INPATIENT PSYCHIATRIC FACILITY
PROSPECTIVE PAYMENT SYSTEM

Target Audience: Medicare Fee-For-Service Providers

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Learn about these Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) topics:

- Background
- Certifications and recertifications
- How IPF PPS payments are determined
- Fiscal year (FY) 2018 update to the IPF PPS
- IPF Quality Reporting (QR) Program
- Resources

When we use “you” is in this publication, we are referring to IPFs.

**BACKGROUND**

Under Section 124 of the Balanced Budget Refinement Act of 1999 (Public Law 106-113), the IPF PPS for psychiatric services furnished to Medicare patients in psychiatric hospitals and distinct part units in acute care hospitals and Critical Access Hospitals was implemented effective January 2005.

Medicare covers patients treated for psychiatric conditions in psychiatric hospitals or distinct part psychiatric units for 90 days of care per benefit period, with a 60-day lifetime reserve. However, payment may not be made for more than a total of 190 days of inpatient psychiatric hospital services during the patient’s lifetime. This 190-day lifetime limit only applies to psychiatric services provided in freestanding psychiatric hospitals and does not apply to inpatient psychiatric services furnished in general hospitals or distinct part IPF units.

**CERTIFICATIONS AND RECERTIFICATIONS**

Physician certifications and recertifications of IPF stays are required as a condition of payment. Certification begins with the order for inpatient admission. The purpose of certification statement(s), therefore, is to help ensure that Medicare pays only for services of the type appropriate for Medicare coverage. Accordingly, Medicare Part A pays for inpatient services in an IPF only if a physician certifies and recertifies the need for services consistent with the requirements below, as appropriate.

- A physician must certify that:
  - Inpatient psychiatric services are required for treatment that could reasonably be expected to improve the patient’s condition or for diagnostic study and
  - Inpatient psychiatric services were provided in accordance with [Title 42, Section 412.3 of the Code of Federal Regulations](#)
- Timing of certifications and recertifications:
  - Certification is required at the time of admission, or as soon thereafter as is reasonable and practicable, and must be completed and documented in the medical record prior to discharge
The first recertification must occur as of the 12th day of hospitalization and subsequent recertifications are required at intervals established by the utilization review committee (on a case-by-case basis, if it so chooses), but no less than every 30 days.

Content of the recertification must include:

- That inpatient services furnished since the previous certification or recertification were, and continue to be, required for treatment that could reasonably be expected to improve the patient’s condition or for diagnostic study.
- Hospital records which show that the services furnished were intensive treatment services, admission and related services necessary for diagnostic study, or equivalent services and that the patient continues to need, on a daily basis, active treatment furnished directly by or requiring the supervision of IPF personnel.

Certificates and recertifications must be signed by the physician responsible for the case or by another physician who has knowledge of the case and is authorized to do so by the responsible physician or by the hospital’s medical staff.

The IPF must provide all necessary covered services to a Medicare patient who is an inpatient of the IPF, either directly or under arrangements. The IPF PPS payment is payment in full for all IPF services.

The IPF PPS does not include payment for professional services of physicians or services of physician assistants, nurse practitioners, clinical nurse specialists, certified nurse midwives, certified registered nurse anesthetists, or clinical psychologists. Covered professional services are paid separately through Medicare Part B.

**HOW IPF PPS PAYMENTS ARE DETERMINED**

Payment under the IPF PPS is a Federal per diem base rate adjusted by factors for facility and patient characteristics that account for variation in patient resource use. Under the IPF PPS, the Federal per diem base rate includes inpatient operating and capital-related costs (including routine and ancillary services). It excludes pass-through costs, such as bad debts and graduate medical education. IPF PPS payments are calculated from the Federal per diem base rate after adjusting for facility and patient characteristics.

- **Facility characteristics:**
  - Geographic differences in wages. The labor-related portion of the Federal per diem base rate is adjusted using the IPF wage index. In FY 2018, the IPF wage index reflects the full adoption of minor updates to the U.S. Office of Management and Budget (OMB) delineations.
    - Effective October 1, 2015, under revised OMB delineations in the IPF PPS wage index, some IPFs may now be located in urban rather than rural areas. The payment adjustment for rural location for those affected facilities was phased out:
      - In FY 2016, affected IPFs received two-thirds of the rural adjustment
      - In FY 2017, affected IPFs received one-third of the rural adjustment and
In FY 2018 and subsequent years, affected facilities will not receive a rural adjustment.

