American Hospital Association

Regulatory Advisory

February 7, 2006

THE INPATIENT PSYCHIATRIC FACILITIES PPS: PROPOSED RATE YEAR 2007 RULE

AT A GLANCE

The Issue:

On Jan. 23, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* the Medicare inpatient psychiatric facilities (IPF) prospective payment system (PPS) proposed rule for rate year (RY) 2007. It would make updates to the payment rates, diagnosis-related groups, labor market areas and outlier fixed-loss threshold amount, among other policies, and can be viewed at: www.access.gpo.gov/su_docs/fedreg/a060123c.html. In addition, on Feb. 2, CMS released corrections to address errors in the proposed rule. Relevant corrections are noted in this advisory. A final rule will be published this spring with an effective date of July 1. Comments are due to CMS by March 14.

Our Take:

This proposed rule makes routine updates to the IPF PPS and includes few policy changes of note. The AHA will submit comments on certain aspects of the proposed rule, but has no major concerns.

What You Can Do:

Share this advisory with your senior management team, chief financial officer and key physician leaders, and consider submitting a comment letter to CMS. The AHA's letter will be posted on the AHA Web site to assist you if you choose to submit comments. Comments are due to CMS by March 14 and can be submitted electronically at: www.cms.hhs.gov/eRulemaking (attachments should be in Microsoft Word, WordPerfect, or Excel; however, CMS prefers Microsoft Word). Written comments (an original and two copies) may be submitted to:

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS –1306 – P
P.O. Box 8010
Baltimore, MD 21244

Further Questions:

Contact Danielle Lloyd, AHA senior associate director of policy, at (202) 626-2340 or dlloyd@aha.org.

AHA's Regulatory Advisories are produced whenever there are significant regulatory developments that affect the job you do in your community. A 5-page, in-depth examination of this issue follows.

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BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) published in the Jan. 23 *Federal Register* the Medicare inpatient psychiatric facilities (IPF) prospective payment system (PPS) proposed rule for rate year (RY) 2007. This is the first update to the new IPF PPS, which began in January of 2005. It proposes updates to the payment rates, diagnosis-related groups (DRGs), labor market areas and outlier fixed-loss threshold amount, among other policies. The proposed rule is available at: www.access.gpo.gov/su_docs/fedreg/a060123c.html. In addition, on Feb. 2, CMS released corrections to address errors in the proposed rule. Relevant corrections are noted in this advisory. A final rule will be published this spring with an effective date of July 1. Comments are due to the agency by March 14.

AT ISSUE

Transition Period

As previously established, CMS is phasing in the new IPF PPS over a three-year period. For cost-reporting periods that began during calendar year (CY) 2005, the payment blend was 75 percent of the current facility-specific payment rate (TEFRA) and 25 percent of the IPF PPS payment rate. For CY 2006, the blend is 50 percent of each, while in CY 2007 the blend will be 25 percent of the TEFRA payment rate and 75 percent of the IPF PPS payment rate. As of Jan. 1, 2008, payment will be based entirely on the IPF PPS. To minimize the effects on providers whose payments would be negatively affected, no providers will be allowed to proceed to the full IPF PPS before the end of the transition period.

Market Basket

Revised market basket. CMS proposes to implement a rehabilitation, psychiatric and long-term care hospital, or "RPL", market basket index, a measure of inflation based on 2002 data for the RY 2007 PPS-based portion of payments. CMS historically has used the inpatient-excluded hospital market basket, which also includes cancer and children's hospitals. However, these provider types are still paid based on costs and consequently have cost structures that differ from providers that have transitioned to prospective payment system. Thus, CMS believes that a separate market basket index is appropriate and is combining the rehabilitation, psychiatric and long-term care hospital market basket indices because it believes there is not enough of each of the three provider types to construct individual indices that are reliable and stable.

The RPL market basket would update the PPS portion of payments, while the inpatient-excluded hospital market basket would update the TEFRA portion of payments. CMS analyses demonstrate that, historically, the new RPL market basket would have closely tracked the excluded hospital market basket. In fact, for RY 2007, the rate of increase for both is estimated to be 3.6 percent. However, because CMS is moving from a calendar year to a rate year, the estimated market basket rate of increase would be 4.7 percent, to account for the longer time period. After adjustments for budget neutrality, the average increase in payments is estimated to be 4.2 percent.

Payment rates. As a result of the inflationary update, CMS proposes to raise the per-diem rate, which includes both operating and capital-related costs, to $594.66 from $575.95 in RY 2006.

Labor-related share. The change in the market basket methodology also will result in a new labor-related share, the portion of the base rate that is attributable to wages and wage-related costs and is adjusted by the wage index. CMS proposes a labor-related share of 75.923 percent (compared to 72.027 under the excluded market basket). This change will help hospitals or units with area wage indices over 1.0, and hurt those with indices below 1.0.

Wage Index

The wage index adjusts payments to reflect the differences in labor costs across geographic areas. CMS proposes to base the RY 2007 IPF PPS wage index on the fiscal year (FY) 2006 inpatient pre-floor, pre-reclassification wage index.

New hospital labor markets. The FY 2006 inpatient wage index incorporates the Office of Management and Budget's revised standards defining Metropolitan Statistical Areas (MSAs), based on the 2000 census data, including its new definitions of Core-Based Statistical Areas (CBSA).

In FY 2005, CMS provided a blend of wage indices – 50 percent of the former MSA and 50 percent of the new CBSA – to those inpatient PPS hospitals that

would have experienced a drop in their wage index because of the adoption of the new labor market areas. As of FY 2006, inpatient hospitals are receiving 100 percent of their wage index based on the new CBSA configurations. For the IPF PPS, CMS is proposing to fully implement the new labor market definitions. CMS asserts that a blend of payments similar to that implemented under the inpatient PPS is unnecessary under the IPF PPS because the TEFRA portion of the payments is not wage adjusted.

