Issue Brief

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KEY POINTS

- The final rule will increase Medicare inpatient psychiatric payments by 1.5 percent totaling $75 million.
- Major changes to the payment and policy rules include the adoption of the use of the Office of Management and Budget's 2010 census data for determining wage index and revisions to the inpatient psychiatric quality reporting program.

CMS Announces Final Inpatient Psychiatric Facilities PPS Update for FY 2016

The Centers for Medicare and Medicaid Services has issued a final rule to update the Medicare Inpatient Psychiatric Facilities Prospective Payment System for fiscal year 2016.

The rule is to be published in the Aug. 5 *Federal Register*. A copy can currently be downloaded at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-18903.pdf. This link will change upon publication.

COMMENT

Most of the current (FY 2015) IPF payment adjustments are remaining unchanged for FY 2016. These items are listed below under the major payment provisions. Many of the rule's changes involve the number of quality reporting measures and related requirements. These elements are listed below under the quality measures update section. This is another well written, easy to follow rule with helpful "Final Decision" sections.

I. THE MAJOR PAYMENT PROVISIONS

CMS is updating the estimated payments to IPFs in FY 2016 relative to estimated payments in FY 2015 by 1.7 percent (compared to a proposed update of 1.9 percent). This amount reflects a 2.4 percent IPF-specific market basket estimate less a productivity adjustment of 0.5 percentage points and less a 0.2 percentage points reduction required by the Affordable Care Act, for a net update of 1.7 percent.

Estimated overall payments to IPFs would be reduced further by 0.2 percent due to updating the outlier fixed-dollar loss threshold amount. The result will be an increase of $75 million.

The FY 2016 labor related share of the IPF-specific market basket is 75.2 percent, which is an increase from the FY 2015 amount of 69.294 percent. CMS is adopting a wage index budget-neutrality factor for FY 2016 of 1.0041.

CMS is updating the current IPF per-diem rate of $728.31 to $743.73. ($728.31 X 1.017 (2.4-0.5-0.2) X 1.0041 (area wage index budget neutrality) = $743.73). Providers that fail to report quality data for FY 2016 payment will receive a FY 2016 per diem rate of $729.10.

CMS is adopting an IPF-specific market basket to replace the Rehabilitation, Psychiatric and Long-Term Care market-basket. The IPF market basket is based on 2012 Medicare cost report data (the RPL market basket is based on 2008 data).

continued

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COMMENT

CMS devotes nearly 80 pages to explain its revised IPF market basket components. That's nearly a third of the entire rulemaking. Perhaps this material would be better served if it was made an appendix and posted on CMS' website.

ECT

CMS is updating the electroconvulsive therapy payment from $313.55 to $320.19. Providers that fail to report quality data for FY 2016 payment will receive a FY 2016 ECT rate of $313.89.

Per Diem Rate	
Federal Per Diem Base Rate	$743.73
Labor Share (0.752)	$559.28
Non-Labor Share (0.248)	$184.45

Per Diem Rate Applying the 2 Percentage Point Reduction	
Federal Per Diem Base Rate	$729.10
Labor Share (0.752)	$548.28
Non-Labor Share (0.248)	$180.82

WAGE INDEX

CMS is updating the Core Based Statistical Areas with the Office of Management and Budget Bulletin No. 13-01 and 2010 US Census Data. CMS will employ a 1-year transition with a 50/50 blended wage index for all providers. The FY 2016 wage index for each provider would consist of a blend of fifty percent of the FY 2015 wage index and fifty percent of the FY 2016 wage index using the revised OMB delineations.

As a result of the new OMB delineations, 37 IPF providers will have their status changed from rural to urban, and therefore will lose their 17 percent rural adjustment. CMS will adopt a gradual phase-out of their rural adjustment, so that these 37 providers would receive two-thirds of the rural adjustment in FY 2016, one-third of the rural adjustment in FY 2017, and no rural adjustment for FY 2018 and subsequent years. CMS is not implementing a transition policy for urban IPFs that become rural in FY 2016 because these IPFs will receive the full rural adjustment of 17 percent beginning Oct. 1, 2015.

The wage index tables for this final rule are available on CMS' website: http://www.cms.gov/Medicare/Medicare-Fee- for-Service-Payment/InpatientPsychFacilPPS/WageIndex.html.

OUTLIER THRESHOLD

CMS will update; i.e., set the fixed dollar loss threshold amount from $8,755 to $9,580 in order to maintain outlier payments that are 2 percent of total IPF PPS payments.

ICD-10-CM

CMS reminds providers that the International Classification of Diseases, 10th Revision, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) will be implemented on Oct. 1, 2015.

UPDATE OF THE IPF PPS ADJUSTMENT FACTORS

CMS notes that IPF PPS patient-level and facility-level adjustments will remain the same as in FY 2015.

