Medicare Inpatient Psychiatric Facility Prospective Payment System

Payment Rule Brief FINAL RULE provided by the Wisconsin Hospital Association
Program Year: FFY 2018

Overview and Resources

On August 7, 2017 and August 14, 2017, the Centers for Medicare and Medicaid Services (CMS) released two regulations that will update the Medicare fee-for-service (FFS) payment rates and policies under the Inpatient Psychiatric Facility (IPF) Prospective Payment System (PPS) for federal fiscal year (FFY) 2018.

The first regulation is an update notice (UN) that updates the IPF payment factors. The second regulation is a final rule (the FFY 2018 Inpatient PPS (IPPS) final rule) that updates the quality reporting program for IPFs.

A copy of the update notice 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 update notice is available at https://federalregister.gov/a/2017-16430.

An online version of the IPPS final rule that updates the IPF quality reporting requirements is available at https://federalregister.gov/a/2017-16434.

A brief of the update notice that updates the IPF payment factors and final rule that updates the quality reporting program along with page references for additional details are provided below. Program changes will be effective for discharges on or after October 1, 2017 unless otherwise noted. Comments on the update notice are due to CMS by October 6, 2017 and can be submitted electronically at http://www.regulations.gov by using the website's search feature to search for file codes "1673-NC".

IPF Payment Rates

Federal Register pages 36775 – 36776

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 2018 compared to the rates currently in effect:

	Final FFY 2017	Final FFY 2018	Percent Change
IPF Per Diem Base Rate	**$761.37**	**$771.35**	**+1.3%**
ECT Base Rate	**$327.78**	**$332.08**	

The table below provides details of the adopted updates to the IPF payment rates for FFY 2018.

	FFY 2018 IPF Rate Update and Budget Neutrality Adjustments
Marketbasket (MB) Update	**+2.6%**

ACA-Mandated Productivity MB Reduction	**-0.6 percentage points**
ACA-Mandated Pre-Determined MB Reduction	**-0.75 percentage points**
Wage Index Budget Neutrality Adjustment	**1.0006**
Overall Rate Change	***+1.3%***

Wage Index, COLA, and Labor-Related Share

Federal Register pages 36775 – 36776, 36777 – 36782

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 2017 pre-floor, pre-reclassification IPPS wage index for FFY 2018, to adjust payment rates for labor market differences.

Based on updates to this year's marketbasket value, CMS has slightly reduced the labor-related share of the IPF per diem base rate and ECT base rate from 75.1% in FFY 2017 to 75.0% for FFY 2018. 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 2018 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 1.0006 for FFY 2018 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 FFY 2014, they are updated for FFY 2018. The updated IPF PPS COLA factors for FY 2018 for Alaska and Hawaii are shown in Table 1 on *Federal Register* page 36782 and Addendum A of the Update Notice.

Adjustments to the IPF Payment Rates

Federal Register pages 36776 – 36780, 36782

For FFY 2018, CMS will retain the facility and patient-level adjustments currently used for FFY 2017 IPF PPS. The adjustments are described in detail below.

- ED Adjustment *(Federal Register page 36782)*: For FFY 2018, IPFs with a qualifying emergency department (ED) will continue to receive an adjustment factor of 1.31, (as opposed to an adjustment factor of 1.19 if an IPF does not have a qualifying ED) 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 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.
- Teaching Adjustment *(Federal Register page 36780)*: 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 2018. 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 would 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 *(Federal Register pages 36779 - 36780)*: Since 2004, IPFs located in rural areas received an adjustment to the per diem rate of 1.17. This adjustment was provided because an analysis by CMS determined that the per diem cost of rural IPFs was 17% higher than that of urban IPFs.

  As a result of the adoption of the new CBSA delineations for the FY 2016 IPF PPS wage index, 37 IPF providers saw a status change from rural to urban and, therefore, lost the 17% rural adjustment. In the FFY 2016 IPF final rule, CMS adopted a gradual phase-out of the rural adjustment for the affected facilities, so that these 37 providers received two-thirds of the rural adjustment in FY 2016, one-third of the rural adjustment in FFY 2017, and no rural adjustment thereafter. So, for FFY 2018 and subsequent years, these IPFs will not receive any rural adjustment.

- Patient Condition (MS-DRG) Adjustment *(Federal Register page 36777)*: For FFY 2018, 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 2018. 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 *(Federal Register pages 36777 - 36778)*: For FFY 2018, 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 2018. 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 *(Federal Register page 36778)*: The IPF PPS will maintain the patient age adjustment for FFY 2018. Analysis by CMS has shown that IPF per diem costs increase with patient age. The following table lists the patient age adjustments for FFY 2018. 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 *(Federal Register page 36778)*: For FFY 2018, 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 2018. 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 36782 - 36783

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. 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 2018, CMS is adopting an outlier threshold of $11,425, a 12.9% increase over the 2017 threshold of $10,120.

