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MEDICARE ANNOUNCES NEW PAYMENT SYSTEM FOR INPATIENT PSYCHIATRIC FACILITIES

The Centers for Medicare & Medicaid Services (CMS) today announced a new Medicare prospective payment system (PPS) final rule for inpatient psychiatric facilities (IPFs) that will foster higher quality and more efficient care for Medicare beneficiaries with severe mental illnesses.

The new system, required by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), is designed to assure appropriate payment for services to Medicare beneficiaries suffering from mental illnesses, while providing incentives to facilities providing more efficient care of those beneficiaries.

The new system replaces the current cost-based payment system for reporting periods beginning on or after January 1, 2005. It will affect about 1,800 inpatient psychiatric facilities, including freestanding psychiatric hospitals and certified psychiatric units in general acute care hospitals.

“We believe that this new payment system will allow us to target payments for inpatient psychiatric services effectively and to reward high-quality efficient care in the inpatient setting,” said CMS Administrator Mark B. McClellan, M.D., Ph.D. “This system helps ensure that beneficiaries in rural areas have access to quality care, and we now have incentives for inpatient psychiatric facilities to provide services that are appropriate to an individual’s needs.”

The final rule includes several provisions to ease the transition to the new payment system. For example, CMS is phasing in the PPS for existing facilities over a three-year period to avoid disrupting the delivery of inpatient psychiatric services. Full payment under the PPS would begin in the fourth year. Also, in response to comments, CMS has included a stop-loss provision to ensure that hospitals avoid significant losses as they adopt more efficient practices during the transition period. The rule also contains an “outlier” policy authorizing additional payments for extraordinarily costly cases and an adjustment to a facility’s base payment if it maintains a full-service emergency department that is staffed and equipped to furnish a comprehensive array of emergency services.

As required by law, CMS is implementing a *per diem* prospective payment system. Hospitals will receive a daily base rate and adjustments to account for certain patient and facility characteristics

that increase the cost of care. The amount paid will cover nearly all costs of furnishing covered inpatient psychiatric services, except for the costs of physician or other professional services that are paid under Medicare's physician fee schedule. The payment will also not include the costs of bad debts and direct graduate medical education costs, which are paid outside the PPS.

CMS has made several changes in response to comments. For example, an adjustment to the *per diem* rate that was proposed to end on the eighth day now continues to the 22nd day and beyond. The final rule also expands the diagnoses that will be recognized from the 15 psychiatric diagnosis related groups (DRG) listed in the proposed rule to all psychiatric diagnoses regardless of the DRG it is assigned to. CMS has also modified the system to better reflect patient conditions and more accurately reflect comorbidities. Medicare payments to facilities in rural areas will increase by 17 percent to continue ensure access to these services for beneficiaries in rural areas. The final rule also includes additional payment for teaching facilities to account for the higher costs they incur in providing patient care, for very costly procedures, and other adjustments for geographic variations in costs

Other features of the final rule include:

- Adjustments to the hospital's daily base rate to account for factors that influence the cost of individual patients' care, such as a patient's psychiatric diagnosis, certain coexisting medical conditions that may complicate treatment and increase costs, and age.
- A geographic wage index adjustment for all IPFs and a cost of living adjustment for IPFs located in Alaska and Hawaii.
- An additional payment per treatment with electroconvulsive therapy in light of the significant costs this treatment adds to a case.
- A definition of a "new" IPF, which would be paid entirely on the new system, as an IPF that has its first cost reporting period that begins on or after January 1, 2005.
- An interrupted stay policy for stays in which a patient is discharged from an IPF, and is readmitted to the same or another IPF by midnight of the third consecutive day. The readmission will be combined with the previous admission, reflecting the lower intensity of administrative and diagnostic resources in the readmission.

The final rule will be published in the November 15 *Federal Register*, and will become effective for cost reporting periods beginning on or after January 1, 2005.

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