Medicare Program; FY 2021 Inpatient Psychiatric Facilities Prospective Payment System [CMS-1731-P]

Summary of Proposed Rule

On April 14, 2020, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* (85 FR 20625) a proposed rule to update the payment rates under the Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) for fiscal year (FY) 2021. IPFs include psychiatric hospitals and excluded psychiatric units of acute hospital or critical access hospitals. Proposed updates to the market basket and payment adjustments for the FY 2021 IPF PPS are described; notably the proposed rule would modify the IPF PPS wage index areas with a transition to mitigate the negative effects of this change. No changes are proposed to the IPF Quality Reporting (IPFQR) Program. **Comments on the proposed rule are due by June 9, 2020.**

Tables summarizing the proposed FY 2021 IPF PPS payment rates and adjustments (Addendum A); the complete listing of ICD-10 Clinical Modification (CM) and Procedure Coding System codes (ICD-10-CM/PCS) (Addendum B); and a provider-level impact file (Addendum C) are not included in the proposed rule but are available online at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools. Similarly, proposed FY 2021 wage index tables are available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/WageIndex

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I. Background

Under the IPF PPS facilities are paid based on a standardized federal per diem base rate adjusted by a series of patient-level and facility-level adjustments as applicable to the IPF stay. The proposed rule reviews in detail the statutory basis and regulatory history of the IPF PPS; the system was implemented in January 2005 and was put on a federal FY updating cycle beginning with FY 2013.

The base payment rate was initially based on the national average daily IPF costs in 2002 updated for inflation and adjusted for budget neutrality. The initial standardized budget-neutral

federal per diem base rate established for cost reporting periods beginning on or after January 1, 2005 was $575.95, and has been updating based on statutory requirements in annual notices or rulemaking since then. Additional payment policies apply for outlier cases, interrupted stays, and a per treatment payment for patients who undergo electroconvulsive therapy (ECT). The ECT per treatment payment rate is also subject to annual updates.

CMS continues to use payment adjustment factors for the IPF PPS that were established in 2005 and derived from a regression analysis of the FY 2002 Medicare Provider and Analysis Review (MedPAR) data file (69 FR 66935- 66936). The patient-level adjustments address age, Diagnosis-Related Group (DRG) assignment, and comorbidities; higher per diem costs at the beginning of a patient's stay and lower costs for later days of the stay. Facility-level adjustments involve the area wage index, rural location, teaching status, a cost-of-living adjustment for IPFs located in Alaska and Hawaii, and an adjustment for the presence of a qualifying emergency department (ED).

In order to bill for ECT services provided to IPF beneficiaries IPFs must include a valid procedure code; CMS reports that no changes were made to the ECT procedure codes as a result of the proposed update to the ICD-10-PCS code set for FY 2021. (The ECT procedure codes for FY 2021 are included in Addendum B; link provided on page 1 of this summary.)

Regulations pertaining to the IPF PPS are found in Subpart N of 42 CFR Part 412.

II. Provisions of the FY 2021 IPF Proposed Rule

A. Market Basket Update

In the FY 2020 final rule (84 FR 38426-38447), a rebased market basket was adopted using 2016 Medicare cost report data for both freestanding psychiatric hospitals and psychiatric units. For FY 2021, CMS proposes to update that 2016-based IPF market basket to reflect projected price increases according to the IHS Global Inc.'s (IGI) fourth quarter 2019 forecast with historical data through the third quarter of 2019. Using that forecast the 2016-based IPF market basket increase factor for FY 2021 is 3.0 percent.

The statute requires application of the multifactor productivity (MFP) adjustment that applies to the Inpatient Prospective Payment System (IPPS) for acute care hospitals. Using the same IGI forecast, the proposed MFP adjustment for FY 2021 (i.e., the 10-year moving average of MFP for the period ending FY 2021) is projected to be -0.4 percent. Therefore, CMS proposes a FY 2021 IPF PPS payment rate update of 2.6 percent (3.0 – 0.4 = 2.6). The final rule figures may change reflecting availability of more recent data. The MFP was discussed in the FY 2016 IPF PPS final rule (80 FR 46675).

