Medicare Inpatient Psychiatric Facility Prospective Payment System

Payment Rule Brief FINAL RULE provided by the Wisconsin Hospital Association
Program Year: FFY 2019

Overview and Resources

On August 6, 2018, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2019 final payment rule for the Inpatient Psychiatric Facility (IPF) Prospective Payment System (PPS). The final rule reflects the annual update to the Medicare fee-for-service (FFS) IRF payment rates and policies.

A copy of the final rule Federal Register (FR) and other resources related to the IPF PPS are available on the CMS Web site at
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/index.html.

An online version of the final rule is available at
https://www.federalregister.gov/documents/2018/08/06/2018-16518/medicare-program-fy-2019-inpatient-psychiatric-facilities-prospective-payment-system-and-quality.

A brief of the final rule along with page references for additional details are provided below. Program changes will be effective for discharges on or after October 1, 2018 unless otherwise noted.

IPF Payment Rates

Federal Register pages 38578 – 38581

Incorporating the adopted updates, with the effect of a budget neutrality adjustment for wage index, the table below lists the IPF federal per diem base rate and the electroconvulsive therapy (ECT) base rate for FFY 2019 compared to the rates currently in effect:

	Final FFY 2018	Final FFY 2019	Percent Change
IPF Per Diem Base Rate	**$771.35**	**$782.78**	**+1.5%**
ECT Base Rate	**$332.08**	**$337.00**	

The table below provides details of the adopted updates to the IPF payment rates for FFY 2019.

	FFY 2019 IPF Rate Update and Budget Neutrality Adjustments
Marketbasket (MB) Update	**+2.9%**
ACA-Mandated Productivity MB Reduction	**-0.8 percentage points**
ACA-Mandated Pre-Determined MB Reduction	**-0.75 percentage points**
Wage Index Budget Neutrality Adjustment	**1.0013**

Overall Rate Change	*+1.5%*

Wage Index, COLA, and Labor-Related Share

Federal Register pages 38579, 38582 - 38589

The labor-related portions of the IPF per diem base rate and ECT base rate are adjusted for differences in area wage levels using a wage index. As has been the case in previous years, the Medicare payment rates for IPFs use the FFY 2018 pre-floor, pre-reclassification IPPS wage index for FFY 2019, to adjust payment rates for labor market differences.

Based on this year's change to a 2012 - based marketbasket, CMS has slightly reduced the labor-related share of the IPF per diem base rate and ECT base rate from 75.0% in FFY 2018 to 74.8% for FFY 2019. This change will provide a small increase in payments to IPFs with a wage index less than 1.0.

A complete list of the IPF wage indexes for payment in FFY 2019 is available on the CMS website https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/WageIndex.html.

CMS is applying a budget neutrality factor of 1.0013 for FFY 2019 to ensure that aggregate payments made under the IPF PPS are not greater or less than would otherwise be made if wage adjustments had not changed.

For IPFs in Alaska and Hawaii, the IPF PPS provides a cost-of-living adjustment (COLA). The COLA is applied by multiplying the nonlabor-related portions of the per diem base rate and ECT base rate by the applicable COLA factor. Under IPPS COLA policy, the COLA updates are determined every four years, when the IPPS market basket is rebased. Since the IPPS COLA factors were last updated in FY 2018, they are not scheduled to be updated again until FY 2022. Therefore, CMS is proposing to continue to use the existing IPF PPS COLA factors for FY 2019. The updated IPF PPS COLA factors for FY 2019 for Alaska and Hawaii are shown in Table 1 of the Federal Register page 44 and Addendum A of the final rule.

Adjustments to the IPF Payment Rates

Federal Register pages 38580 – 38586

For FFY 2019, CMS will retain the facility and patient-level adjustments currently used for FFY 2018 IPF PPS. The adjustments are described in detail below.

- ED Adjustment *(FR page 38586)*: For FFY 2019, IPFs with a qualifying emergency department (ED) will continue to receive an adjustment factor of 1.31 as the variable per diem adjustment for day 1 of each stay. This adjustment is intended to account for the costs associated with maintaining a full-service ED. The ED adjustment applies to all IPF admissions, regardless of whether a patient receives preadmission services in the hospital's ED. A 1.19 ED adjustment is made when a patient is discharged from an acute care hospital or Critical Access Hospital (CAH) and admitted to the same hospital or CAH's psychiatric unit.
- Teaching Adjustment *(FR pages 38584- 38585)*: IPFs with teaching programs will continue to receive an adjustment to the per diem rate to account for the higher indirect operating costs experienced by hospitals that participate in graduate medical education (GME) programs. CMS will maintain the teaching adjustment factor at 0.5150 for FFY 2019. The teaching adjustment is based on the number of full-time equivalent (FTE) interns and residents training in the IPF and the IPF's average daily census (ADC). CMS will maintain the formula to calculate the teaching adjustment and to continue to allow temporary adjustments to FTE caps to reflect residents added due to closure of an IPF or a closure of an IPF's medical residency training program.

