PPS PAYMENT METHODOLOGY

Federal Per Diem Rate

Federal Register page 25712

Background: The federal per diem payment rate for the IPF PPS is calculated to provide reimbursement for the average daily cost of inpatient psychiatric care, including capital-related costs.

CMS Final Rule: For RY 2009, the federal per diem base rate is \$637.78. This updated base rate includes a marketbasket increase (discussed below), an addition of 0.39% for the elimination of the stop-loss provision and a budget neutrality factor of 1.0010.

Marketbasket Update

Federal Register pages 25712 – 25714

Background: CMS uses marketbasket updates to reflect price changes in the mix of goods and services that facilities purchase to furnish patient care. Prior to RY 2007, CMS had been unable to create a separate marketbasket index for IPF PPS and the excluded hospital with capital marketbasket was used to

update the IPF PPS rates. This marketbasket was based on 1997 Medicare cost report data and included data for Medicare participating IPFs, Inpatient Rehabilitation Facilities (IRFs), Long-Term Care Hospitals (LTCHs), cancer hospitals, and children's hospitals.

In the final rule for RY 2007, CMS adopted a rehabilitation, psychiatric, and long-term care (RPL) marketbasket based on 2002 Medicare cost report data. CMS excludes cancer and children's hospitals from the RPL market basket because their payments are based entirely on reasonable costs subject to rate-of-increase limits.

CMS Final Rule: For RY 2009, the “. . . update for the IPF PPS using the FY 2002-based RPL market basket and Global Insight's 1st quarter 2008 forecast for the market basket components is 3.2 percent.”

Based on the relative weights from the RPL marketbasket, CMS is decreasing the labor-related share of the per diem base rate from 75.788% in RY 2008 to 75.631% in RY 2009.

Wage Index

Federal Register pages 25719 - 25721

Background: The IPF PPS adjusts the labor-related portion of the per diem base rate for differences in area wage levels. CMS adjusts for labor costs using pre-reclassified, pre-rural floor inpatient acute care hospital wage indexes based on the assumption that inpatient acute care data reflect wage levels similar to those of psychiatric units as well as freestanding psychiatric hospitals. CMS believes the actual location of the IPF is most appropriate for determining the wage adjustment; hospitals that are geographically reclassified for an inpatient acute payment do not receive the reclassified wage index for an IPF payment and there is no provision for a rural floor. In addition, CMS does not apply the out-migration adjustment to the IPF PPS wage index because this policy only pertains to the Inpatient PPS.

CMS Final Rule: For RY 2009, CMS is “. . . applying the most recent hospital wage index using the most recent hospital wage data, and applying an adjustment in accordance with our budget neutrality policy”

“The wage index budget neutrality factor for RY 2009 is 1.0010.”

Facility-Level Adjustments

CMS will continue to use the same facility-level adjustments as in RY 2008. Therefore, the following facility-level adjustments will remain, based on CMS' prior regression analysis.

Teaching Adjustment

Federal Register page 25721

Background: The teaching adjustment is intended to account for the higher indirect operating costs associated with psychiatric teaching facilities. Psychiatric teaching hospitals paid under TEFRA did not receive separate medical education payments, since payments were based on the hospitals' reasonable costs and these higher costs would have been paid automatically through a hospital's TEFRA payment. However, since psychiatric teaching hospitals are now paid under the PPS, those higher costs need to be incorporated in the hospitals' IPF PPS payment.

To limit the incentives for IPFs to add full-time equivalents (FTEs), CMS imposed a cap on the number of psychiatric residents, similar to the cap that limits increases in residents under the Inpatient PPS. CMS calculates the number of FTE residents that train in the IPF during a “base year” and use that FTE

resident number as the cap. An IPF's FTE resident cap will ultimately be determined based on the final settlement of the IPF's most recent cost report filed before November 15, 2004. Residents with less than full-time status and residents rotating through the psychiatric hospital or unit for less than a full year are counted in proportion to the time they spend in their assignment with the IPF. For purposes of determining the teaching adjustment under the IPF PPS, the number of residents cannot exceed the number of residents in the hospital's base year.