For facilities that fail to meet requirements of the IPFQR Program for a fiscal year, the statute requires a reduction in the update factor that would otherwise apply of 2.0 percentage points. For FY 2021, the update factor for these facilities would be 0.6 percent (3.0 – 2.0 – 0.4 = 0.6).

B. Labor-Related Share

The area wage index adjustment is applied to the labor-related share of the standardized federal per diem base rate. The labor-related share is the national average portion of costs related to, influenced by, or varying with the local labor market, and is determined by summing the relative importance of labor-related cost categories included in the 2016-based market basket.[1]

For FY 2021, the proposed labor-related share based on IGI's fourth quarter 2019 forecast of the 2016-based IPF PPS market basket is 77.2 percent, a change from 76.9 percent for FY 2020. This figure may change in the final rule if more recent data become available.

C. FY 2021 Payment Rates

CMS determines the FY 2021 proposed rates by applying the market basket update factor (3.0 percent), the MFP (-0.4 percent), and the wage index budget neutrality adjustment (0.9979, as discussed in section II.E.3. below) to the final FY 2020 rates. As noted above, the update factor will be reduced by 2.0 percentage points for facilities that fail to meet the requirements of the IPFQR Program for FY 2021.

The table below compares the federal per diem base rate and the ECT payments per treatment proposed for FY 2021 to the final amounts for FY 2020. (The 2020 amounts are taken from Addendum A to the FY 2020 IFP PPS final rule.)

	Final FY 2020*	**Proposed FY 2021**
Federal per diem base rate	$798.55	$817.59
Labor share	*$614.08 (76.9%)*	*$631.18 (77.2%)*
Non-labor share	*$184.47 (23.1%)*	*$186.41 (22.8%)*
ECT payment per treatment	$343.79	$351.99
*Rates for IPFs that fail to meet the IPFQR Program requirements**:*		
Per diem base rate	$782.85	$801.65
Labor share	*$602.01 (76.9%)*	*$618.87(77.2%)*
Non-labor share	*$180.84 (23.1%)*	*$182.78 (22.8%)*
ECT payment per treatment	$337.03	$345.13
*The 2020 amounts are taken from Addendum A to the FY 2020 IFP PPS final rule, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools **Note that the FY 2021 rates for hospitals failing to meet the IPFQR Program requirements are calculated by multiplying the full rates for FY 2020 times the update factor and wage index budget neutrality factor.		

[1] The labor-related market basket cost categories are Wages and Salaries; Employee Benefits; Professional Fees: Labor-Related; Administrative and Facilities Support Services; Installation, Maintenance, and Repair; All Other: Labor-related Services; and a portion (46 percent) of the Capital-Related cost weight. The relative importance reflects the different rates of price change for these cost categories between the base year (FY 2016) and FY 2021.

D. Updates to the IPF PPS Patient-Level Adjustment Factors

Payment adjustments are made for the following patient-level characteristics: Medicare Severity Diagnosis Related Groups (MS–DRGs) assignment of the patient's principal diagnosis, selected comorbidities, patient age, and variable costs during different points in the patient stay. For FY 2021, CMS proposes to continue the existing payment adjustments with some updates, described briefly here. The referenced Addendum A and Addendum B are available through the link that appears on page 1 of this summary.

1. Update to MS-DRG Assignment

For FY 2021, CMS proposes to continue the existing payment adjustment for psychiatric diagnoses that group to one of the existing 17 IPF MS-DRGs listed in Addendum A. Psychiatric principal diagnoses that do not group to one of the 17 designated MS-DRGs would still receive the federal per diem base rate and all other applicable adjustments, but the payment would not include an MS-DRG adjustment.

The diagnoses for each IPF MS-DRG would be updated as of October 1, 2020, using the final IPPS FY 2021 ICD-10-CM/PCS code sets. CMS notes that the FY 2021 IPPS proposed rule includes tables of the proposed changes to the ICD-10-CM/PCS code sets which underlie the FY 2021 IPF MS-DRGs. (At the time this summary was prepared, the FY 2021 IPPS proposed rule had not been released.) The tables will be available on the CMS web page for the FY 2021 IPPS proposed rule.