- Effective October 1, 2017, under minor updates to OMB delineations, one IPF is now located in an urban rather than rural area. These updates do not have a large effect on a substantial number of providers and, therefore, were adopted without any transition period.
  - Rural location, with a 17 percent rural adjustment.
  - IPFs that have a qualifying emergency department (ED) receive a 12 percent higher payment adjustment for the first day of the stay.
  - Teaching hospitals receive payment to account for indirect medical education costs.
  - The nonlabor portion (NLP) of the Federal per diem base rate is adjusted by a cost of living adjustment (COLA) factor to account for a higher cost of living for IPFs in Alaska and Hawaii.
    - In FY 2018 rulemaking, the COLA factors were updated in accordance with the Inpatient Prospective Payment System (IPPS) methodology adopted in FY 2015 IPF PPS rulemaking. The COLA updates are determined every 4 years when the IPPS market basket labor-related share is updated during rebasing.

Patient characteristics:

- Medicare Severity-Diagnosis Related Group (MS-DRG) adjustment, which is based upon the principal psychiatric diagnosis.
- Age.
- Presence of specified comorbidities.
- Length of stay (called a variable per diem adjustment).

Additional payments are provided to IPFs for:

- The number of electroconvulsive therapy (ECT) treatments furnished.
- Cases with extraordinarily high costs, which are outliers. Eligibility for an outlier payment is determined using the adjusted outlier threshold amount, the total IPF PPS payment, and any ECT payments. The outlier threshold amount is adjusted for the wage area and, if applicable, for rural location, teaching status, and location in Alaska or Hawaii. To be eligible for an outlier payment, the sum of the adjusted outlier threshold, the total IPF PPS payment, and the ECT payment must exceed the estimated costs for the case.

To obtain the outlier payment amount, the total estimated cost must first be calculated using IPF charges and the cost-to-charge ratio (CCR). The adjusted outlier threshold, total IPF PPS payment, and any ECT payments are then subtracted from this estimated cost. The result is divided by the length of stay to obtain a daily outlier amount. For each of the first 9 days, multiply the daily outlier amount by 80 percent (0.80). For any days thereafter, multiply the daily outlier amount by 60 percent (0.60). The total outlier payment is the sum of all these amounts.
Payment Under the Inpatient Psychiatric Facility Prospective Payment System

**Step 1.** Adjust the applicable Federal per diem base rate for geographic differences in wages and COLA (Alaska and Hawaii only). The applicable base rate is either the full Federal per diem base rate or the reduced Federal per diem base rate for IPFs that failed to report quality data.

\[
\text{Base rate} \times \text{LRS} = \text{labor portion (LP)}
\]
\[
\text{LP} \times \text{wage index value} = \text{wage-adjusted labor share}
\]
\[
\text{Base rate} - \text{LP} = \text{NLP}
\]
\[
\text{NLP} \times \text{COLA (if applicable)} = \text{adjusted nonlabor share}
\]
\[
\text{Wage and COLA-adjusted base rate}
\]

**Step 2.** Calculate the total adjustment factor for all other applicable facility and patient adjustments, except for the variable per diem adjustment and ED adjustment:

\[
\text{Rural adjustment} \times \text{teaching adjustment} \times \text{age adjustment} \times \text{DRG adjustment} \times \text{comorbidity adjustment} = \text{Adjustment Factor}
\]

**Step 3.** Multiply the adjustment factor from Step 2 by the wage and COLA-adjusted base rate from Step 1 to get a partially-adjusted Federal per diem base rate, without variable per diem and ED adjustments.

\[
\text{Wage and cola-adjusted base rate} \times \text{Adjustment factor} = \text{Partially-adjusted base rate}
\]

**Step 4.** Multiply the partially-adjusted Federal per diem base rate for each day of the stay by its applicable variable per diem adjustment factor. For Day 1, use a factor of 1.31 if the IPF has a qualifying ED and a factor of 1.19 if the IPF does not have a qualifying ED.
**Step 5.** Sum the IPF PPS payments for each day of the stay to get the total IPF PPS payment amount.

- Variable per diem Day 1 (with ED factor, if applicable) $\times$ Partially-adjusted base rate $=$ IPF PPS payment Day 1
- Variable per diem Day 2 $\times$ Partially-adjusted base rate $=$ IPF PPS payment Day 2
- Variable per diem Day 3 $\times$ Partially-adjusted base rate $=$ IPF PPS payment Day 3
- Variable per diem Day 4 $\times$ Partially-adjusted base rate $=$ IPF PPS payment Day 4

**Total = Sum of IPF PPS payments for each day of stay**

**Additional Payment for ECT Treatment**

Multiply the units of ECT treatment provided during the stay by the applicable wage and COLA-adjusted ECT per treatment amount to get the total ECT payment. The applicable ECT per treatment amount is either the full ECT per treatment amount or the reduced ECT per treatment amount for IPFs that failed to report quality data.

