mln BOOKLET

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PRINT-FRIENDLY VERSION

INPATIENT PSYCHIATRIC FACILITY PROSPECTIVE PAYMENT SYSTEM

Target Audience: Medicare Fee-For-Service Providers

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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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BACKGROUND

Section 124 of the Balanced Budget Refinement Act (BBRA) implemented the IPF PPS for psychiatric services to Medicare patients in psychiatric hospitals and distinct part (DP) units in acute care hospitals and Critical Access Hospitals, effective January 2005.

Medicare covers patients for psychiatric conditions in psychiatric hospitals or DP psychiatric units for 90 days of care per benefit period, with a 60-day lifetime reserve. Medicare pays for 190 days of inpatient psychiatric hospital services during the patient's lifetime. This 190-day lifetime limit applies to psychiatric services in freestanding psychiatric hospitals, but not to inpatient psychiatric services in general hospitals or DP IPF units.

CERTIFICATIONS AND RECERTIFICATIONS

As a condition of payment, Medicare requires physician certifications and recertifications for IPF stays. Certification begins with the inpatient admission order. The certification statement helps ensure Medicare pays only for appropriate services. Medicare Part A pays for inpatient services in an IPF **if** a physician certifies and recertifies the need for services consistent with the following requirements:

- A physician must certify:
  - Inpatient psychiatric services are required for treatment that could reasonably be expected to improve the patient's condition or for diagnostic study.
  - Inpatient psychiatric services were provided according to the Code of Federal Regulations (CFR) at 42 CFR 412.3.
- Timing of certifications and recertifications:
  - Certification is required at admission, or as soon as reasonable and practicable, and must be completed and documented in the medical record prior to discharge.
  - The first recertification must occur by the 12th day of hospitalization.
  - Medicare requires subsequent recertifications at least every 30 days. The utilization review committee can establish different review intervals on a case-by-case basis at its own choice, such as every third day.
- Content of the recertification must include:
  - Documentation that the inpatient services furnished since the previous certification or recertification were, and continue to be, required for treatment, and could reasonably be expected to improve the patient's condition or for diagnostic study.
  - Hospital records that document intensive treatment services, admission and related services necessary for diagnostic study, or equivalent services.
  - Documentation that the patient needs daily active treatment furnished directly by, or that requires the supervision of, IPF personnel.

The physician responsible for the case, or another physician with knowledge of the case authorized by the responsible physician or the hospital's medical staff, must sign the certifications and recertifications.

The IPF must provide all necessary covered services directly or under arrangement to a Medicare patient. The IPF PPS payment is payment in full for all IPF services.

The IPF PPS does not include payment for physicians', physician assistants', nurse practitioners', clinical nurse specialists', certified nurse-midwives', certified registered nurse anesthetists', or clinical psychologists' professional services. Medicare pays covered professional services separately under Part B.

DETERMINING IPF PPS PAYMENTS

Federal law requires Medicare to pay a 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. The Federal government calculates the IPF PPS per diem payment after adjusting the IPF PPS per diem base rate for facility and patient characteristics.

- **Facility characteristics**:
  - Geographic differences in wages. The Federal government adjusts the labor-related portion of the per diem base rate 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 changed status to 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.
      - 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 have little effect on a substantial number of providers and were adopted without a transition period.
  - IPFs in a rural location receive a 17 percent rural adjustment.
  - IPFs with a qualifying emergency department (ED) receive a 12 percent higher payment adjustment for the first day of 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 Federal government updated the COLA factors according to the IPPS methodology adopted in FY 2015 IPF PPS rulemaking. COLAs are updated 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, based on the principal psychiatric diagnosis
  - Age
  - Presence of specified comorbidities
  - Length of stay (a variable per diem adjustment)

IPFs receive additional payments for:

- The number of electroconvulsive therapy (ECT) treatments furnished.
- Outlier cases, which are cases with extraordinarily high costs. An IPF is eligible for an outlier payment when its estimated total cost for a case exceeds a fixed dollar threshold amount (multiplied by the IPF's facility-level adjustments for wage index, rural location, teaching status, and location in Alaska or Hawaii) plus the Federal per diem payment amount for the case.

  To obtain the outlier payment amount, first calculate the total estimated cost by multiplying the IPF charges by the cost-to-charge ratio (CCR). Second, subtract the sum of the adjusted outlier threshold amount and the total IPF PPS per diem payment for the case from the estimated cost. Third, divide the result 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.

INPATIENT PSYCHIATRIC FACILITY PROSPECTIVE PAYMENT

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.