- Rural Adjustment *(FR page 38584)*: Since 2004, IPFs located in rural areas have received an adjustment to the per diem rate of 1.17. This adjustment is provided as an analysis by CMS had determined that the per diem cost of rural IPFs was 17% higher than that of urban IPFs.

- Patient Condition (MS-DRG) Adjustment *(FR pages 38580 - 38581)*: For FFY 2019, CMS will continue to use the Medicare-Severity Diagnosis Related Group (MS-DRG) system used under the IPPS to classify Medicare patients treated in IPFs.

  As has been the case in prior years, principal diagnoses codes (ICD-10-CMs) that group to one of 17 MS-DRGs recognized under the IPF PPS will receive a DRG adjustment. Principal diagnoses that do not group to one of the designated MS-DRGs recognized under the IPF PPS still receive the federal per diem base rate and all other applicable adjustments, but the payment will not include a DRG adjustment. The following table lists the 17 MS-DRGs that will be eligible for a MS-DRG adjustment under the IPF PPS for FFY 2019. These are the same adjustment levels currently in place.

MS-DRG	Description	Adjustment Factor
056	Degenerative nervous system disorders w MCC	1.05
057	Degenerative nervous system disorders w/o MCC	1.05
080	Non-traumatic stupor & coma w MCC	1.07
081	Non-traumatic stupor & coma w/o MCC	1.07
876	O.R. procedure w principal diagnoses of mental illness	1.22
880	Acute adjustment reaction & psychosocial dysfunction	1.05
881	Depressive neuroses	0.99
882	Neuroses except depressive	1.02
883	Disorders of personality & impulse control	1.02
884	Organic disturbances & mental retardation	1.03
885	Psychoses	1.00
886	Behavioral & developmental disorders	0.99
887	Other mental disorder diagnoses	0.92
894	Alcohol/drug abuse or dependence, left AMA	0.97
895	Alcohol/drug abuse or dependence w rehabilitation therapy	1.02
896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC	0.88
897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	0.88

- Patient Comorbid Condition Adjustment *(FR pages 38581 - 38582)*: For FFY 2019, the IPF PPS will continue to recognize 17 comorbidity categories for which an adjustment to the per diem rate can be applied. For each claim, an IPF may receive only one comorbidity adjustment per comorbidity category, but it may receive an adjustment for more than one category. The following table lists the comorbid condition payment adjustments for FFY 2019. These are the same adjustment levels currently in place.

Description of Comorbidity	Adjustment Factor
Artificial Openings—Digestive and Urinary	1.08
Cardiac Conditions	1.11
Chronic Obstructive Pulmonary Disease	1.12
Coagulation Factor Deficits	1.13
Developmental Disabilities	1.04
Drug and/or Alcohol Induced Mental Disorders	1.03
Eating and Conduct Disorders	1.12
Gangrene	1.10
Infectious Diseases	1.07

Oncology Treatment	1.07
Poisoning	1.11
Renal Failure, Acute	1.11
Renal Failure, Chronic	1.11
Severe Musculoskeletal and Connective Tissue Diseases	1.09
Severe Protein Calorie Malnutrition	1.13
Tracheostomy	1.06
Uncontrolled Diabetes Mellitus	1.05

- Patient Age Adjustment *(FR page 38582)*: The IPF PPS will maintain the patient age adjustment for FFY 2019. Analysis by CMS has shown that IPF per diem costs increase with patient age. The following table lists the patient age adjustments for FFY 2019. These are the same adjustment levels currently in place.

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

- Patient Variable Per Diem Adjustment *(FR page 38582)*: For FFY 2019, the per diem rate will continue to be adjusted based on patient length-of-stay (LOS) using variable per diem adjustment. Analysis by CMS has shown that per diem costs decline as the LOS increases. Currently, variable per diem adjustments begin on day 1 (adjustment of 1.19 or 1.31 depending on the presence of an ED – see “ED Adjustment” section) and gradually decline until day 21 of a patient’s stay. For day 22 and thereafter, the variable per diem adjustment remains the same each day for the remainder of the stay. The following table lists the variable per diem adjustment factors for FFY 2019. These are the same adjustment levels currently in place.

Day-of-Stay	Adjustment Factor	Day-of-Stay	Adjustment Factor
Day 1	1.19 (w/o ED) or 1.31 (w/ED)	Day 12	0.99
Day 2	1.12	Day 13	0.99
Day 3	1.08	Day 14	0.99
Day 4	1.05	Day 15	0.98
Day 5	1.04	Day 16	0.97
Day 6	1.02	Day 17	0.97
Day 7	1.01	Day 18	0.96
Day 8	1.01	Day 19	0.95
Day 9	1.00	Day 20	0.95
Day 10	1.00	Day 21	0.95
Day 11	0.99	After Day 21	0.92

Outlier Payments

Federal Register pages 38586 - 38587

Outlier payments were established under the IPF PPS to provide additional payments for extremely costly cases. Outlier payments are made when an IPF’s estimated total cost for a case exceeds a fixed dollar loss threshold amount (multiplied by the IPF’s facility-level adjustments) plus the federal per diem payment amount for the case. Costs are determined by multiplying the facility’s overall cost-to-charge ratio (CCR) by the allowable charges for the case. When a case qualifies for an outlier payment, CMS pays 80% of the difference between the estimated cost for the case and the adjusted threshold amount for days 1 through 9 of the stay

and 60% of the difference for day 10 and thereafter. These "loss sharing ratios" were established to discourage IPFs from increasing patient LOS in order to receive outlier payments.