CMS discusses the Code First policy which follows the ICD–10–CM Official Guidelines for Coding and Reporting, and notes that for FY 2021, there were 18 ICD-10-PCS codes deleted from the proposed IPF Code First table, which is shown in Addendum B (link on page 1 of this summary.) The Code First table was unchanged for FYs 2018, 2019 and 2020. Under the Code First policy, when a primary (psychiatric) diagnosis code has a ''code first'' note, the provider would follow the instructions in the ICD–10–CM text to determine the proper sequencing of codes.

2. Comorbidity Adjustment

The comorbidity adjustment provides additional payments for certain existing medical or psychiatric conditions that are secondary to the patient's principal diagnosis and are expensive to treat. Diagnoses that relate to an earlier episode of care and have no bearing on the current hospital stay are excluded and must not be reported on IPF claims. Comorbid conditions must exist at the time of admission or develop subsequently, and affect the treatment received, the length of stay, or both.

FY 2021, CMS proposes to continue to use the same 17 comorbidity adjustment factors in effect for FY 2020, which are found in Addendum A,

CMS has updated the ICD-10-CM/PCS codes associated with the existing IPF PPS comorbidity categories, based upon the proposed FY 2021 update to the ICD-10-CM/PCS code set. These updates include the addition of codes to the Drug and/or Alcohol Induced Mental Disorders and Oncology comorbidity categories and the addition and deletion of codes in the Infectious Disease, Poisoning, and Renal Failure comorbidity categories. These updates are detailed in Addendum B.

Under previously adopted policy, CMS reviewed all new FY 2021 ICD-10-CM codes to remove codes that were site "unspecified" in terms of laterality from the FY 2020 ICD-10-CM/PCS codes in instances where more specific codes are available. None of the proposed additions to the FY 2021 ICD-10-CM/PCS codes were site "unspecified" by laterality, therefore none are proposed for removal.

3. Age Adjustment

The current payment adjustments for age, which provide for increased payments ranging from an adjustment factor of 1.01 for patients age 45 to 50 to 1.17 for patients age 80 and older, would be continued for FY 2021 The age adjustments are shown in Addendum A.

4. Variable Per Diem Adjustments

The variable per diem adjustments recognize higher ancillary and administrative costs that occur disproportionately in the first days after admission to an IPF and are shown in Addendum A. For FY 2021, CMS proposes to continue the FY 2020 variable per diem adjustments. The adjustment is highest on day 1 of the stay and gradually declines through day 22. The day 1 adjustment factor is 1.31 if the IPF has a qualifying ED; otherwise the adjustment factor is 1.19. For days 22 and later the adjustment is 0.92. The qualifying ED adjustment is discussed in section II.C.6 below.

E. Updates to the IPF PPS Facility-Level Adjustments

Facility-level adjustments provided under the IPF PPS are for the wage index, IPFs located in rural areas, teaching IPFs, cost of living adjustments for IPFs located in Alaska and Hawaii, and IPFs with a qualifying ED.

1. Wage index adjustment

To recognize geographic variation in wages for the IPF PPS, CMS uses the pre-floor, pre-reclassified IPPS hospital wage data to compute the IPF wage index. It believes that IPFs generally compete in the same labor market as IPPS hospitals, and that the pre-floor, pre-reclassified IPPS hospital wage index to be the best available data to use as proxy for an IPF specific wage index. As to the time frame for the wage index data, beginning with FY 2020, CMS uses the IPPS wage index for the concurrent fiscal year. For example, the FY 2020 IPF wage index is based on the FY 2020 pre-floor, pre-reclassified IPPS hospital wage Index. (Previous policy was to use the IPPS wage index data for the prior fiscal year.)

