



WISCONSIN HOSPITAL
ASSOCIATION

**SUMMARY OF THE
RATE YEAR 2010
UPDATE NOTICE
FOR THE MEDICARE
INPATIENT PSYCHIATRIC FACILITY
PROSPECTIVE PAYMENT SYSTEM**

May 2009

SUBMISSION OF COMMENTS

The Centers for Medicare and Medicaid Services (CMS) typically provides a public comment period before the provisions in a published notice are finalized. This notice does not enact any policy changes for the Medicare Inpatient Psychiatric Facility (IPF) Prospective Payment System (PPS); it 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 the rate year (RY) 2010 IPF PPS rule. **However, CMS has included two specific issues on which they are seeking public comments; a stand-alone IPF marketbasket index and a full-time equivalent (FTE) intern and resident cap adjustment.**

This document provides an overview of the Medicare final rule for the IPF PPS for RY 2010. The final rule is available on the Centers for Medicare and Medicaid Services (CMS) Web site at <http://www.cms.hhs.gov/InpatientPsychFacilPPS/>.

CMS will only accept comments on the two specified issues by 5 p.m. on June 30. CMS requests that comments reference the file code CMS-1495-NC.

Comments on the specific issues requested within this final rule can be:

Submitted electronically at:

<http://www.regulations.gov>

Click on the “Submit electronic comments on CMS regulations with an open comment period” link. (Attachments should be in Microsoft® Word, WordPerfect®, or Excel format.)

-OR-

Regular Mail (an original and two copies):
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1495-NC
P.O. Box 8010
Baltimore, MD 21244-1850

Express/Overnight Mail (an original and two copies):
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1495-NC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

-OR-

Hand-deliver to (an original and two copies):
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

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Summary of the RY 2010 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 IPF PPS in the May 1 *Federal Register*. Changes are effective for discharges beginning on or after July 1, 2009. The notice provides updates to the Medicare payment rates for 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 \$637.78 in RY 2009 to \$651.76 for RY 2010;
- increase the outlier fixed-dollar loss threshold from \$6,113 in RY 2009 to \$6,565 for RY 2010; and
- increase the payment for electroconvulsive therapy (ECT) treatment from \$274.58 in RY 2009 to \$280.60 for RY 2010.

Note: Text in italics is extracted from the May 1, 2009 *Federal Register*.

II. BACKGROUND

The IPF PPS covers inpatient psychiatric services that are furnished in specialized hospitals, psychiatric distinct part or exempt units located within 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 Medicare Severity Diagnosis Related Group (MS-DRG) classification, age, length of stay, and the presence of specified comorbidities. Additional payments are provided for cost outlier cases and electroconvulsive therapy (ECT) treatments.

III. IPF PPS PAYMENT METHODOLOGY

Federal Per Diem Rate

Federal Register page 20365

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 2010, the federal per diem base rate is \$651.76. This updated base rate includes a marketbasket increase of 2.1 percent and a budget neutrality factor of 1.0009.

Marketbasket Update

Federal Register pages 20365 - 20366

Background: The marketbasket updates is intended to reflect price changes for the 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 - the "excluded hospital with capital" marketbasket was used to update the IPF PPS rates. That 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 2010, the "... update for the IPF PPS using the FY 2002-based RPL market basket and Information Handling Services (IHS) Global Insight's 1st quarter 2009 forecast for the market basket components is 2.1 percent."

CMS is seeking comments on the possibility of creating a stand-alone IPF marketbasket that reflects the cost structure of only IPF providers. CMS' intent is to combine cost report data from hospital-based IPF providers with that of freestanding IPF's. However, CMS has been unable to fully understand the underlying difference for the variations in cost structures between freestanding and hospital-based IPF's.

Wage Index

Federal Register page 20373

Background: The labor-related portion of the IPF PPS per diem base rate is adjusted 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 2010, CMS is "...applying the most recent hospital wage index (that is, the FY 2009 pre-floor, prereclassified hospital wage index because this is the most appropriate index as it best reflects the variation in local labor costs of IPFs in the various geographic areas) using the most recent hospital wage data (that is, data from FY 2005 hospital cost reports)..."

"The wage index budget neutrality factor for RY 2010 is 1.0009."

Based on the relative weights from the RPL marketbasket, CMS is increasing the labor-related share of the per diem base rate from 75.631 percent in RY 2009 to 75.889 percent in RY 2010.

Facility-Level Adjustments

CMS will continue to use the same facility-level adjustments as in RY 2009; therefore, the following facility-level adjustments will remain unchanged.

Teaching Adjustment

Federal Register page 20374

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. Now psychiatric teaching hospitals are paid under PPS and 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 those rotating through the psychiatric hospital or unit for less than a full year are counted in proportion to the time that 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 2010, CMS is "...retaining 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.