CMS Final Rule: For RY 2009, CMS will continue “. . .the coefficient value of 0.5150 for the teaching adjustment to the Federal per diem base rate.”

An example of the calculation of the teaching adjustment is shown below.

IPF ADC = 4,000 (total IPF patient days) / 365 = 10.96
IPF Resident to ADC Ratio = 2.0 (residents) / 10.96 (calculated ADC) = .1825
IPF Teaching Adjustment = {1 + .1825 (teaching status)} ^ .5150 = 1.0902

Rural Location Adjustment

Federal Register page 25721

Background: CMS provides a rural location adjustment to account for the higher costs that smaller facilities experience on a per diem basis.

CMS Final Rule: For RY 2009, CMS will continue to apply “. . . the 17 percent payment adjustment for IPFs located in a rural area . . .”

Emergency Department Adjustment

Federal Register page 25722

Background: CMS provides a facility-specific adjustment to the federal per diem base rate to account for the costs associated with maintaining a full-service ED. CMS was concerned about creating an incentive for psychiatric units in acute care hospitals to admit all psychiatric patients through the ED. Therefore, as an alternative, CMS decided to provide a facility-level adjustment for psychiatric hospitals, acute care hospitals with a distinct part psychiatric unit, and Critical Access Hospitals (CAHs) with a distinct part psychiatric unit that maintain qualifying EDs. The adjustment is provided only to hospitals or CAHs with EDs that are staffed and equipped to furnish a comprehensive array of emergency services and that meet the definition of a dedicated emergency department. The only exception for the ED adjustment is when a patient is discharged from an acute care hospital or CAH and admitted to the same hospital or CAH's psychiatric unit. CMS states that, in those cases, the costs associated with the ED are covered through the DRG payment to the acute care hospital or through the reasonable cost payment made to the CAH. CMS maintains that an ED adjustment would result in double payment for the overhead costs of the ED in these cases. The ED adjustment is incorporated into the variable per diem adjustment for the first day of each stay; that is, IPFs with qualifying EDs receive a higher variable per diem adjustment for the first day of each stay.

CMS Final Rule: For RY 2009, CMS is “. . .retaining the 1.31 adjustment factor for IPFs with qualifying EDs.” The variable per diem payments are described below.

Patient-Level Adjustments

CMS provides adjustments to the per diem base rate for patient characteristics based on each patient's DRG assignment, age, and for specified comorbid conditions. For RY 2009, CMS will continue to use the same patient-level adjustment factors as in RY 2008.

MS-DRG Adjustment

Federal Register pages 25714 - 25716

Background: Even though the mental health community uses the Diagnostic and Statistical Manual of Mental Disorders (DSM) for diagnostic patient assessment, mental health care providers are required to report the ICD-9-CM code on the medical claim. CMS continues to believe that it is important to maintain the same diagnostic coding and DRG classification for IPFs that is used under the IPFS for providing the same psychiatric care. Therefore, in federal fiscal year 2008 when CMS adopted the Medicare-Severity (MS) DRGs for inpatient PPS, the same MS-DRGs were adopted for IPF PPS. Under the prior CMS-DRGs, the IPF PPS established separate weights for 15 specified DRGs; there are now 17 MS-DRG that are recognized: DRGs 521 and 522 are consolidated into MS-DRG 895 and receive an adjustment of 1.02; and a few DRGs are now split into two separate MS-DRGs. Annual updates to the ICD-9-CM coding are addressed in the Inpatient PPS proposed and final rule each year.

CMS Final Rule: For RY 2009, CMS will continue to provide payment weights for the following MS-DRGs.