The geographic areas used for the wage index are based on the Office of Management and Budget (OMB) Core Based Statistical Area (CBSA) delineations. These are generally subject to major revisions every 10 years to reflect information from the decennial census, but OMB also issues minor revisions in the intervening years through OMB Bulletins. When OMB changes delineations that modify the IPPS wage index, these changes are also adopted for purposes of the IPF wage index. The history of these changes to the IPF wage index is discussed in the proposed rule. For purposes of the IPF wage index, OMB-designated Micropolitan Statistical Areas[2] are considered to be rural areas. The OMB Bulletins are available at https://www.whitehouse.gov/omb/information-for-agencies/bulletins/.

For FY 2021, CMS proposes to modify the IPF wage index to reflect changes included in OMB Bulletin No. 18-04, issued on September 14, 2018 and to provide for a transition policy as detailed further below. CMS notes that on March 6, 2020, OMB issued OMB Bulletin 20-01, but it was not issued in time for development of this proposed rule. CMS does not believe that the minor updates included in that Bulletin would impact its proposed updates to the labor market area delineations. If needed, CMS will include any updates from that bulletin in any changes adopted in the FY 2021 final rule.

Adopting the revised delineations included in OMB Bulletin No 18-04 would change 34 urban counties and 5 providers from urban to rural; another 47 counties and 4 providers from rural to urban, and would shift some urban counties between existing and new CBSAs. Tables 1, 2 and 4 in the proposed rule detail the areas affected by these substantive changes. Table 3 identifies areas where only the CBSA name or number would change, without affecting assignment of a wage index.

Under the proposed transition policy, a 5 percent cap on decreases would apply to any IPF's wage index for FY 2021 when compared to FY 2020. It would be applied regardless of the reason for the wage index decline, that is, whether or not the decline was the result of changes to the wage area delineations. The cap would provide for what CMS refers to as a two-year transition to the new wage index areas. No cap would be applied in FY 2022.

CMS discusses alternative transition policies it considered, including a longer transition period and a blended wage index approach. CMS believes its proposal strikes the right balance between giving providers time to adapt to the changes while maintaining accuracy of the wage index. Further, it believes the proposal would be consistent with a similar cap on wage index decreases provided under the IPPS in FY 2020 and would be more transparent and less complex than calculating a blended wage index that in the end would only apply to areas experiencing a wage index decrease. **Comments are invited on the proposed implementation of the new OMB delineations and proposed transition methodology**

[2] OMB defines a Micropolitan Statistical Area as an area 'associated with at least one urban cluster that has a population of at least 10,000, but less than 50,000.

2. Adjustment for Rural Location

CMS proposes to continue the 17 percent adjustment for IPFs located in a rural area that has been part of the IPF PPS since its inception.

3. Wage Index Budget Neutrality Adjustment

Changes to the IPF PPS wage index are made in a budget neutral manner; CMS estimates the budget neutrality adjustment for FY 2021 to be 0.9979. To make this calculation, CMS estimates aggregate IPF PPS payments using the FY 2020 labor-related share and wage index values and the FY 2019 IPF PPS claims data and then estimates aggregate payments using the proposed FY 2021 labor share and wage index values and the same utilization data. The ratio of the amount based on the FY 2020 index to the amount estimated using the proposed 2021 index is the budget neutrality adjustment to be applied to the federal per diem base rate for FY 2021.

4. Teaching Adjustment

CMS proposes to continue for FY 2021 the coefficient value of 0.5150 for the teaching adjustment to recognize the higher indirect operating costs experienced by hospitals that participate in graduate medical education programs. The teaching adjustment formula follows, where ADC = average daily census.

$$1 + \left(\frac{Interns\ and\ Residents}{ADC}\right) \text{^}0.5150$$

For example, the teaching adjustment for an IPF with a ratio of interns and residents to ADC of 0.2 equals 1.098. This adjustment is applied to the federal per diem base rate.

5. Cost of Living Adjustment for Alaska and Hawaii

The proposed IPF PPS cost of living adjustment (COLA) factors for Alaska and Hawaii in FY 2021 are unchanged from FY 2020, and are shown in Addendum A. The adjustment is 1.25 for all areas except the county of Hawaii, for which the adjustment is 1.21.