Hold-harmless for certain urban hospitals re-designated as rural. By adopting the new CBSAs in FY 2005, a small number of hospitals that were classified as urban in FY 2004 under the inpatient PPS became classified as rural. Because moving from an MSA to the rural statewide average would have resulted in a significant decline in these hospitals' inpatient wage indices, CMS implemented a three-year transition period (FYs 2005-2007) to allow them time to seek geographic reclassification. However, CMS does not propose implementing this hold-harmless provision under the IPF PPS because the rural adjustment is likely to be more favorable than retaining the urban designation. Furthermore, reclassification is not available under the IPF PPS.

Payment Adjustments

CMS is not proposing significant changes to the payment adjustments in RY 2007, as it plans to wait until at least one year's worth of claims and cost report data are available. As a result, adjustments will remain the same for age, DRG, comorbidity, variable per diem, emergency department, rural and teaching until at least RY 2008. However, it will update a few adjustments, as described below.

Diagnosis-related groups. The proposed rule would incorporate the changes in coding and DRG classifications that were adopted in the inpatient PPS final rule for FY 2006.

Emergency department. Currently, hospitals that operate 24-hour, full-service emergency departments (EDs) receive a payment increase of 12 percent for the first day of treatment (a 31 percent increase in total versus the 19 percent hospitals without EDs receive). CMS adjusts for the presence of an ED, rather than for admissions made through the department, because it does not want to create an incentive to admit patients in this manner to receive higher payments.

This adjustment does not apply when the patient is transferred from an acute-care unit, as DRG payments capture the costs associated with maintaining an ED. Thus, CMS notifies the field in this proposed rule that there is a new code for "source of admission." The National Uniform Billing Committee has approved the code "D" to indicate that a patient has been transferred from the same hospital into the psychiatric unit. CMS proposes to stop paying the ED adjustment in these instances. If a patient is transferred from a different hospital into a psychiatric unit of a hospital that has a full-service ED, then code "4" would be used and the ED adjustment would be paid.

Cost of living adjustment. While the cost of living adjustments for Hawaii and Alaska will not change for RY 2007, CMS plans to update the adjustment as newer data become available from the Office of Personnel Management.

Electro-convulsive therapy. Additional payment is provided for each treatment of electroconvulsive therapy (ECT) services to help cover the higher costs of caring for these patients. CMS proposes to increase the payment rate for ECT in RY 2007 to $254.86 (instead of the erroneous rate of $268.21 published in the *Federal Register*) based on the latest hospital median cost data. Note that claims must include revenue code 901, procedure code 94.27, the date of the patient's last ECT treatment, and the number of units of treatment in order to receive additional payment.

Outlier payments. Currently, outlier payments are made for discharges in which estimated costs exceed a fixed-loss threshold amount ($5,700 multiplied by the IPF facility adjustments in RY 2006) plus the total PPS payment amount for the discharge. Two marginal cost ratios are applied to the difference between the computed cost of the discharge and the threshold: 80 percent for the first nine days of the stay and 60 percent applied to day 10 and any additional days thereafter. In the proposed rule, CMS raises the outlier fixed-dollar loss threshold amount to $6,200 to ensure that is does not spend more than the 2 percent of total payments set aside for such cases.

Comorbidities. In Table 11 of the Jan. 23 *Federal Register* notice, which includes the adjustment factors for comorbidity categories, CMS published an incorrect adjustment factor of 1.11 for Severe Musculoskeletal and Connective Tissue Diseases. The correct factor is 1.09, as published in the Comorbidity Adjustments table in Addendum A.

Physician Certification

During the first year of the PPS, CMS required physician certification of medical necessity upon admission and again by day 18. However, there has been significant confusion regarding the conditions of participation for inpatient acute-care facilities versus inpatient psychiatric facilities. In the proposed rule, CMS would make the physician certification requirements consistent between the two. Thus, physician certification would be required at admission (or shortly thereafter), and recertification would be required on day 12. Subsequent recertification would be required depending on the recommendation of the hospital utilization review committee.

Stop-Loss Provision

As recommended by the AHA in last year's final rule, CMS developed a stop-loss protection for hospitals or units that experience extreme losses. The provision will continue to apply to facilities with PPS payments that are less than 70 percent of their original TEFRA payments upon cost settlement.

Financial Impact on Hospitals

Including policy changes, IPFs will receive, on average, 4.2 percent more in payments, or approximately $170 million, in RY 2007. The table illustrates the impact of the rule by type of hospital, including the effects of transitioning from the 75 percent TEFRA/25 percent PPS blend to a 50 percent blend of both payment rates.

Provider Type	Increase in Payments
All Facilities	4.2%
Freestanding government owned	15.7%
Freestanding non-profit	6.1%
Freestanding for-profit	8.9%
Hospital-based unit	2.5%
Rural	3.0%
Urban	4.3%

NEXT STEPS

Comments

Although we have no major concerns with the proposed RY 2007 IPF PPS rule, the AHA will submit comments to CMS, and we recommend you do as well. Watch for a sample letter, to be posted on the AHA Web site, to assist you in preparing your comments. All comments are due to CMS by March 14.

Comments may be submitted electronically at: www.cms.hhs.gov/eRulemaking (attachments can be in Microsoft Word, WordPerfect, or Excel; however, CMS prefers Microsoft Word).

You may also submit written comments (an original and two copies) to:

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