Illinois Health and Hospital Association

MEDICARE PAYMENT FACT SHEET

APRIL 2021

FFY 2022 INPATIENT PSYCHIATRIC FACILITY PROSPECTIVE PAYMENT SYSTEM PROPOSED RULE (CMS-1750-P)

On April 7, the Centers for Medicare & Medicaid Services (CMS) posted the unpublished version of the federal fiscal year (FFY) 2022 Inpatient Psychiatric Facility (IPF) Prospective Payment System (PPS) proposed rule effective Oct. 1, 2021 through Sept. 30, 2022. After accounting for all payment and budget neutrality factors, CMS proposed a 2.3% update to IPF PPS payment rates. Comments are due June 7.

Market Basket (*Federal Register (FR) pp. 19482-19483)*: CMS proposed a 2.3% IPF market basket update, a multifactor productivity (MFP) reduction of 0.2 percentage points and a 0.2 percentage point increase for the outlier fixed-dollar loss threshold amount. The payment rate for IPFs that fail to submit required quality data will decrease by two percentage points.

Base Per Diem and Electroconvulsive Therapy (ECT) Rates (*FR pp. 19483-19484*): Proposed FFY 2022 rate updates include:

Proposed Per Diem Base Rates			Proposed ECT – Per Treatment Rates		
FFY 2022	FFY 2022, No Quality Data	FFY 2021	FFY 2022	FFY 2022, No Quality Data	FFY 2021
$833.50	$817.18	$815.22	$358.84	$351.81	$350.97

CMS proposed decreasing the labor-related share to 77.1% for FFY 2022 (down from 77.3% in FFY 2021).

IPF Patient-Level Adjustment Factors (*FR pp. 19484-19486*): CMS did not propose any changes to the IPF MS-DRG, comorbidity, patient age, or variable per diem adjustment factors. For FFY 2022, CMS proposed to continue to make the existing payment adjustment for psychiatric diagnoses that group to one of the existing 17 IPF MS-DRGs listed in Addendum A. The proposed FFY 2022 Code First table for certain conditions is available in Addendum B.[1] The diagnoses for each IPF MS-DRG will be updated on Oct. 1, 2021 using the final inpatient prospective payment system (IPPS) ICD-10-CM/PCS code sets.[2]

Outlier Payments (*FR pp. 19492-19493*): CMS proposed decreasing the outlier threshold amount from $14,630 in FFY 2021 to $14,030 in FFY 2022 to maintain estimated outlier payments at 2% of total estimated aggregate IPF PPS Payments. CMS used FFY 2019 claims to calculate the updated outlier threshold.

[1] Addendums A and B are available on CMS' IPF Tools and Worksheets website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools.

[2] The IPPS proposed rule and tables of proposed changes to the ICD-10-CM/PCS code sets are available on CMS' IPPS website: https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps.

Proposed FFY 2022 IPF Cost-to-Charge Ratio (CCR) Ceiling and Median (*FR pp. 19493-19494*):

Rural Ceiling	Rural Median	Urban Ceiling	Urban Median
2.0398	0.5720	1.6126	0.4200

Wage Index (*FR pp. 19486-19493*): CMS proposed to continue using the concurrent pre-floor, pre-reclassified IPPS hospital wage index as the basis for the FFY 2022 IPF wage index:

CBSA	Proposed FFY 2022	Final FFY 2021
Bloomington	0.9138	0.9114
Cape Girardeau	0.8300	0.8019
Carbondale	0.8197	0.8184
Champaign-Urbana	0.8699	0.8655
Chicago-Naperville-Evanston	1.0392	1.0442
Danville	0.9427	0.9032
Decatur	0.8371	0.8326
Elgin	1.0254	1.0559
Kankakee	0.8934	0.9068
Lake County	1.0069	1.0192
Peoria	0.8475	0.8644
Rock Island	0.8391	0.8520
Rockford	0.9922	0.9693
St. Louis	0.9595	0.9317
Springfield	0.9156	0.9256
Rural	0.8404	0.8297

CMS proposed the continued application of a 17% payment adjustment to IPFs located in rural areas. CMS also proposed retaining the 1.31 adjustment factor for IPFs with qualifying emergency departments (EDs).