6. Adjustment for IPFs with a Qualifying ED

The IPF PPS includes a facility-level adjustment for IPFs with qualifying EDs, which is applied through the variable per diem adjustment described in section II.B.4 above. The adjustment applies to a psychiatric hospital with a qualifying ED or an IPPS-excluded psychiatric unit of an IPPS hospital or critical access hospital (CAH), and is intended to account for the costs of maintaining a full-service ED. This includes costs of preadmission services otherwise payable under the Medicare Hospital Outpatient Prospective Payment System that are furnished to a beneficiary on the date of the beneficiary's admission to the hospital and during the day immediately preceding the date of admission to the IPF, and the overhead cost of maintaining the ED.

As described in section II.B.4 above, the ED adjustment is incorporated into the variable per diem adjustment for the first day of each stay. Those IPFs with a qualifying ED receive a variable per diem adjustment factor of 1.31 for day 1; IPFs that do not have a qualifying ED receive a first-day variable per diem adjustment factor of 1.19.

With one exception, this facility-level adjustment applies to all admissions to an IPF with a qualifying ED, regardless of whether the patient receives preadmission services in the hospital's ED. The exception is for cases when a patient is discharged from an IPPS hospital or CAH and admitted to the same IPPS hospital's or CAH's excluded psychiatric unit. The adjustment is not made in this case because the costs associated with ED services are reflected in the DRG payment to the IPPS hospital or through the reasonable cost payment made to the CAH. In these cases, the IPF receives the day 1 variable per diem adjustment of 1.19.

F. Other Proposed Payment Adjustments and Policies

The IPF PPS provides for outlier payments when an IPF's estimated total cost for a case exceeds a fixed dollar loss threshold amount (multiplied by the IPF's facility-level adjustments) plus the federal per diem payment amount for the case. For qualifying cases, the outlier payment equals 80 percent of the difference between the estimated cost for the case and the adjusted threshold amount for days 1 through 9 of the stay, and 60 percent of the difference for day 10 and thereafter. The differential in payment between days 1 through 9 and 10 and above is intended to avoid incenting longer lengths of stay.

For FY 2021, CMS proposes to continue to set the fixed dollar loss threshold amount at a level such that outlier payments would account for 2 percent of total payments made under the IPF PPS. Based on an analysis of the latest available data (the December 2019 update of FY 2019 IPF claims) and rate increases, CMS estimates that for FY 2020 IPF outlier payments will be 2.2 percent of total payments. Therefore, CMS proposes to increase the outlier threshold amount to $16,520 from the FY 2020 level of $14,960 in order to maintain estimated outlier payments at 2 percent of estimated aggregate IPF PPS payments for FY 2021.

In estimating the total cost of a case for comparison to the outlier threshold amount, CMS substitutes the national median urban or rural CCR if the IPF's CCR exceeds a ceiling that is equal to the 3 times the standard deviation from the appropriate (i.e., urban or rural) geometric mean CCR. The national median also applies to new IPFs and those for which the data are inaccurate or incomplete. CMS proposes to update these amounts for FY 2021 as shown in the table below, which also appears in Addendum A.

National Median and Ceiling Cost-to-Charge Ratios (CCRs)

CCRs	**Rural**	**Urban**
National Median	0.5720	0.4280
National Ceiling	1.9572	1.7387

III. Update on IPF PPS Refinements

As noted earlier, the IPF PPS adjustments are based on analyses conducted when the program was implemented for 2005, based on MedPAR data from FY 2002. CMS has previously determined that it would make refinements to the IPF PPS once it has completed a thorough analysis of IPF PPS data that include as much information as possible regarding the patient-level characteristics of the population that each IPF serves. It has begun and will continue these analyses with the intention of refining the IPF PPS adjustments in the future, as appropriate. CMS reviews concerns about variation in IPF cost and claims data, particularly related to labor costs, drugs costs, and laboratory services, and its efforts to improve IPF cost reports with respect to ancillary costs.

IV. Regulatory Impact Analysis

CMS estimates that payments to IPF providers for FY 2021 would increase by $100 million under the proposed rule. This reflects an estimated $110 million increase from the update to the payment rates and a $10 million decrease resulting from the updated outlier threshold amount. Reduced payments associated with the required 2.0 percentage point reduction to the market basket increase factor for any IPF that fails to meet the IPFQR Program requirements are not included in the estimate.

