Illinois Health and Hospital Association

RULE SUMMARY

JUNE 2024

MEDICARE INPATIENT PSYCHIATRIC FACILITY PROSPECTIVE PAYMENT SYSTEM

Overview and Resources

On March 28, 2024, the Centers for Medicare & Medicaid Services (CMS) released the federal fiscal year (FFY) 2025 proposed payment rule for the Inpatient Psychiatric Facility (IPF) Prospective Payment System (PPS). The proposed rule reflects the annual update to the Medicare fee-for-service (FFS) IPF payment rates and policies.

A copy of the proposed rule and other resources related to the IPF PPS are available on the CMS website. An online version of the proposed rule is available here.

A brief of the proposed rule, along with page references for additional details, is provided below. Program changes adopted by CMS will be effective for discharges on or after Oct. 1, 2024, unless otherwise noted. CMS estimates the overall economic impact of the proposed payment rate updates to be an increase of $70 million in aggregate payments to IPFs in FFY 2025 over FFY 2024.

Comments on the proposed rule were due to CMS by May 28, 2024. This analysis was delayed due to CMS' very late release of a requested limited data set and validation of data sources and interpretation which were necessary to complete the analysis.

IPF Payment Rates

The table below lists the IPF federal per diem and the electroconvulsive therapy (ECT) base rates proposed for FFY 2025 compared to the rates currently in effect:

	Final FFY 2024	Proposed FFY 2025	Percent Change
IPF Per Diem Base Rate	$895.63	$874.93	-2.31%
ECT Base Rate	$385.58	$660.30	+71.25%
ECT Base Rate (based on OPPS Geometric Mean Cost)	$675.93		-2.31%

The following table provides details of the proposed updates to the IPF payment rates for FFY 2025:

	Proposed FFY 2025 IPF Base Rate Update
Market Basket Update	+3.1%
ACA-Mandated Productivity Adjustment	-0.4 percentage points (PPT)
Wage Index Budget Neutrality Adjustment	0.9998
Refinement Standardization Factor	0.9514
Overall Rate Change	**-2.31%**

Wage Index, Cost-of-Living Adjustment (COLA), Labor-Related Share, and Revised CBSA Delineations

The labor-related portions of the IPF per diem base rate and the ECT base rate are adjusted for differences in area wage levels using a wage index. CMS proposes to continue to use the current year pre-floor, pre-reclassification Inpatient PPS (IPPS) wage index for FFY 2025 to adjust payment rates for labor market differences.

CMS applies the wage index to the estimated labor-related portion of the IPF standard rate to adjust for differences in area wage levels. Using the previously adopted 2021-based market-basket, CMS is proposing to increase the labor-related share of the IPF per diem base rate and the ECT base rate from 78.7% in FFY 2024 to 78.8% for FFY 2025.

CMS is proposing a wage index budget neutrality factor of 0.9995 for FFY 2025 to ensure that aggregate payments made under the IPF PPS are not greater or less than would otherwise be made if wage adjustments had not changed. This includes the budget neutrality associated with the 5% wage index cap.

On July 21, 2023, the Office of Management and Budget (OMB) issued OMB Bulletin No. 23-01 that made a number of significant changes related Core-Based Statistical Area (CBSA) delineations. To align with these changes, CMS is proposing to adopt the newest OMB delineations for the FFY 2025 IPF PPS wage index. If CMS adopts this proposal, 54 counties, listed in Table 12 of the proposed rule, that are currently part of an urban CBSA would be considered located in a rural area. An additional 54 counties, listed in Table 13 of the proposed rule, that are currently located in rural areas would be considered located in urban areas. Since CMS already applies a 5% cap on wage index loses from year-to-year, CMS does not believe any additional transition policies are needed to account for the changes in wage index.

CMS states that 15 facilities designated as rural in FFY 2024 would become urban in FFY 2025 if this proposal is adopted, resulting in a loss of the 17% rural adjustment. To mitigate the impacts of this loss, CMS is proposing that these 15 IPF providers would be provided with a gradual phase out of their rural adjustment over a three-year period. Specifically, these providers would receive two-thirds of the rural adjustment in FFY 2025, one-third of the rural adjustment in FFY 2026, and no rural adjustment in FFY 2027. For the IPF providers changing from urban to rural status, there will be no phase-in; they would receive the full rural adjustment in FFY 2025.

A complete list of the proposed IPF wage indexes used for payment in FFY 2025 is available on the CMS website.

Adjustments to the IPF Payment Rates

For FFY 2025, CMS is proposing to revise the facility and patient-level adjustments using CY 2019-2021 MedPAR files and FFY 2019-2021 cost report data. If a provider does not have a Medicare cost report for one or more years, CMS used the most recent available cost report prior to the year for which the cost report was missing. These revisions consider comments received by CMS in FFY 2024 rulemaking on topics of refining the IPF PPS as required by the Consolidated Appropriations Act (CAA) of 2023, reporting of ancillary charges on IPF claims, and CMS analysis of social drivers of health.