Base rate x Labor-Related Share (LRS) = labor portion (LP) LP x wage index value = wage-adjusted labor share	+	Base rate – LP = nonlabor portion (NLP) NLP x COLA (if applicable) = adjusted nonlabor share	=	**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:

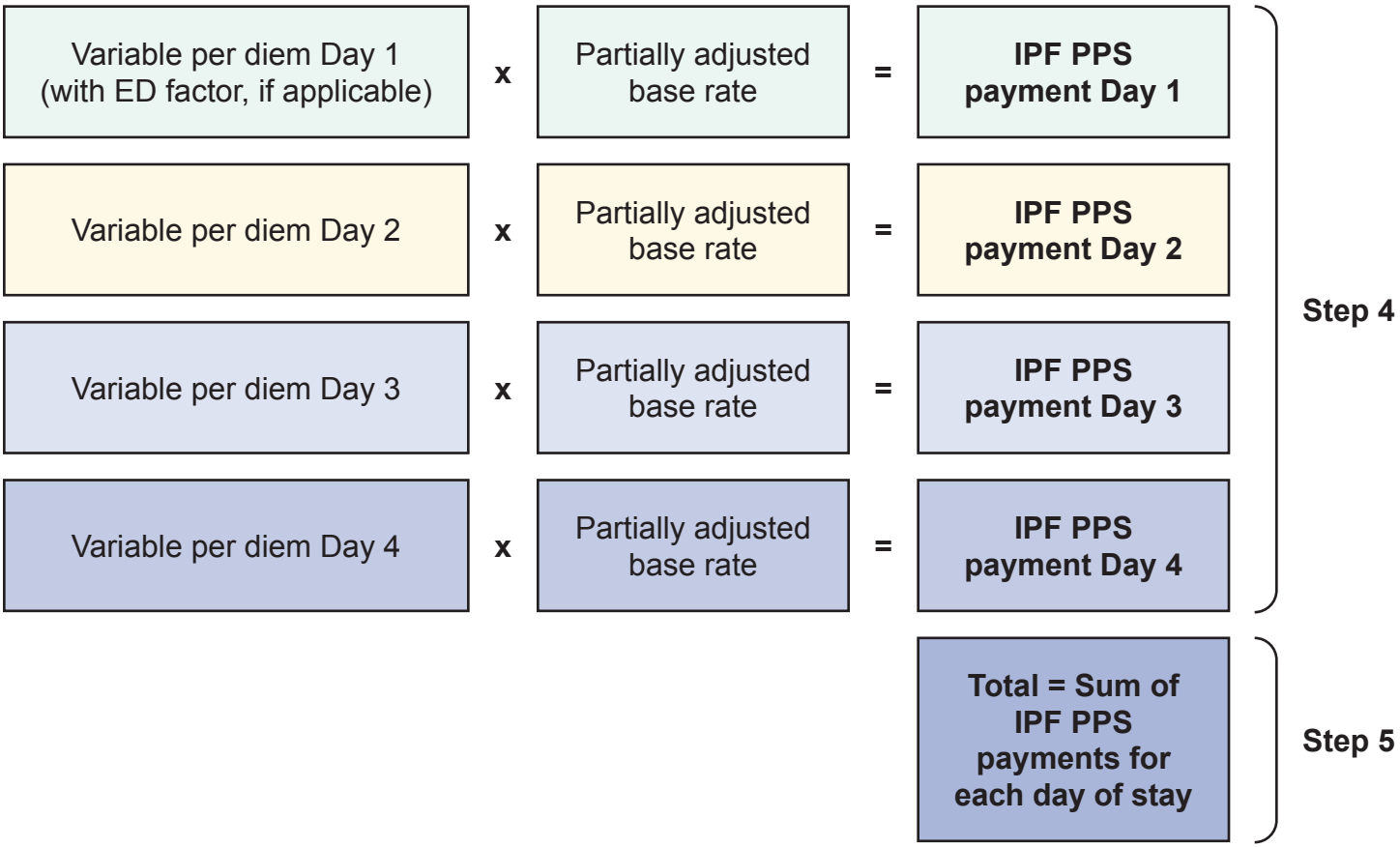
Rural adjustment x teaching adjustment x age adjustment x DRG adjustment x comorbidity adjustment = **Adjustment Factor**

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.