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

Federal Register page 36783

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 therefore the national CCR ceiling for FFY 2018 for rural IPFs is 1.9634 and 1.7071 for urban IPFs. If an individual IPF's CCR exceeds this ceiling for FFY 2018, the IPF's CCR will be replaced with the appropriate national median CCR, urban or rural. CMS is finalizing a national median CCR of 0.5930 for rural IPFs and 0.4420 for urban IPFs.

Request for Information on CMS Flexibilities and Efficiencies

Federal Register pages 36784 - 36785

CMS is issuing a Request for Information on how Medicare can contribute to making the healthcare delivery system less bureaucratic and complex, and how they can reduce burden to clinicians, providers, and patients in a way that increases the quality of care and decreases costs. CMS is soliciting ideas for regulatory, subregulatory, policy, practice, and procedural changes to better accomplish these goals including:

- Payment system design;
- Elimination or streamlining of reporting;
- Monitoring and documentation requirements;
- Aligning Medicare requirements and processes with those from Medicaid and other payers;
- Operational flexibility;
- Feedback mechanisms and data sharing that would enhance patient care;
- Support of the physician-patient relationship in case delivery; and
- Facilitation of individual preferences.

IPF Quality Reporting Program

IPPS Federal Register pages 38461 - 38474

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 sought comment in the proposed rule on whether or not CMS should account for social risk factors in the IPFQR program, and if so, which factors to include and how the collection would be operationalized. A discussion of these comments can be found on *Federal Register* page 38463.

CMS finalized new: (1) measure removal factors; (2) criteria for determining when a measure is “topped-out;” and (3) measure retention factors. Specifically, CMS adopted the following measure removal factors for the IPFQR Program:

- Measure performance among IPFs is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made (“topped out”);
- Measure does not align with current clinical guidelines or practice;
- Measure can be replaced by a more broadly applicable measure or a measure that is more proximal in time to desired patient outcomes for the particular topic;
- Measure performance or improvement does not result in better patient outcomes;
- Measure can be replaced by a measure that is more strongly associated with desired patient outcomes for the particular topic;
- Measure collection or public reporting leads to negative unintended consequences other than patient harm; and
- Measure is not feasible to implement as specified.

CMS is also aligning the criteria for determining that a measure is “topped-out” with the Hospital IQR Program’s criteria whereby a measure is “topped-out” if there is statistically indistinguishable performance at the 75th and 90th percentiles and the truncated coefficient of variation is less than or equal to 0.10.

CMS is adopting the following factors in deciding whether to retain a measure in the IPFQR Program:

- the measure aligns with other CMS and HHS policy goals, or
- aligns with other CMS programs, or
- it supports efforts to move IPFs towards reporting electronic measures.

CMS proposed to adopt one additional measure, Medication Continuation following Inpatient Psychiatric Discharge, for the FFY 2020 payment determination and subsequent years. After consideration of public comments, CMS has decided not to finalizing the adoption of this measure because of the undue burden that developing and implementing efforts for this measure will pose on facilities. CMS will consider re-proposing this measure in future rulemaking.

The number of measures for the FFY 2020 payment determination and subsequent years totals to 18 as set forth 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
SUB-1—Alcohol Use Screening	#1661	FFY 2016 and beyond
FUH—Follow-Up After Hospitalization for Mental Illness	#0576	FFY 2016 and beyond

Assessment of Patient Experience of Care (web-based attestation)	N/A	FFY 2016 and beyond
Use of an electronic health record (web-based attestation)	N/A	FFY 2016 and beyond
IMM-2—Influenza Immunization	#1659	FFY 2017 and beyond
Influenza Vaccination Coverage Among Healthcare Personnel	#0431	FFY 2017 and beyond
TOB-1—Tobacco Use Screening	#1651	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

For future consideration, CMS welcomed comments on a measure of *Medication Reconciliation on Admission* and a measure of *Identification of Opioid Use Disorder among Patients Admitted to Inpatient Psychiatric Facilities* for future inclusion in the IPFQR Program. A discussion of these comments is on *Federal Register* pages 38470 – 38471. Other areas that CMS is studying possible new measures for include:

- Family and caregiver engagement;
- Patient experience of care;
- Opioid use and treatment;
- Access to care; and
- Inpatient assaults and violence.

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