# Medicare Inpatient Psychiatric Facility Prospective Payment System

Proposed Payment Rule Brief provided by the Wisconsin Hospital Association
Program Year: FFY 2022

## Overview and Resources

On April 7, 2021, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2022 proposed payment rule for the Inpatient Psychiatric Facility (IPF) Prospective Payment System (PPS). The proposed rule reflects the annual update to the Medicare fee-for-service (FFS) IPF payment rates and policies.

A copy of the proposed rule and other resources related to the IPF PPS are available on the CMS website at

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS.

An online version of the proposed rule is available at https://federalregister.gov/d/2021-07433.

A brief of the proposed rule along with page references for additional details are provided below. Program changes adopted by CMS would be effective for discharges on or after October 1, 2021 unless otherwise noted. CMS estimates the overall economic impact of this proposed payment rate update to be an increase of $90 million in aggregate payments to IPFs in FFY 2022 over FFY 2021.

Comments on the proposed rule are due to CMS by June 7, 2021 and can be submitted electronically at http://www.regulations.gov by using the website's search feature to search for file code "1750-P".

***Note:*** Text in italics is extracted from the *Federal Register*.

## IPF Payment Rates

***Federal Register pages 19,483 – 19,484 and 19,521 – 19,522***

The table below lists the proposed IPF federal per diem base rate and the proposed electroconvulsive therapy (ECT) base rate for FFY 2022 compared to the rates currently in effect:

| | Final FFY 2021 | Proposed FFY 2022 | Percent Change |
|---|---|---|---|
| **IPF Per Diem Base Rate** | **$815.22** | **$833.50** | **+2.24%** |
| **ECT Base Rate** | **$350.97** | **$358.84** | |

The following table provides details of the proposed updates to the IPF payment rates for FFY 2022:

| | FFY 2022 IPF Rate Update |
|---|---|
| Marketbasket (MB) Update | **+2.3%** |
| ACA-Mandated Productivity MB Reduction | **0.2 percentage points** |
| Wage Index Budget Neutrality Adjustment | **1.0014** |

| *Overall Rate Change* | *+2.24%* |
|---|---|

In the past, CMS has used the Moody's AAA Corporate Bond Yield index as the price proxy for the For-profit Interest cost category of the 2016-based IPF marketbasket. Instead, CMS is proposing to use the iBoxx AAA Corporate Bond Yield index, which closely resembles the Moody's AAA Corporate Bond Yield index, as the Moody's AAA Corporate Bond series is no longer available for use under license to IHS Global Inc. (IGI) and therefore IGI discontinued the publication of the associated historical data and forecasts of this series.

## Wage Index, COLA, Labor-Related Share, and Revised CBSA Delineations

***Federal Register pages 19,483, 19,486 – 19,489, and 19,491 – 19,492***

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. The Medicare payment rates for IPFs are proposed to continue to use the current year pre-floor, pre-reclassification IPPS wage index for FFY 2022, to adjust payment rates for labor market differences.

CMS estimates the labor-related portion of the IPF standard rate and also adjust for differences in area wage levels using a wage index. CMS is proposing to decrease the labor-related share of the IPF per diem base rate and ECT base rate from 77.3% in FFY 2021 to 77.1% for FFY 2022.

A complete list of the proposed IPF wage indexes for payment in FFY 2022 is available on the CMS website https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/WageIndex.html.

CMS is proposing a budget neutrality factor of 1.0014 for FFY 2022 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 non-labor-related portions of the per diem base rate and ECT base rate by the applicable COLA factor. Under the IPPS COLA policy, the COLA updates are determined every four years, when the IPPS market basket is rebased. As the IPPS COLA factors were last updated in FFY 2018, they are now due to be updated for FFY 2022. The proposed IPF PPS COLA factors for FFY 2022 for Alaska and Hawaii are shown in Addendum A as well as in Table 1 on page 19,492 of the *Federal Register*.

## Adjustments to the IPF Payment Rates

***Federal Register pages 19,484 – 19,486, 19,488 – 19,492***

For FFY 2022, CMS will retain the facility and patient-level adjustments currently used for FFY 2021 IPF PPS. The adjustments are described in detail below.

- ED Adjustment *(Federal Register page 19,492)*: For FFY 2022, IPFs with a qualifying emergency department (ED) are proposed to 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. The 1.31 ED adjustment is not 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, and in such cases the IPF receives an ED adjustment factor of 1.19.
- Teaching Adjustment *(Federal Register pages 19,489 – 19,490)*: 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 is proposing to maintain the teaching adjustment coefficient value at 0.5150 for FFY 2022. 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 is proposing to also 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 closure of an IPF's medical residency training program. For FFY 2022, CMS is proposing to align the IPF PPS teaching policy with those changes adopted in the FFY 2021 Inpatient Prospective Payment System (IPPS) final rule, with the specification that the resident FTE caps under the two payment systems must remain separate, and that a provider cannot add its IPF resident cap to its IPPS resident cap.