Wage and COLA-adjusted base rate	x	Adjustment factor	=	**Partially adjusted base rate**

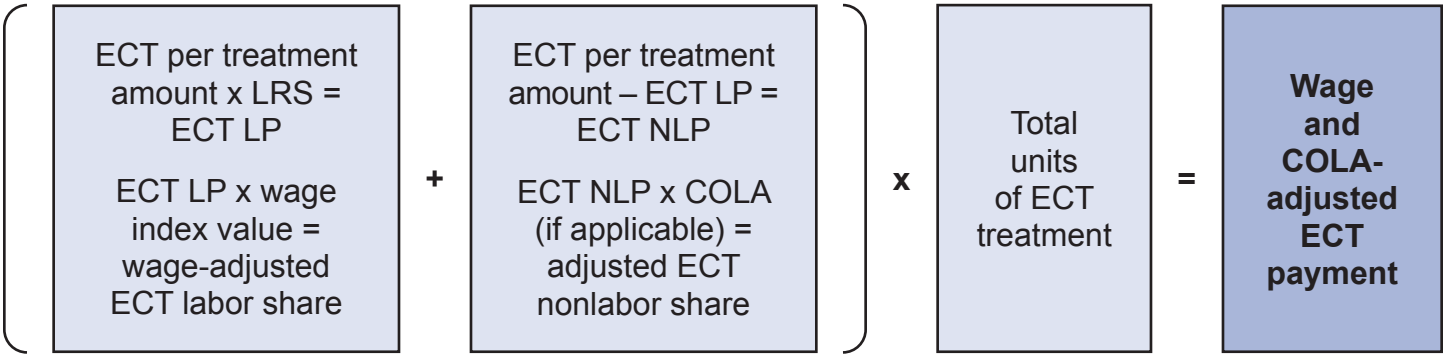
Step 4. Multiply the partially adjusted Federal per diem base rate for each day of the stay by its applicable variable per diem adjustment factor. For Day 1, use a factor of 1.31 if the IPF has a qualifying ED and a factor of 1.19 if the IPF has no qualifying ED.

Step 5. Sum the IPF PPS payments for each day of the stay to get the total IPF PPS payment amount.



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.



When submitting claims for payments, record charges that are reasonably and consistently related to the costs for the items and services provided to patients during an IPF stay. Even though IPFs receive a per diem payment, providers must completely and accurately report their charges on claims. This information is needed to accurately calculate outlier payments and periodically refine 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 started the IPF PPS.

IPF PPS FISCAL YEAR (FY) 2019 UPDATE

The FY 2019 update to the IPF PPS includes:

- Market basket update:
  - The Federal government adjusts the per diem base rate annually by the IPF market basket update percentage. The FY 2019 IPF market basket update is 2.9 percent, less a statutorily required productivity adjustment of 0.8 percentage point, less a statutorily required other adjustment of 0.75 percentage point, for a total FY 2019 update of 1.35 percent.
  - The Federal market basket update is reduced by 2 percentage points for IPFs that failed to comply with quality data submission requirements. For FY 2019, IPFs out of compliance with quality data submission requirements receive a negative update of -0.65 percent (1.35 percent – 2.0 percentage points).
  - The LRS of the Federal per diem base rate for FY 2019: 74.8 percent.
- Pricer updates:
  - Federal per diem base rate: $782.78.
  - Federal per diem base rate with the 2.0 percentage point reduction for IPFs out of compliance with quality data submission requirements: $767.33.
  - Fixed-dollar loss threshold amount: $12,865.
  - LRS (74.8 percent) of the Federal per diem base rate: $585.52.
  - LRS (74.8 percent) of the Federal per diem base rate with the 2.0 percentage point reduction for IPFs out of compliance with quality data submission requirements: $573.96.
  - Nonlabor-related share (25.2 percent) of the Federal per diem base rate: $197.26.
  - Nonlabor-related share (25.2 percent) of the Federal per diem base rate with the 2.0 percentage point reduction for IPFs out of compliance with quality data submission requirements: $193.37.
  - ECT per treatment payment amount: $337.00.
  - ECT per treatment payment amount with the 2.0 percentage point reduction for IPFs out of compliance with quality data submission requirements: $330.35.

- The MS-DRG, comorbidity, age, teaching, and rural adjustment factors did not change.
- The Federal government based the FY 2019 IPF wage index on the FY 2018 pre-floor, pre-reclassified hospital wage index.
- The wage index budget neutrality factor is 1.0013. The Federal government applies it to the per diem base rate when updating the base rate.
- National median CCRs that apply to IPFs in the following situations:
  - New IPFs that have not submitted their first cost report
  - IPFs whose operating or capital CCR exceeds 3 standard deviations above the corresponding national geometric mean (the ceiling)
  - IPFs for which their Medicare Administrative Contractors obtain inaccurate or incomplete data to calculate a CCR

FY 2019 National CCRs

CCR	Median	Ceiling
Urban	0.4365	1.6862
Rural	0.5890	2.0068

For more information about IPF PPS payment updates, refer to the FY 2019 Final Payment Updates Addendum and the FY 2019 IPF PPS Final Rule.