Proposed Update to IPF Teaching Policy (*FR pp. 19489-19490*): CMS proposed several changes to its policy regarding residents displaced when an IPF closes, better aligning the IPF policy with the IPPS. Proposed updates include:

1. Using the day that an IPF/program closure is publicly announced as the day that determines a resident's status as displaced, rather than the day before or day of the IPF/program closure;
2. Considering the second and third groups of residents who are not physically at the closing IPF/program displaced. This includes residents who intend to train or plan to return to train at the closing IPF/program, allowing residents to continue training and arrange transfers while the program winds down; and
3. Requiring IPFs/programs receiving displaced residents and applying for a temporary increase in the full-time equivalent resident cap to submit a letter to its Medicare Administrative Contractor (MAC) within 60 days of beginning the training of said displaced residents. This letter must identify the name of each displaced resident, the

last four digits of each displaced resident's social security number, the IPF/program each displaced resident was training in previously, and the amount of the cap increase needed for each resident.

CMS clarified that providers cannot combine the actual caps under the IPF PPS and IPPS, meaning a provider cannot add its IPF resident cap to its IPPS resident cap (or vice versa) and increase the number of residents it receives payment for under either payment system.

IPF Quality Reporting (IPFQR) Program (*FR pp. 19494-19515*): Table 4 (*pp. 19510-19511*) displays the 14 measures currently adopted for the FFY 2023 IPFQR payment determination.

COVID-19 Vaccination Coverage among Healthcare Personnel (COVID-19 HCP): For the FFY 2023 IPFQR, CMS proposed adopting COVID-19 Vaccination Coverage among Healthcare Personnel (COVID-19 HCP). This proposed measure supports CMS' Meaningful Measures framework under the "Promote Effective Prevention and Treatment of Chronic Disease" quality priority. COVID-19 HCP is a process measure developed with the Centers for Disease Control and Prevention (CDC) to track COVID-19 vaccination coverage among HCP. The National Quality Forum (NQF) has not endorsed this measure; however, CMS justified collecting the measure before securing an NQF endorsement given the ongoing COVID-19 public health emergency (PHE).

The COVID-19 HCP numerator is the cumulative number of HCP eligible to work in an IPF for at least one day during the reporting period and who received a complete vaccination course against SARS-CoV-2. The denominator is the number of HCP eligible to work in an IPF for at least one day during the reporting period, excluding persons with contraindications to COVID-19 vaccination as described by the CDC.[3] IPFs would submit COVID-19 HCP data for at least one week per month.

If finalized, IPFs would begin submitting COVDI-19 HCP data Oct. 1, 2021 for the FFY 2023 IPFQR program year; CMS would begin publicly reporting the COVID-HCP measure with the October 2022 *Care Compare* refresh.

IPFs would submit data for COVID-19 HCP through the CDC/National Healthcare Safety Network (NHSN) web-based surveillance system using the COVID-19 vaccination data-reporting module in the NHSN Healthcare Personnel Safety Component. CMS acknowledged that IPFs do not currently submit data through the NHSN web-based surveillance system; however, CMS has required IPFs to use this system in the past, and thus CMS reasons IPFs should be somewhat familiar with the platform.

Follow-Up After Psychiatric Hospitalization (FAPH) Measure: For the FFY 2024 IPFQR, CMS proposed adopting Follow-Up After Psychiatric Hospitalization (FAPH). A claims-based measure, FAPH uses Medicare fee-for-service (FFS) claims to measure the percentage of inpatient discharges from an IPF with a principal diagnosis of select mental illness or substance use disorders (SUD) for which the patient received a follow-up visit for treatment of that diagnosed condition. Because FAPH is a claims-based measure, it would not require additional data collection on the part of IPFs.

[3] Centers for Disease Control and Prevention. Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Authorized in the United States, Appendix B. Available at https://www.cdc.gov/vaccines/covid-19/info-by-product/clinicalconsiderations.html#Appendix-B.

CMS proposed the calculation of two rates for this measure: (1) the percentage of discharges for which the patient received follow-up treatment within 7 days of discharge; and (2) the percentage of discharges for which the patient received follow-up treatment within 30 days of discharge. The NQF did not endorse FAPH.