The IPF PPS utilizes a set of patient-level and facility adjustments. The FY 2016 adjustments are provided in the following tables:

Patient-Level Adjustments

Adjustment for MS-DRG Assignment
For FY 2016, payment adjustments for psychiatric diagnoses that group to one of the 17 MS-IPF-DRGs are listed in the following table.

continued

FY 2016 MS–IPF-DRGs Applicable for the Principal Diagnosis Adjustment		
MS-DRG	MS-DRG Descriptions	Adjustment Factor
056	Degenerative nervous system disorders w MCC	1.05
057	Degenerative nervous system disorders w/o MCC	
080	Nontraumatic stupor & coma w MCC	1.07
081	Nontraumatic stupor & coma w/o MCC	
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	

Payment for Comorbid Conditions

The intent of the comorbidity adjustment is to recognize the increased costs associated with comorbid conditions by providing additional payments for certain concurrent medical or psychiatric conditions that are expensive to treat.

Currently, IPFs are receiving 17 comorbidity adjustments using ICD-9-CM diagnosis codes. The 17 comorbidity categories were converted to ICD-10-CM/PCS in the FY 2015 IPF PPS final rule. Further information for the ICD-10-CM/PCS MS-DRG conversion project can be found on the CMS ICD-10-CM website at: http://www.cms.hhs.gov/Medicare/Coding/ICD10/ICD-10-MS-DRG-Conversion-Project.html.

The 17 adjustments are in the following table.

Comorbidity Adjustments for FY 2016	
Description of Comorbidity	Adjustment Factor
Developmental Disabilities	1.04
Coagulation Factor Deficits	1.13
Tracheostomy	1.06
Eating and Conduct Disorders	1.12
Infectious Diseases	1.07
Renal Failure, Acute	1.11
Renal Failure, Chronic	1.11
Oncology Treatment	1.07
Uncontrolled Diabetes Mellitus	1.05
Severe Protein Malnutrition	1.13

continued

Comorbidity Adjustments for FY 2016	
Description of Comorbidity	**Adjustment Factor**
Drug and/or Alcohol Induced Mental Disorders	1.03
Cardiac Conditions	1.11
Gangrene	1.10
Chronic Obstructive Pulmonary Disease	1.12
Artificial Openings— Digestive and Urinary	1.08
Severe Musculoskeletal and Connective Tissue Diseases	1.09
Poisoning	1.11

Patient Age Adjustments

The patient age adjustments are shown in the following table.

Age	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 Adjustments

The variable per diem adjustment factors are shown in the following table.

Day-Of-Stay	Adjustment Factor
Day 1- IPF Without a Qualified ED	1.19
Day 1- IPF With a Qualified ED	1.31
Day 2	1.12
Day 3	1.08
Day 4	1.05
Day 5	1.04
Day 6	1.02
Day 7	1.01
Day 8	1.01
Day 9	1.00
Day 10	1.00
Day 11	0.99
Day 12	0.99
Day 13	0.99
Day 14	0.99
Day 15	0.98
Day 16	0.97
Day 17	0.97
Day 18	0.96
Day 19	0.95

continued

Day-Of-Stay	Adjustment Factor
Day 20	0.95
Day 21	0.95
After Day 21	0.92

Facility-Level Adjustments

The IPF PPS includes facility-level adjustments for the wage index for IPFs located in rural areas, teaching IPFs, cost of living adjustments for IPFs located in Alaska and Hawaii, and IPFs with a qualifying emergency department.

Wage Index Adjustment

As noted earlier CMS is adopting revised OMB CBSA delineations for the FY 2016 IPF PPS wage index. The rule's tables 15, 16, 17, and 18 identify changes in urban and rural status resulting from the application of the new definitions.

Table 15 identifies 105 counties and 37 IPFs that will move from rural to urban status.

Table 16 also shows the percentage change in values for those counties that will change from urban to rural, beginning in FY 2016.

Table 17 shows those counties that will experience a change in their wage index value in FY 2016 due to the new OMB CBSAs. Table 17 also shows the urban CBSA delineations and wage index values for FY 2015 based on existing CBSA delineations, compared with the urban CBSA delineations and wage index values for FY 2016 based on the new OMB delineations, and the percentage change in these values, for counties that will remain urban even though the CBSA boundaries and/or counties included in that CBSA will change.

Table 18 shows the FY 2015 CBSA delineations and rural statewide wage index values, compared with the FY 2016 CBSA delineations and rural statewide wage index values, and the percentage change in these values, for those rural areas that will change.

CMS notes that approximately 23.3 percent of IPFs will experience a decrease in wage index values due to CBSA changes, while 12.3 percent of IPFs will experience an increase. The remaining 64.4 percent of IPFs will experience no change.

Adjustment for Rural Location

CMS will continue to apply a 17 percent payment adjustment for IPFs located in a rural area.

