Medicare Inpatient Psychiatric Facility Prospective Payment System Update Notice Impact Analysis Federal Fiscal Year 2017

-Version 1, August 2016-

Analysis Description

The federal fiscal year (FFY) 2016 Medicare Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) Update Notice Analysis is intended to show providers how Medicare fee-for-service (FFS) payments would change from FFY 2016 to FFY 2017 based on the policies set forth in the FFY 2017 IPF PPS Update Notice. The analysis incorporates changes to IPF payments mandated by Congress and implemented by the Centers for Medicare and Medicaid Services (CMS).

FFY 2017 IPF Update Notice Payment Changes Modeled in this Analysis:

- Marketbasket Update: A 2.8% marketbasket increase to account for price increases in the services furnished by providers.

- Wage Index Budget Neutrality: Increase of 0.07% to maintain program budget neutrality due to changes in the wage index.

- ACA-Mandated Marketbasket Reductions: Combined 0.3% productivity reduction and 0.2% pre-determined reduction to the marketbasket authorized by the Affordable Care Act (ACA) of 2010.

- Wage Index and Labor Share: Updated wage index values based on the FFY 2016 facility wage index without the rural floor or reclassifications. This impact includes the increase in the labor-share from 75.2% for FFY 2016 to 75.1% for FFY 2017.

- Rural Adjustment: Impact of gain or loss of the rural adjustment due to new CBSA definitions. IPFs losing the adjustment received 2/3 of the adjustment in FFY 2016, will receive 1/3 of the adjustment in FFY 2017 and will no longer receive the adjustment beginning in FFY 2018. IPFs gaining the adjustment will receive the full adjustment in FFY 2016 and beyond.

The impacts provided do not include the 2.0% sequestration reduction to all lines of Medicare payment authorized by Congress and currently in effect through FFY 2025 unless Congress intervenes. The impact of sequester applicable to IPF PPS-specific payment has been calculated separately and is provided at the bottom of the impact table.

Data Sources

IPF payments and individual IPF characteristics/factors to derive the IPF rural and teaching adjustments are from the most recent Medicare cost report (2013, 2014, or 2015) provided by CMS. The federal per diem base rates, wage indexes, and labor shares are from the FFY 2016 IPF Final Rule and the FF 2017 IPF Update Notice as published in the *Federal Register.* Wage indexes used in this analysis reflect facility wage index values without the rural floor or reclassifications.

Note: All components related to facility operations are held constant (e.g. patient volume and case-mix index) in order to measure the impacts of policy changes only.

Methods

The dollar impact of each component change has been calculated by first estimating 2016 IPF PPS payments. Estimated 2016 payments reflect IPF revenues from the most recent (2013, 2014, or 2015) Medicare cost report updated by the component change in the IPF federal per diem base rate. Then, the 2016 to 2017 component change, for each IPF payment change component analyzed, is calculated and applied to estimated 2016 payments. The component impacts are applied sequentially in order to capture the compounded dollar impacts. For example, the component changes due to the marketbasket update, as well as the component change in the ACA-mandated marketbasket reductions, are applied to total 2016 payments. Then, the component change of the wage index budget neutrality is applied to the dollar result of the previous changes. This method continues for the remaining changes, creating a compounded effect. The difference between the results after each layered component is the impact of that component.

This analysis does NOT include impact estimates due to high cost outliers, estimates for payments for Managed Care patients, or any modifications in FFS payments as a result of facility participation in new payment models being tested under Medicare demonstration/pilot programs. Dollar impacts in this analysis may differ from those provided by other organizations/associations due to differences in source data and analytic methods.

Note: Individual percentages and dollars shown in this analysis may not add to total due to compounding and rounding. Dollar amounts less than $50 and percentages less than 0.05% will appear as zeros due to rounding.

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Medicare Inpatient Psychiatric Facility Prospective Payment System

Payment Rule Brief — FINAL RULE

Program Year: FFY 2017

Overview and Resources

On August 1, 2016, 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) 2017.

The first regulation is an update notice (UN) that updates the IPF payment factors. The second regulation is a final rule (the FFY 2017 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/2016-17982.

An online version of the IPPS final rule that updates the IPF quality reporting requirements is available at https://federalregister.gov/a/2016-18476.

The submission of comments is not permitted on the IPF PPS update notice. The update does not initiate any policy changes and reflects the application of established methodologies that have been previously subject to public comment. The submission of comments is also not permitted on the IPPS final rule.

A brief of the update notice that updates the IPF payment factors and final rule that updates the quality reporting program along with Display copy page references for additional details are provided below. Program changes will be effective for discharges on or after October 1, 2016 unless otherwise noted.

IPF Payment Rates

UN pages 50505-50507

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 2017 compared to the rates currently in effect:

	Final FFY 2016	Final FFY 2017	Percent Change
IPF Per Diem Base Rate	**$743.73**	**$761.37**	**+2.37%**
ECT Base Rate	**$320.19**	**$327.78**	

The table below provides details of the adopted updates to the IPF payment rates for FFY 2017.