IPF QUALITY REPORTING (QR) PROGRAM

Section 1886(s)(4)(C) of the Social Security Act required establishing the IPF QR Program. Beginning in FY 2014, if quality data is unreported, an IPF is subject to a 2.0 percentage point reduction to the applicable annual update. This law requires IPFs to report their quality data annually to avoid the 2.0 percentage point reduction. The Centers for Medicare & Medicaid Services calculates claims-based measures, indicated by asterisks in the table below. These are unreported by IPFs.

Quality Measures for FYs 2013, 2015, 2016, 2017, 2018, 2019, and 2020

Fiscal Year	Quality Measures
Report in FY 2013, with reduction to annual update in FY 2014 if quality data is unreported	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)

Quality Measures for FYs 2013, 2015, 2016, 2017, 2018, 2019, and 2020 (cont.)

Fiscal Year	Quality Measures
Report in FY 2015, with reduction to annual update in FY 2016 if quality data is unreported	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 unreported	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)

Quality Measures for FYs 2013, 2015, 2016, 2017, 2018, 2019, and 2020 (cont.)

Fiscal Year	Quality Measures
Report in FY 2017, with reduction to annual update in FY 2018 if quality data is unreported	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. 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)

Quality Measures for FYs 2013, 2015, 2016, 2017, 2018, 2019, and 2020 (cont.)

Fiscal Year	Quality Measures
Report in FY 2018, with reduction to annual update in FY 2019 if quality data is unreported	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. 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 (NQF #1664) 7. Tobacco Use Screening (NQF #1651) 8. Tobacco Use Treatment Provided or Offered and the subset, Tobacco Use Treatment (during the hospital stay) (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 (NQF #0647) 11. Timely Transmission of Transition Record (NQF #0648) 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) (NQF #2860)* 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)

Quality Measures for FYs 2013, 2015, 2016, 2017, 2018, 2019, and 2020 (cont.)

Fiscal Year	Quality Measures
Report in FY 2019, with reduction to annual update in FY 2020 if quality data is unreported	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 Brief Intervention Provided or Offered and the subset, Alcohol Use Brief Intervention (NQF #1663) 5. Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and the subset, Alcohol and Other Drug Use Disorder Treatment at Discharge (NQF #1664) 6. Tobacco Use Treatment Provided or Offered and the subset, Tobacco Use Treatment (NQF #1654) 7. Tobacco Use Treatment Provided or Offered at Discharge, and the subset, Tobacco Use Treatment at Discharge (NQF #1656) 8. Transition Record with Specified Elements Received by Discharged Patients (NQF #0647) 9. Timely Transmission of Transition Record (NQF #0648) 10. Screening for Metabolic Disorders 11. Follow-up After Hospitalization for Mental Illness (NQF #0576)* 12. 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF) (NQF #2860)* 13. Influenza immunization (NQF #1659)

Quality Measures for FYs 2013, 2015, 2016, 2017, 2018, 2019, and 2020 (cont.)

Fiscal Year	Quality Measures
Report in FY 2020, with reduction to annual update in FY 2021 if quality data is unreported	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. Follow-up After Hospitalization for Mental Illness (NQF #0576)* 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 (NQF #1664) 7. Tobacco Use Treatment Provided or Offered and the subset, Tobacco Use Treatment (NQF #1654) 8. Tobacco Use Treatment Provided or Offered at Discharge and the subset, Tobacco Use Treatment at Discharge (NQF #1656) 9. Influenza Immunization (NQF #1659) 10. Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (NQF #0647) 11. Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (NQF #0648) 12. Screening for Metabolic Disorders 13. 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (NQF #2860)*

* Beginning in FY 2017, IPFs must annually report aggregate total discharges as a single number as well as by payer, age strata, and diagnostic category.

RESOURCES

IPF PPS Resources

For More Information About…	Resource
Inpatient Psychiatric Facility Prospective Payment System	CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.html (Chapters 2–4) CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf
Inpatient Psychiatric Facility Quality Reporting Program	Qualitynet.org
Medicare Learning Network® (MLN) Products	CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf

Hyperlink Table

Embedded Hyperlink	Complete URL
42 CFR 412.3	https://www.ecfr.gov/cgi-bin/text-idx?SID=210b3ca76ffac34d306455a6b733762d&mc=true&node=pt42.2.412&rgn=div5#se42.2.412_13
FY 2019 Final Payment Updates Addendum	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/Downloads/FY-2019-Final-Addendum-A-IPF-PPS-Payment-Updates.pdf
FY 2019 IPF PPS Final Rule	https://www.federalregister.gov/d/2018-16518
November 15, 2004, IPF PPS Final Rule	https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/Downloads/cms1213f.pdf
Section 1886(s)(4)(C) of the Social Security Act	https://www.ssa.gov/OP_Home/ssact/title18/1886.htm