Teaching Adjustment

CMS is retaining the coefficient value of 0.5150 for the teaching status adjustment to the Federal per diem base rate.

Cost of Living Adjustment for IPFs Located in Alaska and Hawaii

IPFs located in Alaska and Hawaii will continue to receive an updated COLA factors based on the COLA area in which the IPF is located and as shown in the following table.

	Factor
Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.23
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.23
City of Juneau and 80-kilometer (50-mile) radius by road	1.23
Rest of Alaska	1.25
Hawaii:	
City and County of Honolulu	1.25
County of Hawaii	1.19
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

Adjustment for IPFs with a Qualifying Emergency Department

The ED adjustment is incorporated into the variable per diem adjustment for the first day of each stay for IPFs with a qualifying ED. That is, IPFs with a qualifying admission from an ED will receive an adjustment factor of 1.31 as the variable per diem adjustment for day one of each stay. If an IPF does not have a qualifying ED, it will receive an adjustment factor of 1.19 as the variable per diem adjustment for day one of each patient stay.

II. QUALITY MEASURES UPDATES AND OTHER CHANGES TO THE IPFQR PROGRAM

Since the inception of the IPFQR Program in FY 2013, CMS has adopted a total of 14 mandatory measures.

Removal of HBIPS-4 from the IPFQR Program Measure Set for the FY 2017 Payment Determination and Subsequent Years

CMS is, as proposed, removing HBIPS-4 Patients Discharged on Multiple Antipsychotic Medications beginning with FY 2017.

New Quality Measures for the FY 2018 Payment Determination and Subsequent Years

For the FY 2018 payment determination and subsequent years, CMS is adopting five new measures.

New IPFQR Program Measures for the FY 2018 Payment Determination and Subsequent Years			
National Quality Strategy Priority	**NQF #**	**Measure ID**	**Measure**
Effective Prevention and Treatment	1656	TOB-3 and TOB-3a	Tobacco Use Treatment Provided or Offered at Discharge and the subset measure Tobacco Use Treatment at Discharge
Effective Prevention and Treatment	1663	SUB-2 and SUB-2a	Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention
Communication and Care Coordination; Person and Family Engagement	0647	N/A	Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
Communication and Care Coordination	0648	N/A	Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
Making Care Safer	N/A	N/A	Screening for Metabolic Disorders

CMS will remove beginning with the FY 2018 payment determination the two measures set forth below.

IPFQR Program Measures to be Removed for the FY 2018 Payment Determination and Subsequent Years		
NQF #	**Measure ID**	**Measure**
557	HBIPS-6	Post-Discharge Continuing Care Plan
558	HBIPS-7	Post Discharge Continuing Care Plan Transmitted to the Next Level of Care Provider Upon Discharge

The number of measures for the FY 2018 IPFQR Program will total 16, as set forth below.

Measures for FY 2018 and Subsequent Years		
NQF #	**Measured ID**	**Measures**
0640	HBIPS-2	Hours of Physical Restraint Use
O641	HBIPS-3	Hours of seclusion Use
0560	HBIPS-5	Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification
0576	FUH	Follow-up After Hospitalization for Mental Illness
1661	SUB-1	Alcohol Use Screening
1663	SUB-2 and SUB-2a	Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention*
1651	TOB-1	Tobacco Use Screening
1654	TOB-2 TOB-2a	Tobacco Use Treatment Provided or Offered and Tobacco Use Treatment
1656	TOB-3 and TOB-3a	Tobacco Use Treatment Provided or Offered at Discharge and the subset measure Tobacco Use Treatment at Discharge*
1659	IMM-2	Influenza Immunization

continued

Measures for FY 2018 and Subsequent Years		
NQF #	**Measured ID**	**Measures**
0647	N/A	Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)*
0648	N/A	Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)*
N/A	N/A	Screening for Metabolic Disorders*
N/A	N/A	Influenza Vaccination Coverage Among Healthcare Personnel
N/A	N/A	Assessment of Patient Experience of Care
N/A	N/A	Use of an Electronic Health Record

**Measures proposed for the FY 2018 payment determination and future years.*

Changes to Reporting Requirements

CMS is making the following changes to the reporting requirements for FY 2017 and subsequent years:

- Requiring that measures be reported as a single yearly count rather than by quarter and age; and
- Requiring that aggregate population counts be reported as a single yearly number rather than by quarter.

FINAL COMMENT

The rule devotes nearly 90 pages, some 35 percent of the material, to the quality aspects of the IPF PPS. More and more of the yearly PPS updates involve quality measures and reporting. The quality items and their reporting requirements are much more complex than the above tables alone can convey. As quality becomes a more important determinate in the payment system, a complete analysis of the rule's quality section is paramount. To do less would imply a potential loss in payments.

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