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

CMS is seeking comments on the FTE intern and resident cap adjustment. CMS has been asked to consider a revision to their current policy that would allow an increase in the FTE resident cap when residents are relocated to another IPF due to a closure of the IPF or psychiatry residency program. CMS would like to hear from the public on how IPFs are impacted by this resident cap and is specifically asking for the following information:

- "How many IPFs currently training additional residents from a closed residency program have exceeded their caps because of those residents?"
- How many IPFs have been asked to train additional residents from a closed residency program but have not currently agreed because these additional residents would cause them to exceed the caps?"

Rural Location Adjustments

Federal Register page 20374

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

CMS' Final Rule: For RY 2010, CMS will continue to apply “. . . the 17 percent payment adjustment for IPFs located in a rural area . . .”

Emergency Department Adjustment

Federal Register page 20375

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 to 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 under the DRG payment to the acute care hospital or through the reasonable cost payment made to the CAH. CMS maintains that an ED adjustment to the IPF PPS payment would result in double payment of the overhead costs for 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 2010, CMS is “. . . retaining the 1.31 adjustment factor for IPFs with qualifying EDs.”

Patient-Level Adjustments

CMS provides adjustments to the per diem base rate for patient characteristics based on each patient's MS-DRG assignment, age, and for specified comorbid conditions. For RY 2010, CMS will continue to use the same patient-level adjustment factors as in RY 2009.

MS-DRG Adjustment

Federal Register pages 20368 - 20369

Background: Although 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 Inpatient PPS because the same care can be provided in both settings. Therefore, in federal fiscal year 2008 when CMS adopted the 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-DRGs that are recognized for IPF PPS payments. 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 2010, 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
523	896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC	0.88
	897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	

The following table lists the new 2009 ICD-9-CM codes that are eligible to receive a MS-DRG adjustment in RY 2010.

New FFY 2009 ICD-9-CM Diagnosis Codes that Qualify for a MS-DRG Adjustment

Diagnosis Code	MS-DRG
046.11 Variant Creutzfeldt-Jakob disease	056/057
046.19 Other and unspecified Creutzfeldt-Jakob disease	056/057
046.71 Gerstmann-Straussler-Scheinker syndrome	056/057
046.72 Fatal familial insomnia	056/057
046.79 Other and unspecified prion disease of central nervous system	056/057

Comorbidities

Federal Register pages 20369 - 20372

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

CMS' Final Rule: For RY 2010, CMS will continue to apply the current 17 comorbid condition adjustment factors to the per diem base rate. CMS has added new ICD-9-CM codes and removed three

codes that were 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.”

Patient Age

Federal Register pages 20372 - 20373

Background: CMS’ 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 2010, 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

Variable Per Diem Adjustment

Federal Register page 20373

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 2010, 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 pages 20375 - 20376

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 a loss sharing ratio. The outlier calculation converts the charges for a patient stay to cost using the facility's cost-to-charge ratio (CCR). This approach is consistent with the approach used under the Inpatient PPS and other PPSs. 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 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, the remaining days are paid at 60% of the difference.

CMS' Final Rule: For RY 2010, CMS "...will use \$6,565 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, "*The upper threshold CCR for IPFs in RY 2010 is 1.7381 for rural IPFs, and 1.7647 for urban IPFs, based on CBSA-based geographic designations.*"

"The national CCRs for RY 2010 are 0.6515 for rural IPFs and 0.5300 for urban IPFs . . ." CMS will apply the updated national urban and rural CCRs in 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 which the Medicare contractor obtains inaccurate or incomplete data with which to calculate CCR.*"

Electroconvulsive Therapy Adjustment

Federal Register page 20365

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 2010, the ECT payment rate is \$280.60. The ECT payment is adjusted by the wage index.

IV. FUTURE ISSUES

One-Time Prospective Adjustment

Federal Register page 20367

When CMS first implemented the IPF PPS in the November 2004 final rule, they estimated aggregate payments made under the IPF PPS and applied budget neutrality factors so that payments would equal the estimated aggregate payments that would have been made under TEFRA. Each year CMS updates its budget neutrality factor adjustments in order to maintain the system in a budget neutral manner. CMS has indicated that it is possible that the actual amount of aggregate payments during the first 18 months of IPF PPS may have been significantly different than originally anticipated. Under Section 124 of the Balanced Budget Refinement Act (BBRA), CMS has the authority to make a one-time prospective adjustment to the IPF PPS rates to neutralize for significant differences between actual and estimated payments in the first year of the IPF PPS.

CMS is not, at this time including a one-time adjustment to the RY 2010 IPF PPS final rule, due to a lack of a complete final cost report data for the IPF PPS 18-month implementation period. However, CMS plans to revisit this issue at a later date, once the cost report data is available.