The proposed adjustments to facility and patient-level adjustments are described below.

Patient Condition Medicare-Severity Diagnosis Related (MS-DRG) Adjustment: For FFY 2025, CMS proposes to continue to utilize the MS-DRG system used under the IPPS to classify Medicare patients treated in IPF, with revisions, in a budget neutral manner.

Similar to prior years, principal diagnoses codes (ICD-10-CM) that group to one of 19 MS-DRGs recognized under the IPF PPS are proposed to receive a DRG adjustment. Principal diagnoses that do not group to one of the designated MS-DRGs recognized under the IPF PPS would receive the federal per diem base rate and all other applicable adjustments but would not include a DRG adjustment in the payment.

CMS is proposing to maintain 15 of the existing 17 IPF MS-DRGs and to make the following changes:

- Replace DRGs 080 (Nontraumatic stupor & coma w MCC) and 081 (Nontraumatic stupor & coma w/o MCC) with DRGs 947 (Signs and Symptoms w MCC) and 948 (Signs and Symptoms w/out MCC); and

- Add DRGs 917 (Poisoning and toxic effects of drugs w MCC) and 918 (Poisoning and toxic effects of drugs w/out MCC).

Table 5 in the proposed rule lists the 19 MS-DRGs proposed as eligible for a MS-DRG adjustment under the IPF PPS for FFY 2025 and the updates to the adjustment factor for each DRG.

Additionally, CMS is proposing to incorporate a sub-regulatory process for handling routine coding updates, which would remove the requirement to discuss coding updates in the *Federal Register* during regulatory updates prior to implementation. This approach mirrors that of the IPPS.

Patient Comorbid Condition Adjustment: For FFY 2025, CMS is proposing to revise the 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.

CMS is proposing the following changes to the number of ICD-10-CM codes in various comorbidity categories:

- Eating and Conduct Disorders – removing all conduct disorder codes and designate as "Eating Disorders";
- Chronic Obstructive Pulmonary Disease – adding four codes associated with sleep apnea and designate as "Chronic Obstructive Pulmonary Disease and Sleep Apnea"; and
- Oncology Treatment – adding two codes.

CMS is proposing to add a new comorbidity category to address costs of patients exhibiting violent behavior as well as other high-risk, non-violent behaviors. The Intensive Management for High-Risk Behavior category is proposed to include the following codes:

- R451 – Restlessness and agitation;
- R454 – Irritability and anger; and
- R4584 – Anhedonia.

Table 8 in the proposed rule lists all the proposed comorbid condition payment adjustment changes for FFY 2025.

Patient Age Adjustment: CMS proposes to continue the patient age adjustment for FFY 2025. However, an analysis by CMS has shown that the IPF per diem costs, which increase with patient age, warrant revision. The following table lists the proposed patient age adjustments for FFY 2025, which includes merging "45 and under 50" with "50 and under 55" to form the new age group "45 and under 55"; and merging "70 and under 75" with "75 and under 80" to form the new age group "70 and under 80". The proposed age adjustment factors are in Table 9 of the proposed rule.

Patient Variable Per Diem Adjustment: For FFY 2025, CMS proposes to continue the per diem rate adjustment, which is based on patient length-of-stay (LOS) using a variable per diem adjustment factor. An 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 Emergency Department (ED)) and gradually decline until day 21 of a patient's stay. For day 22 and onwards, the variable per diem adjustment remains the same for the remainder of the stay.

A more recent analysis by CMS has shown that there is not a statistically significant decrease in cost per day after day 10. As such, CMS proposes to increase the adjustment factors for days 1-9 and that days 10 and above would receive an adjustment of 1.00. Table 10 of the proposed rule lists the proposed variable per diem adjustment factors for FFY 2025.

Rural Adjustment: IPFs located in rural areas 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. CMS proposes to continue this adjustment in FFY 2025 without any revisions.

Teaching Adjustment: CMS is proposing that IPFs with teaching programs 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 programs. CMS also proposes to maintain the teaching adjustment coefficient value at 0.5150 for FFY 2025. The teaching adjustment is based on the number of full-time equivalent interns and residents training in the IPF and the IPF's average daily census.

ED Adjustment: For FFY 2025, CMS is proposing to continue the policy where IPFs with a qualifying ED would receive a 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. This adjustment is proposed to increase from 1.31 in FFY 2024 to 1.53 in FFY 2025 and would 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. In such cases, the IPF receives a proposed ED adjustment factor of 1.27 for FFY 2025, an increase from the adjustment factor of 1.19 from FFY 2024.