CMS is proposing that the key day for linking temporary Medicare funding would be the day that the IPF/residency program closure was publicly announced, allowing residents time to find a new facility at which to complete their training while the residency program of the originating IPF winds down. This would be instead of the current method of linking Medicare temporary funding for the affected residents to the day prior to or the day of program or hospital closure.

CMS is also proposing to allow funding to be transferred temporarily for the second and third group of residents who are not physically present at the closing IPF/closing program, but had intended to train at (or return to training at, in the case of residents on rotation) the closing IPF program.

To apply for the temporary Medicare resident cap increase, the receiving IPF would have to submit a letter to its Medicare Administrative Contractor (MAC) within 60 days of beginning the training of the displaced residents (residents added by a receiving IPF due to an IPF or program closure). This letter must include the name of each displaced resident; the last four digits of each resident's social security number; the IPF and program in which the resident was previously training; and the amount of cap increase needed for each resident.

CMS is also proposing that if there are more displaced IPF residents than available cap slots, the slots may be apportioned according to the displaced residents, with the amount determined by the originating IPF.

Finally, CMS is proposing that for future rulemaking, it would deviate from the IPPS teaching policy pertaining to displaced residents for the IPF teaching adjustment only when necessary for the IPF PPS.

- Rural Adjustment *(Federal Register page 19,488)*: IPFs located in rural areas receive an adjustment to the per diem rate of 1.17. This adjustment is provided because an analysis by CMS determined that the per diem cost of rural IPFs was 17% higher than that of urban IPFs. CMS is proposing to continue this adjustment in FFY 2022.
- Patient Condition (MS-DRG) Adjustment *(Federal Register pages 19,484 – 19,485)*: For FFY 2022, 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 would 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 are proposed to be eligible for a MS-DRG adjustment under the IPF PPS for FFY 2022. These are the same as the 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 *(Federal Register pages 19,485 – 19,486)*: For FFY 2022, CMS is proposing that 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 proposed comorbid condition payment adjustments for FFY 2022. These are the same as the 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 *(Federal Register page 19,486)*: CMS is proposing to maintain the patient age adjustment for FFY 2022 as analysis by CMS has shown that IPF per diem costs increase with patient age. The following table lists the proposed patient age adjustments for FFY 2022. These are the same as the 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 *(Federal Register page 19,486)*: For FFY 2022, the per diem rate is proposed to 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"

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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 proposed variable per diem adjustment factors for FFY 2022. These are the same as the 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 19,492 – 19,493***

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 the first through ninth day of the stay, and then 60% of the difference for the tenth day onwards. The varying 80% and 60% "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 2022, CMS is proposing an outlier threshold of $14,030, a 4.1% decrease over the FFY 2021 threshold of $14,630. To calculate this outlier threshold, CMS is also proposing to use FFY 2019 claims, instead of FFY 2020 claims. Had CMS used FFY 2020 claims, due to the impact of the COVID-19 pandemic, the proposed outlier threshold for FFY 2021 would instead be $19,840.

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

***Federal Register pages 19,493 – 19,494***

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 FFY;
- Accurate data to calculate an overall CCR are not available for IPFs.

CMS is proposing to continue to set the national CCR ceilings at 3 standard deviations above the mean CCR, and therefore the proposed national CCR ceiling for FFY 2022 for rural IPFs would be 2.0398 and 1.6126 for urban IPFs. If an individual IPF's CCR exceeds this ceiling for FFY 2022, the IPF's CCR will be replaced with the appropriate

national median CCR, urban or rural. CMS is proposing a national median CCR of 0.5720 for rural IPFs and 0.4200 for urban IPFs, both values are the same as were adopted for FFY 2021.

## IPF Quality Reporting (IPFQR) Program

***Federal Register pages 19,494 – 19,515***

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

CMS had previously finalized 14 measures for the FFY 2022 payment determination and subsequent years. These, along with the two proposed measures for FFY 2023 and FFY 2024, listed below. There are also four measures marked for removal beginning FFY 2024 denoted below:

| Measure | NQF # | Payment Determination Year |
|---|---|---|
| HBIPS-2—Hours of Physical Restraint Use | #0640 | FFY 2015+ |
| HBIPS-3—Hours of Seclusion Use | #0641 | FFY 2015+ |
| HBIPS-5—Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification | #0560 | FFY 2015+ |
| FUH—Follow-Up After Hospitalization for Mental Illness | #0576 | FFY 2016+ ***Proposal:*** *Remove for FFY 2024+* |
| IMM-2—Influenza Immunization | #1659 | FFY 2017+ |
| TOB-2/2a—Tobacco Use Treatment Provided or Offered and Tobacco Use Treatment | N/A | FFY 2017+ ***Proposal:*** *Remove for FFY 2024+* |
| TOB-3/3a Tobacco Use Treatment Provided or Offered at Discharge and Tobacco Use Treatment at Discharge | N/A | FFY 2018+ |
| SUB-2/2a Alcohol Use Brief Intervention Provided or Offered and Alcohol Use Brief Intervention | N/A | FFY 2018+ ***Proposal:*** *Remove for FFY 2024+* |
| Transition record with specified elements received by discharged patients | N/A | FFY 2018+ |
| Timely Transmission of Transition Record | N/A | FFY 2018+ ***Proposal:*** *Remove for FFY 2024+* |
| Screening for Metabolic Disorders Measure | N/A | FFY 2018+ |
| 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 | N/A | FFY 2019+ |
| 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization inn an Inpatient Facility | #2860 | FFY 2019+ |
| Medication Continuation Following Inpatient Psychiatric Discharge | #3205 | FFY 2021+ |
| COVID-19 Healthcare Personnel (HCP) Vaccination Measure | TBD | ***Proposal:*** *Add for FFY 2023+* |
| Follow-Up After Psychiatric Hospitalization (FAPH) | N/A | ***Proposal:*** *Add for FFY 2024+* |

Please note that CMS is proposing to remove "FUH—Follow-Up After Hospitalization for Mental Illness" (NQF #0576) from the IPFQR Program only if the measure "Follow-Up After Psychiatric Hospitalization (FAPH)" is adopted for the Inpatient Quality Reporting (IQR) Program.

Beginning with FFY 2023 payment determinations, CMS is proposing to use the term "QualityNet security official" in place of "QualityNet system administrator" to denote the authority invested in the role, and to align with other

programs. Additionally, for FFY 2023 and subsequent years, CMS is proposing to no longer require that IPFs maintain an active QualityNet security official account to qualify for payment.

Beginning with FFY 2024 payment determinations, CMS is proposing to convert various chart-abstracted measures over to the use of patient-level data reporting as shown in Table 6 on page 19,514 of the *Federal Register*. CMS is also proposing a one-year transition period, beginning with the FFY 2023 payment determination, for IPFs to submit voluntary patient-level data. This submission would then become mandatory with the FFY 2024 IPFQR payment determination.

## Request for Information – Closing the Health Equity Gap in CMS Quality Reporting Programs

*Federal Register pages 19,494 – 19,500*

CMS is requesting public comment on potential revisions to the IPFQR Program to make reporting of health disparities based on social risk factors and race/ethnicity more comprehensive and actionable for providers and patients. CMS states it is committed to achieving equity in health care outcomes and supporting providers in quality improvement activities to reduce health inequities.

Specifically, CMS is seeking comment on:

*"<u>Future potential stratification of quality measure results</u>*

- *The possible stratification of facility-specific reports for IPFQR program measure data by dual-eligibility status given that over half of the patient population in IPFs are dually eligible, including, which measures would be most appropriate for stratification;*
- *The potential future application of indirect estimation of race and ethnicity to permit stratification of measure data for reporting facility-level disparity results until more accurate forms of self-identified demographic information are available;*
- *Appropriate privacy safeguards with respect to data produced from the indirect estimation of race and ethnicity to ensure that such data are properly identified if/when it is shared with providers.*
- *Ways to address the challenges of defining and collecting accurate and standardized self-identified demographic information, including information on race and ethnicity and disability, for the purposes of reporting, measure stratification and other data collection efforts relating to quality.*
- *Recommendations for other types of readily available data elements for measuring disadvantage and discrimination for the purposes of reporting, measure stratification and other data collection efforts relating to quality, in addition, or in combination with race and ethnicity*
- *Recommendations for types of quality measures or measurement domains to prioritize for stratified reporting by dual eligibility, race and ethnicity, and disability.*
- *Examples of approaches, methods, research, and/or considerations for use of data-driven technologies that do not facilitate exacerbation of health inequities, recognizing that biases may occur in methodology or be encoded in datasets.*

*<u>Improving Demographic Data Collection</u>*

- *Experiences of users of certified health IT regarding local adoption of practices for collection of social, psychological, and behavioral data elements, the perceived value of using these data for improving decision-making and care delivery, and the potential challenges and benefits of collecting more granular, structured demographic information, such as the "Race & Ethnicity—CDC" code system.*
- *The possible collection of a minimum set of social, psychological, and behavioral data elements by hospitals at the time of admission using structured, interoperable data standards, for the purposes of reporting, measure stratification and other data collection efforts relating to quality*

*<u>Potential Creation of a Facility Equity Score to Synthesize Results Across Multiple Social Risk Factors</u>*

- *The possible creation and confidential reporting of a Facility Equity Score to synthesize results across multiple social risk factors and disparity measures.*
- *Interventions facilities could institute to improve a low facility equity score and how improved demographic data could assist with these efforts."*

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