If finalized, FAPH would replace the current IPFQR measure Follow-Up After Hospitalization for Mental Illness (FUH, NQF #5076). FUH measures the percentage of inpatient discharges from an IPF with a principal diagnosis of select mental illness for which the patient received a follow-up visit for treatment of that diagnosed condition. However, FUH excludes patients with a primary diagnosis of SUD. Additionally, FAPH does not limit the provider type billing for the follow-up visit so long as the relevant diagnosis of mental illness or SUD is present on the claim. FUH is endorsed by the NQF, and CMS stated it will only remove the FUH measure if the proposed FAPH measure is finalized.

Adoption of Patient-Level Reporting for Chart-Abstracted Measures: Citing the potential for human error with aggregated data, CMS proposed adopting patient-level reporting for several chart-abstracted data measures for the FFY 2023 IPFQR measure set. Table 6 (*p. 19514*) lists proposed patient-level data submission requirements. Reporting patient-level data would be voluntarily for FFY 2023 payment determination (i.e., data submitted during calendar year 2022), and mandatory for FFY 2024 payment determination and subsequent years. CMS also requested comments on a potential data validation pilot for IPFQR patient-level data.

Proposed Measure Removal: CMS proposed removing three chart-abstracted measures from the IPFQR:

- Alcohol Use Brief Intervention Provided or Offered and Alcohol Use Brief Intervention (SUB-2/2a);
- Tobacco Use Brief Intervention Provided or Offered and Tobacco Use Brief Intervention (TOB-2/2a); and
- Timely Transmission of Transitional Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care).

CMS stated it believes these measures are no longer necessary due to consistently high performance nationally across IPFs, leaving little room for improvement. Further, CMS stated it is attempting to move away from burdensome chart-abstracted measures in general. If finalized, CMS would remove these measures from the IPFQR beginning with the FFY 2024 payment determination.

Additional Measure Topics: CMS requested comments on the following topics and future measures considerations:

- Instruments currently used, but not required, in the IPF setting, including whether the HCAHPS survey is appropriate for the IPF setting, and information on how facilities that currently use the HCAHPs survey addressed challenges with using HCAHPS within the IPF setting;
- The value of patient reported outcomes measures that assess functional outcomes (such as psychotic symptoms or emotional liability), comparing a patient's responses to a

standardized functional outcomes assessment instrument at admission with the patient's results on the same assessment instrument at discharge; and

- Measures, either already within the IPFQR or appropriate for adoption into the IPFQR, that would be appropriate for digital data collection.

Request for Information on Closing the Health Equity Gap (*FR pp. 19494-19500*): CMS requested comments on the potential stratification of quality measures in the IPFQR by dual eligibility, race, ethnicity and co-occurring disability status. CMS may use stratified IPFQR measures to look at disparities within facilities and across facilities.

CMS also requested comments on how to improve demographic data collection. Specifically, CMS is interested in how facilities capture demographic data elements such as race, ethnicity, sex, sexual orientation and gender identity (SOGI); primary language; and disability status. CMS also seeks input on potential challenges facilities face in collecting a minimum set of demographic data elements that align with national data standards,[4] particularly standards for interoperable exchange.[5]

Finally, CMS requested comments on the potential creation of a facility equity score based on the Medicare Advantage Health Equity Summary Score (HESS), but reflective of risk-adjusted facility outcome measures (i.e., the stratification of outcomes based on dual eligibility, race, ethnicity and co-occurring disability status) and potentially additional IPF quality measures.

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Sources:

Centers for Medicare & Medicaid Services. Medicare Program: FY 2022 Inpatient Psychiatric Facilities Prospective Payment System and Quality Reporting Updates for Fiscal Year Beginning October 1, 2021 (FY 2022). Available from: https://www.federalregister.gov/public-inspection/2021-07433/medicare-program-fy-2022-inpatient-psychiatric-facilities-prospective-payment-system-and-quality. Accessed April 12, 2021.

Centers for Medicare & Medicaid Services. IPF Wage Index. Available from: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/WageIndex. Accessed April 12, 2021.

[4] CMS suggests data collection standards such as those finalized under the Affordable Care Act. Available from: https://minorityhealth.hhs.gov/assets/pdf/checked/1/Fact_Sheet_Section_4302.pdf.

[5] CMS suggests the U.S. Core Data for Interoperability as a potential interoperability standard, which was incorporated into certified health IT products as part of the 2015 Edition of health IT certification criteria. Available from: https://www.healthit.gov/sites/default/files/2020-08/2015EdCures_Update_CCG_USCDI.pdf.