Outlier Payments

CMS proposes to continue to use the established target of 2% of total IPF PPS payments to be set aside for high-cost outliers. To meet this target for FFY 2025, CMS proposes to update the outlier threshold to $35,590, a 6.3% increase over the FFY 2024 threshold of $33,470. To calculate this outlier threshold, CMS used FFY 2023 claims, excluding providers if their change in estimated average cost per day is outside 3 standard deviations from the mean.

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

CMS proposes to continue to set the national CCR ceilings at 3 standard deviations above the mean CCR, and therefore the national CCR ceiling for FFY 2025 is proposed to be 2.3362 for rural IPFs and 1.8600 for urban IPFs. If an individual IPF's CCR exceeds this ceiling for FFY 2025, the IPF's CCR would be replaced with the appropriate national median CCR, urban or rural. CMS proposes a national median CCR of 0.5720 for rural IPFs and 0.4200 for urban IPFs, with both values being the same as were adopted for FFY 2024. Calculations of both the proposed national CCR ceiling and national median CCR are based on current (FFY 2024) CBSA-based geographic designations.

Requirements for Reporting Ancillary Charges and All-Inclusive Status Eligibility Under the IPF PPS

Currently, IPFs and psychiatric units are required to report ancillary charges on cost reports. However, analysis by CMS has found a notable increase in IPFs erroneously identifying as eligible for filing all-inclusive cost reports (indicating that they have one charge covering all services, listed on Worksheet S-2, Part 1, line 115). These providers are consistently reporting no or very minimal ancillary charges where CMS would otherwise expect to see ancillary services and correlated charges. The CAA of 2023 authorizes CMS to collect data and information on charges related to ancillary services to inform revisions to the IPF PPS. In the FFY 2024 proposed rule, CMS included a request for information related to reporting of charges for these services.

Based on comments received in prior rulemaking, CMS is clarifying the eligibility criteria to be approved to file all-inclusive cost reports. For cost report periods beginning on or after Oct. 1, 2024, only government-owned or tribally owned facilities will satisfy these criteria, and these will be the only facilities permitted the option to file an all-inclusive cost report.

IPF Quality Reporting (IPFQR) Program

IPFs that do not successfully participate in the IPFQR Program are subject to a 2.0 percentage point reduction to the market basket update for the applicable year. CMS had previously finalized 16 measures for the FFY 2025 payment determination and for subsequent years, listed in Table 22 of the proposed rule.

CMS is proposing to include the *30-Day Risk-Standardized All-Cause ED Visit Following an IPF Discharge* Measure (reporting CY 2025 performance period/FFY 2027 payment determination) in the IPFQR.

For the FFY 2027 payment determination, and subsequent years, CMS is proposing that IPFQR data be submitted quarterly rather than yearly. If finalized, data submission for each calendar quarter would be required during a period of at least 45 days beginning three months after the end of the calendar quarter. Additionally, all data which continue to be reported on an annual basis (non-measure data, aggregate measures, and attestations) is proposed to be reported concurrently with the data from the fourth quarter of the applicable year. Table 24 of the proposed rule shows the proposed quarterly submission deadlines for the CY 2025 and CY 2026 performance periods.

Request for Information – Patient Assessment Instruments under IPFQR Program (IPF-PAI) to Improve the Accuracy of the PPS

The CAA of 2023 requires IPFs participating in the IPFQR program to collect and submit certain standardized assessment data using a standardized PAI for FFY 2028 and subsequent years. As CMS develops the IPF-PAI, CMS seeks to collect information to achieve the following goals:

- Improve quality of care in IPFs;
- Improve accuracy of the IPF PPS in accordance with the provisions included in the CAA of 2023; and
- Improve health equity.

Specifically, CMS is seeking comment each of the following topics:

- The framework for development of the IPF-PAI;
- Potential approaches that could be used to develop data elements that make up the PAI, including data elements used in PAIs for other healthcare setting that could be adapted for use in the IPF-PAI;
- Potential approaches to collect patient assessment data;
- Selecting Patient Assessment Data Elements to be collected on the IPF-PAI;
- Implementation; and
- Relationship to the IPFQR program.

Request for Information: Informing Future Revisions to the IPF PPS

The CAA of 2023 requires revisions to the methodology for determining the payment rates under the IPF PPS for FFY 2025 and future years, if appropriate. This includes collecting data and information to revise payments, beginning no later than Oct. 1, 2024. CMS seeks comments on their analysis of the following topics:

- Calculation of the rural location adjustment to include control variables;
- Inclusion of occupancy control variables in the determination of teaching adjustments; and
- Using the Medicare Safety Net Index developed by MedPAC to adjust IPF payments.

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