IPF PPS MS-DRGs

(v24) DRG Prior to 10/01/07	(v25) MS-DRG After 10/01/07	MS-DRG Descriptions	Adjustment Factor
12	056	Degenerative nervous system disorders w MCC	1.05
	057	Degenerative nervous system disorders w/o MCC	
023	080	Nontraumatic stupor & coma w MCC	1.07
	081	Nontraumatic stupor & coma w/o MCC	
424	876	O.R. procedure w principal diagnoses of mental illness	1.22
425	880	Acute adjustment reaction & psychosocial dysfunction	1.05
426	881	Depressive neuroses	0.99
427	882	Neuroses except depressive	1.02
428	883	Disorders of personality & impulse control	1.02
429	884	Organic disturbances & mental retardation	1.03
430	885	Psychoses	1.00
431	886	Behavioral & developmental disorders	0.99
432	887	Other mental disorder diagnoses	0.92
433	894	Alcohol/drug abuse or dependence, left AMA	0.97
521 522	895	Alcohol/drug abuse or dependence w rehabilitation therapy	1.02
	896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC	
523	897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	0.88

The following table lists the new 2008 ICD-9-CM codes that are eligible to receive a DRG adjustment in RY 2009.

New FY 2008 ICD-9 Diagnosis Codes that Qualify for a MS-DRG Adjustment Under IPF PPS

Diagnosis Code		MS-DRG
315.34	Speech and language development delay due to hearing loss	886
331.50	Idiopathic normal pressure hydrocephalus (INPH)	056/057

Patient Age

Federal Register page 25718

Background: CMS’ prior analysis determined that IPF per diem costs rise as a patient’s age increases. CMS established adjustment factors for eight age groups as shown below.

CMS Final Rule: For RY 2009, CMS will continue “. . . to use the patient age adjustments currently in effect. . .”

IPF PPS Age Groupings

Age Group	Adjustment Factor
Under 45	1.00
45 and under 50	1.01
50 and under 55	1.02
55 and under 60	1.04
60 and under 65	1.07
65 and under 70	1.10
70 and under 75	1.13
75 and under 80	1.15
80 and over	1.17

Comorbidities

Federal Register pages 25716 - 25718

Background: Psychiatric patients with comorbid conditions are generally more costly on a per diem basis. Comorbidities are specific patient conditions that are secondary to a patient’s principal diagnosis, and require treatment during that stay.

CMS Final Rule: For RY 2009, CMS will continue to apply the current 17 comorbid condition adjustment factors to the per diem base rate. However, CMS has added some new ICD-9-CM codes and removed one code that was no longer applicable for the comorbidity adjustment. The following table reflects the updated ICD-9-CM codes within each of the comorbidity categories.

IPF PPS Comorbidity Categories

Comorbidity Category	ICD-9-CM Codes	Adjustment Factor
Developmental Disabilities	317, 318.0, 318.1, 318.2, and 319	1.04
Coagulation Factor Deficits	2860 through 2864	1.13
Tracheostomy	51900 – through 51909 and V440	1.06
Renal Failure, Acute	5845 through 5849, 63630, 63631, 63632, 63730, 63731, 63732, 6383, 6393, 66932, 66934, and 9585	1.11
Renal Failure, Chronic	40301, 40311, 40391, 40402, 40412, 40413, 40492, 40493, 5853, 5854, 5855, 5856, 5859, 586, V451, V560, V561, and V562	1.11
Oncology Treatment	1400 through 2399 WITH a radiation therapy code 92.21-92.29 or chemotherapy code 99.25	1.07
Uncontrolled Diabetes-Mellitus with or without complications	25002, 25003, 25012, 25013, 25022, 25023, 25032, 25033, 25042, 25043, 25052, 25053, 25062, 25063, 25072, 25073, 25082, 25083, 25092, and 25093	1.05
Severe Protein Calorie Malnutrition	260 through 262	1.13
Eating and Conduct Disorders	3071, 30750, 31203, 31233, and 31234	1.12
Infectious Disease	01000 through 04110, 042, 04500 through 05319, 05440 through 05449, 0550 through 0770, 0782 through 07889, and 07950 through 07959	1.07
Drug and/or Alcohol Induced Mental Disorders	2910, 2920, 29212, 2922, 30300, and 30400	1.03
Cardiac Conditions	3910, 3911, 3912, 40201, 40403, 4160, 4210, 4211, and 4219	1.11
Gangrene	44024 and 7854	1.10
Chronic Obstructive Pulmonary Disease	49121, 4941, 5100, 51883, 51884, V4611 and V4612, V4613 and V4614	1.12
Artificial Openings - Digestive and Urinary	56960 through 56969, 9975, and V441 through V446	1.08
Severe Musculoskeletal and Connective Tissue Diseases	6960, 7100, 73000 through 73009, 73010 through 73019, and 73020 through 73029	1.09
Poisoning	96500 through 96509, 9654, 9670 through 9699, 9770, 9800 through 9809, 9830 through 9839, 986, 9890 through 9897	1.11