	FFY 2017 IPF Rate Update and Budget Neutrality Adjustments
Marketbasket (MB) Update	**+2.8%**
ACA-Mandated Productivity MB Reduction	**-0.3 percentage points**
ACA-Mandated Pre-Determined MB Reduction	**-0.2 percentage points**
Wage Index Budget Neutrality Adjustment	**+0.07%**
Overall Rate Change	***+2.37%***

Wage Index, COLA, and Labor-Related Share

UN pages 50506, 50508-50511

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 prior year's pre-floor, pre-reclassification IPPS wage index, to adjust payment rates for labor market differences. In FFY 2016, CMS implemented Core Based Statistical Area CBSA changes using a 1-year transition with a blended wage index for all providers. The FFY 2017 IPF and subsequent IPF PPS wage indices will be based solely on the new CBSA delineations.

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 75.2% in FFY 2016 to 75.1% for FFY 2017. 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 2017 is available on the CMS website https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/WageIndex.html.

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 2014, they are not scheduled to be updated again until FY 2018. Therefore, CMS will continue to use the existing IPF PPS COLA factors for FY 2017. The IPF PPS COLA factors for FY 2017 for Alaska and Hawaii are shown in Addendum A of the Update Notice.

Adjustments to the IPF Payment Rates

UN pages 50507-50512

For FFY 2017, CMS will retain the facility and patient-level adjustments currently used for FFY 2016 IPF PPS. The adjustments are described in detail below.

- ED Adjustment *(UN page 50511)*: For FFY 2017, 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 *(UN page 50510)*: 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 2017. 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 *(UN page 50509)*: IPFs located in rural areas will continue to 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.

  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, are losing the 17% rural adjustment. 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, and will receive one-third of the rural adjustment in FFY 2017, and no rural adjustment thereafter.

- Patient Condition (MS-DRG) Adjustment *(UN page 50507)*: For FFY 2017, 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 2017. 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 *(UN page 50508):* For FFY 2017, 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 2017. 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 *(UN page 50508):* The IPF PPS will maintain the patient age adjustment for FFY 2017. Analysis by CMS has shown that IPF per diem costs increase with patient age. The following table lists the patient age adjustments for FFY 2017. 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 *(UN page 50508):* For FFY 2017, 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 2017. 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

UN pages 50511-50512

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 2017, CMS is adopting an outlier threshold of $10,120, a 5.6% increase over the 2016 threshold of $9,580.

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

UN page 50512

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 2017 for rural IPFs is 1.9315 and 1.6374 for urban IPFs. If an individual IPF's CCR exceeds this ceiling for FFY 2017, the IPF's CCR will be replaced with the appropriate national median CCR, urban or rural. CMS is finalizing a national median CCR of 0.5960 for rural IPFs and 0.4455 for urban IPFs.

IPF Quality Reporting Program

Display pages 1975-2026

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.

In the final rule, CMS adopted two additional measures for the FFY 2019 payment determination and subsequent years:

- Thirty-day All-Cause Readmission Following Psychiatric Hospitalization in an IPF

    - The term all-cause refers to readmissions for any reason following the index admission, including both psychiatric and medical settings.

    - The measure is risk-adjusted for several factors, including gender, co-morbidities, and history of aggression.

    - CMS will calculate and report the readmission rates based on Medicare claims; therefore, IPFs are not required to collect or report data for this measure.

- Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge (SUB-3) and the subset Alcohol & Other Drug Use Disorder Treatment at Discharge (NQF #1664) measure (SUB-3a)

    - This will address alcohol and other substance abuse issues which are a major problem among inpatient psychiatric patients. These two new measures will provide a fuller picture of the entire episode of care for alcohol screening (SUB-1) and treatment (SUB-2/-2a), and information about treatment and/or referral for other substance use disorders upon discharge (SUB-3/-3a).

    - Reporting requirements for SUB-3 and SUB-3a include chart-abstracted measure reported as two rates, and requires collection and submission of annual, aggregate data to CMS by IPFs.

On the previously finalized **Screening for Metabolic Disorders** measure, CMS finalized its proposal to exclude patients with a length of stay equal to or greater than 365 days, or less than 3 days. CMS also delayed the data collection and payment determination year on that measure, along with the **Transition record with specified elements received by discharged patients** and the **Timely transmission of transition record** measures, until FFY 2019 (instead of FFY 2018) in order to provide IPFs sufficient time to prepare.

The current IPF Quality Reform Program (IPF QRP) measure set includes 16 measures. CMS increased the IPFQR Program measure set to 18 measures with the addition of two measures.
The following lists the 18 adopted IPFQR Program measures and applicable payment determination years:

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
NHSN Influenza Vaccination Coverage Among Healthcare Personnel	N/A	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	**Delayed in Final Rule until** FFY 2019 and beyond
Timely transmission of transition record	#0648	**Delayed in Final Rule until** FFY 2019 and beyond
Screening for Metabolic Disorders Measure	N/A	**Delayed in Final Rule until** FFY 2019 and beyond
SUB-3 and SUB 3-a 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 **(Adopted in Final Rule)**
30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization inn an Inpatient Facility	Submitted to NQF for endorsement	FFY 2019 and beyond **(Adopted in Final Rule)**

CMS finalized its proposal to change timeframe specifications for public display of data and data preview via subregulatory methods, including ListServs and/or the CMS website, as opposed to rulemaking.

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