Table 6 in the proposed rule, reproduced below, shows the estimated effects of the propose rule policies by type of IPF.

TABLE 6: FY 2021 IPF PPS Proposed Payment Impacts
[Percent Change in Columns 3 through 6]

Facility by Type	Number of Facilities	Outlier	Wage Index FY21	Wage Index FY21 New CBSA and 5% Loss Cap	Total Percent Change[1]
(1)	(2)	(3)	(4)	(5)	(6)
All Facilities	1,565	-0.2	0.0	0.0	2.4
Total Urban	1,255	-0.2	0.0	0.0	2.4
Urban unit	770	-0.3	0.0	0.1	2.3
Urban hospital	485	-0.1	0.0	-0.1	2.4
Total Rural	310	-0.1	-0.1	0.1	2.5
Rural unit	246	-0.2	-0.1	0.0	2.2
Rural hospital	64	0.0	0.1	0.4	3.1
By Type of Ownership:					
Freestanding IPFs					
Urban Psychiatric Hospitals					
Government	118	-0.3	0.3	0.0	2.6
Non-Profit	96	-0.1	0.0	-0.2	2.3
For-Profit	271	0.0	0.0	-0.1	2.5

Facility by Type	Number of Facilities	Outlier	Wage Index FY21	Wage Index FY21 New CBSA and 5% Loss Cap	Total Percent Change[1]
Rural Psychiatric Hospitals					
Government	32	-0.1	-0.2	0.1	2.5
Non-Profit	14	-0.1	0.5	2.7	5.8
For-Profit	18	0.0	0.2	-0.1	2.8
IPF Units					
Urban					
Government	111	-0.5	0.1	0.3	2.5
Non-Profit	504	-0.3	-0.1	0.1	2.3
For-Profit	155	-0.1	0.0	-0.1	2.3
Rural					
Government	66	-0.1	-0.3	0.0	2.2
Non-Profit	134	-0.3	0.1	-0.1	2.3
For-Profit	46	-0.1	-0.4	-0.1	2.0
By Teaching Status:					
Non-teaching	1,371	-0.2	0.0	-0.1	2.4
Less than 10% interns and residents to beds	108	-0.3	0.0	0.5	2.8
10% to 30% interns and residents to beds	65	-0.5	0.0	0.2	2.3
More than 30% interns and residents to beds	21	-0.7	0.3	0.0	2.2
By Region:					
New England	106	-0.2	-1.0	-0.1	1.3
Mid-Atlantic	221	-0.3	0.5	0.5	3.3
South Atlantic	243	-0.1	0.1	0.0	2.5
East North Central	262	-0.2	0.0	-0.1	2.3
East South Central	156	-0.1	0.0	-0.1	2.4
West North Central	115	-0.2	-0.5	-0.1	1.8
West South Central	229	-0.1	0.0	-0.1	2.4
Mountain	106	-0.1	-0.5	-0.1	1.9
Pacific	127	-0.3	0.4	-0.1	2.6
By Bed Size:					
Psychiatric Hospitals					
Beds: 0-24	87	-0.2	0.2	0.0	2.6
Beds: 25-49	83	0.0	0.2	-0.1	2.7
Beds: 50-75	87	0.0	-0.1	-0.1	2.3
Beds: 76 +	292	-0.1	0.1	-0.1	2.5
Psychiatric Units					
Beds: 0-24	569	-0.3	-0.1	0.0	2.1
Beds: 25-49	265	-0.2	-0.1	-0.1	2.2
Beds: 50-75	115	-0.3	-0.1	0.1	2.3
Beds: 76 +	67	-0.4	0.3	0.6	3.0

[1] This column includes the impact of the updates in columns (3) through (5) above, and of the IPF market basket increase factor for FY 2021 (3.0 percent), reduced by 0.4 percentage point for the productivity adjustment as required by section 1886(s)(2)(A)(i) of the Act.