CMS has established a target of 2.0% of total IPF PPS payments to be set aside for high cost outliers. To meet this target for FFY 2019, CMS is adopting an outlier threshold of $12,865, a 12.6% increase over the 2018 threshold of $11,425.

Updates to the IPF Cost-to-Charge Ratio (CCR) Ceiling

Federal Register page 38587

CMS applies a ceiling to IPF's CCRs. If an individual IPF's CCR exceeds the appropriate urban or rural ceiling, the IPF's CCR is replaced with the appropriate national median CCR for that FFY, either urban or rural. The national urban and rural CCRs and the national urban and rural CCR ceilings for IPFs are updated annually based on analysis of the most recent data that is available. The national median CCR is applied when:

- New IPFs have not yet submitted their first Medicare cost report;
- IPFs overall CCR is in excess of 3 standard deviations above the corresponding national CCR ceiling for the current FY;
- Accurate data to calculate an overall CCR are not available for IPFs.

CMS will continue to set the national CCR ceilings at 3 standard deviations above the mean CCR, and resulting in a national CCR ceiling for FFY 2019 for rural IPFs will be 2.0068 and 1.6862 for urban IPFs. If an individual IPF's CCR exceeds this ceiling for FFY 2019, the IPF's CCR will be replaced with the appropriate national median CCR, urban or rural. CMS is finalizing a national median CCR of 0.5890 for rural IPFs and 0.4365 for urban IPFs.

IPF Quality Reporting (IPFQR) Program

Federal Register pages 38589 - 38608

IPFs that do not successfully participate in the IPFQR Program are subject to a 2.0 percentage point reduction to the marketbasket update for the applicable year.

CMS is considering options to improve health disparities among patient groups within and across hospitals by increasing transparency of disparities through quality measures and quality programs.

For FFY 2019 and subsequent years, CMS is adding an additional factor to consider when evaluating measures for removal from the IPFQR program measure set:

- Factor 8: The costs associated with a measure outweigh the benefit of its continued use in the program.

For the FFY 2020 and subsequent years, CMS will remove 5 measures (the first four due to costs outweighing benefits and the last TOB-1 due to measures being topped-out) from the IPFQR program:

- Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431);
- SUB-1—Alcohol Use Screening (NQF #1661);
- Assessment of Patient Experience of Care;
- Use of an electronic health record; and
- TOB-1—Tobacco Use Screening (NQF #1651).

The adopted set of 13 measures for FFY 2020 payment determination and subsequent years are shown below:

Measure	NQF #	Payment Determination Year
HBIPS-2—Hours of Physical Restraint Use	#0640	FFY 2015 and beyond
HBIPS-3—Hours of Seclusion Use	#0641	FFY 2015 and beyond
HBIPS-5—Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification	#0560	FFY 2015 and beyond
FUH—Follow-Up After Hospitalization for Mental Illness	#0576	FFY 2016 and beyond
IMM-2—Influenza Immunization	#1659	FFY 2017 and beyond
TOB-2/2a—Tobacco Use Treatment Provided or Offered and Tobacco Use Treatment	#1654	FFY 2017 and beyond
TOB-3/3a Tobacco Use Treatment Provided or Offered at Discharge and Tobacco Use Treatment at Discharge	#1656	FFY 2018 and beyond
SUB-2/2a Alcohol Use Brief Intervention Provided or Offered and Alcohol Use Brief Intervention	#1663	FFY 2018 and beyond
Transition record with specified elements received by discharged patients	#0647	FFY 2018 and beyond
Timely transmission of transmission record	#0648	FFY 2018 and beyond
Screening for Metabolic Disorders Measure	N/A	FFY 2018 and beyond
SUB-3/3a Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and Alcohol and Other Drug Use Disorder Treatment at Discharge	#1664	FFY 2019 and beyond
30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization inn an Inpatient Facility	#2860	FFY 2019 and beyond

CMS is considering proposing measures that meet the following needs in future program years:

- A process measure that measures administration of a standardized depression assessment instrument at admission and discharge for patients admitted with depression; and
- A patient reported outcome measure which assesses change in patient reported function based on the change in results on the standardized depression assessment instrument between admission and discharge.

Lastly, CMS currently requires IPFs to submit “non-measure data” (i.e. aggregate population counts and sample size counts for measures for which sampling is performed) for Medicare and non-Medicare discharges by age group and diagnostic group on a yearly basis. The requirement to submit the sample size counts has created confusion for some facilities and therefore beginning FFY 2020, CMS will no longer require facilities to report the sample size counts for measures for which sampling is performed.

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