- $\text{ECT per treatment amount} \times \text{LRS} = \text{ECT LP}$
- $\text{ECT LP} \times \text{wage index value} = \text{wage-adjusted ECT labor share}$
- $\text{ECT per treatment amount} - \text{ECT LP} = \text{ECT NLP}$
- $\text{ECT NLP} \times \text{COLA (if applicable)} = \text{adjusted ECT nonlabor share}$

$\text{Total units of ECT treatment} \times \text{Wage and COLA-adjusted ECT payment}$
When submitting claims for payments, you should record charges that are reasonably and consistently related to your costs for the items and services you provide to your patients during an IPF stay. Even though you receive a per diem payment, providers still must completely and accurately report their charges on claims, which are needed for accurate calculation of outlier payments and periodic refinement of the IPF PPS.

For more information about the Federal per diem base rate, facility and patient adjustments, ECT payments, and outlier payments refer to the November 15, 2004, IPF PPS Final Rule that implemented the IPF PPS (69 FR 66922).

**FISCAL YEAR (FY) 2018 UPDATE TO THE IPF PPS**

The FY 2018 update to the IPF PPS includes:

- **Market basket update:**
  - The Federal per diem base rate is adjusted annually by the IPF market basket update percentage. The FY 2018 IPF market basket update is 2.6 percent, less a statutorily required productivity adjustment of 0.6 percentage point, less a statutorily required other adjustment of 0.75 percentage point, for a total FY 2018 update of 1.25 percent.
  - The market basket update is reduced by 2 percentage points for IPFs that failed to comply with quality data submission requirements. For FY 2018, IPFs that did not comply with quality data submission requirements will receive a negative update of -0.75 percent (1.25 percent – 2.0 percentage points).
  - The labor-related share (LRS) of the Federal per diem base rate for FY 2018: 75.0 percent.

- **Pricer updates:**
  - Federal per diem base rate: $771.35.
  - Federal per diem base rate with the 2.0 percentage point reduction for IPFs that do not comply with quality data submission requirements: $756.11.
  - Fixed-dollar loss threshold amount: $11,425.
  - LRS (75.0 percent) of the Federal per diem base rate: $578.51.
  - LRS (75.0 percent) of the Federal per diem base rate with the 2.0 percentage point reduction for IPFs that do not comply with quality data submission requirements: $567.08.
  - Nonlabor-related share (25.0 percent) of the Federal per diem base rate: $192.84.
  - Nonlabor-related share (25.0 percent) of the Federal per diem base rate with the 2.0 percentage point reduction for IPFs that do not comply with quality data submission requirements: $189.03.
  - ECT per treatment payment amount: $332.08.
  - ECT per treatment payment amount with the 2.0 percentage point reduction for IPFs that do not comply with quality data submission requirements: $325.52.
• The MS-DRG, comorbidity, age, teaching, and rural adjustment factors did not change.
• The FY 2018 IPF wage index is based on the FY 2017 pre-floor, pre-reclassified hospital wage index.
• The wage index budget neutrality factor is 1.0006, which is applied to the Federal per diem base rate when updating the base rate.
• National median CCRs apply to IPFs:
  ○ That are new and have not yet submitted their first cost report or
  ○ Whose operating or capital CCR is in excess of 3 standard deviations above the corresponding national geometric mean (the ceiling) or
  ○ Whose Medicare Administrative Contractors obtain inaccurate or incomplete data to calculate a CCR

FY 2018 National CCRs

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<th>CCR</th>
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<th>Ceiling</th>
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<td>1.7071</td>
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<tr>
<td>Rural</td>
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<td>1.9634</td>
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For more information about IPF PPS payment updates, refer to FY 2018 Medicare Payment and Policy Updates for Inpatient Psychiatric Facilities and FY 2018 Inpatient Psychiatric Facility PPS Notice with Comment Period.

IPF QUALITY REPORTING (QR) PROGRAM

Section 1886(s)(4)(C) of the Social Security Act requires establishment of the IPFQR Program. Beginning in FY 2014, if you do not report the quality data, you will be subject to a 2.0 percentage point reduction to the applicable annual update. The Centers for Medicare & Medicaid Services calculates claims-based measures, indicated by asterisks in the table below, which are not reported by IPFs.