CMS states, “. . . an IPF may receive only one comorbidity adjustment per comorbidity category, but it may receive an adjustment for more than one comorbidity category.”

Variable Per Diem Adjustment

Federal Register page 25719

Background: CMS applies an adjustment to the per diem rate to account for the higher costs associated with the earlier days of an IPF stay.

CMS Final Rule: For RY 2009, CMS will continue “. . . to use the variable per diem adjustment factors currently in effect. . .”

Day-of-Stay	Adjustment Factor
Day 1	1.31 (with ED) or 1.19 (without ED)
Day 2	1.12
Day 3	1.08
Day 4	1.05
Day 5	1.04
Day 6	1.02
Day 7 and Day 8	1.01
Day 9 and Day 10	1.00
Day 11 through Day 14	0.99
Day 15	0.98
Day 16 and Day 17	0.97
Day 18	0.96
Day 19 through Day 21	0.95
Over 21 Days	0.92

Other IPF PPS Payments

Outlier Payments

Federal Register page 25723

Background: Outlier payments are provided when the cost of the patient’s entire stay exceeds the outlier threshold amount, defined as the total IPF PPS payment for the stay plus a fixed-dollar loss threshold amount. The costs that exceed the outlier threshold are adjusted by the loss sharing ratio. The outlier calculation requires that the charges for a patient stay be converted to cost using the facility’s cost-to-charge ratio (CCR). This approach is consistent with the approach used under the IPPS and other PPSs. Therefore, CMS uses the CCR from the latter of the most recently settled Medicare IPF cost report or the most recent tentatively settled IPF Medicare cost report. CMS also applies a ceiling in determining a facility’s CCR that is based on three times the standard deviation for the urban and rural IPF CCR.

CMS pays 80% of the difference between the estimated cost for the case and the adjusted threshold amount for days 1 through 9 of the stay, than the remaining days are paid at 60% of the difference.

CMS Final Rule: For RY 2009, CMS will “. . . use \$6,113 as the fixed dollar loss threshold amount in the outlier calculation in order to maintain the 2 percent outlier policy.” CMS will also continue to use the current loss sharing ratios.

In addition, CMS annually updates the national urban and rural CCRs (median and ceiling) for IPFs based on the latest available IPF PPS provider-specific file. *“The upper threshold CCR for IPFs in RY 2009 is 1.8041 for rural IPFs, and 1.6724 for urban IPFs, based on CBSA-based geographic designations.”*

“The national CCRs for RY 2009 are 0.686 for rural IPFs and 0.5370 for urban IPFs . . .” CMS will apply the updated national urban and rural CCRs to the following three situations: *“New IPFs that have not yet submitted their first Medicare cost report; IPFs whose CCR is in excess of 3 standard deviations above the corresponding national geometric mean (that is, above the ceiling); or Other IPFs for whom the Medicare contractor obtains inaccurate or incomplete data with which to calculate CCR.”*

Electroconvulsive Therapy Adjustment

Federal Register page 25712

Background: Facilities that furnish electroconvulsive therapy (ECT) treatments for their patients during an IPF stay incur additional costs of care. CMS conducted an analysis and found that ECT cases can be approximately twice as expensive as a case without ECT, due primarily to the length of stay. To receive an additional IPF payment for ECT, facilities are instructed to indicate revenue code 901 and include ICD-9-CM procedure code 94.27 on their claims with the total number of ECT treatments provided.

CMS Final Rule: For RY 2009, the ECT payment rate is \$274.58. The ECT payment is adjusted by the wage index.