<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Quality Measures</th>
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</table>
| Report in FY 2013, with reduction to annual update in FY 2014 if quality data is not reported | 1. Hours of physical restraint use (National Quality Forum [NQF] #0640)  
2. Hours of seclusion use (NQF #0641)  
3. Patients discharged on multiple antipsychotic medications (NQF #0552)  
4. Patients discharged on multiple antipsychotic medications with appropriate justification (NQF #0560)  
5. Post-discharge continuing care plan created (NQF #0557)  
6. Post-discharge continuing care plan transmitted to next level of care provider upon discharge (NQF #0558) |

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<tr>
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| Report in FY 2015, with reduction to annual update in FY 2016 if quality data is not reported | 1. Hours of physical restraint use (NQF #0640)  
2. Hours of seclusion use (NQF #0641)  
3. Patients discharged on multiple antipsychotic medications (NQF #0552)  
4. Patients discharged on multiple antipsychotic medications with appropriate justification (NQF #0560)  
5. Post-discharge continuing care plan created (NQF #0557)  
6. Post-discharge continuing care plan transmitted to next level of care provider upon discharge (NQF #0558)  
7. Alcohol use screening (NQF #1661)  
8. Follow-up after hospitalization for mental illness (NQF #0576)*  
9. Assessment of Patient Experience of Care  
10. Use of an Electronic Health Record |
| Report in FY 2016, with reduction to annual update in FY 2017 if quality data is not reported | 1. Hours of physical restraint use (NQF #0640)  
2. Hours of seclusion use (NQF #0641)  
3. Patients discharged on multiple antipsychotic medications with appropriate justification (NQF #0560)  
4. Alcohol use screening (NQF #1661)  
5. Tobacco Use Screening (NQF #1651)  
6. Tobacco Use Treatment Provided or Offered and the subset, Tobacco Use Treatment (during the hospital stay) (NQF #1654)  
7. Follow-up after hospitalization for mental illness (NQF #0576)*  
8. Assessment of Patient Experience of Care  
9. Use of an Electronic Health Record  
10. Influenza immunization (NQF #1659)  
11. Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431) |

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2. Hours of seclusion use (NQF #0641)  
3. Patients discharged on multiple antipsychotic medications with appropriate justification (NQF #0560)  
4. Alcohol use screening (NQF #1661)  
5. Alcohol Use Brief Intervention Provided or Offered and the subset, Alcohol Use Brief Intervention (NQF #1663)  
6. Tobacco Use Screening (NQF #1651)  
7. Tobacco Use Treatment Provided or Offered and the subset, Tobacco Use Treatment (during the hospital stay) (NQF #1654)  
8. Tobacco Use Treatment Provided or Offered at Discharge, and the subset, Tobacco Use Treatment at Discharge (NQF #1656)  
9. Follow-up after hospitalization for mental illness (NQF #0576)*  
10. Assessment of Patient Experience of Care  
11. Use of an Electronic Health Record  
12. Influenza immunization (NQF #1659)  
13. Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431)|

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5. Alcohol Use Brief Intervention Provided or Offered and the subset, Alcohol Use Brief Intervention (NQF #1663)  
6. Tobacco Use Screening (NQF #1651)  
7. Tobacco Use Treatment Provided or Offered and the subset, Tobacco Use Treatment (during the hospital stay) (NQF #1654)  
8. Tobacco Use Treatment Provided or Offered at Discharge, and the subset, Tobacco Use Treatment at Discharge (NQF #1656)  
9. Transition Record with Specified Elements Received by Discharged Patients  
10. Timely Transmission of Transition Record  
11. Screening for Metabolic Disorders  
12. Follow-up after hospitalization for mental illness (NQF #0576)*  
13. Assessment of Patient Experience of Care  
14. Use of an Electronic Health Record  
15. Influenza immunization (NQF #1659)  
16. Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431) |

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4. Alcohol use screening (NQF #1661)  
5. Alcohol Use Brief Intervention Provided or Offered and the subset, Alcohol Use Brief Intervention (NQF #1663)  
6. Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and the subset, Alcohol and Other Drug Use Disorder Treatment at Discharge  
7. Tobacco Use Screening (NQF #1651)  
8. Tobacco Use Treatment Provided or Offered and the subset, Tobacco Use Treatment (NQF #1654)  
9. Tobacco Use Treatment Provided or Offered at Discharge, and the subset, Tobacco Use Treatment at Discharge (NQF #1656)  
10. Transition Record with Specified Elements Received by Discharged Patients  
11. Timely Transmission of Transition Record  
12. Screening for Metabolic Disorders  
13. Follow-up after hospitalization for mental illness (NQF #0576)*  
14. 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)*  
15. Assessment of Patient Experience of Care  
16. Use of an Electronic Health Record  
17. Influenza immunization (NQF #1659)  
18. Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431) |

Beginning in FY 2017, you must also report on a yearly basis aggregate population counts as a single number, by payer, age strata, and diagnostic category.
## RESOURCES

### IPF PPS Resources

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<td>Inpatient Psychiatric Facility PPS Chapters 2, 3, and 4 of the Medicare Benefit Policy Manual (Publication 100-02)</td>
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<tr>
<td>Inpatient Psychiatric Facility Quality Reporting Program Overview and Requirements</td>
<td>Qualitynet.org</td>
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<td>All Available Medicare Learning Network® (MLN) Products</td>
<td>MLN Catalog</td>
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