American Hospital Association

Regulatory Advisory

May 16, 2006

THE INPATIENT PSYCHIATRIC FACILITIES PPS: FINAL RATE YEAR 2007 RULE

AT A GLANCE

The Issue:

On May 9, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* the Medicare inpatient psychiatric facilities (IPF) prospective payment system (PPS) final rule for rate year (RY) 2007. The rule affects roughly 1,800 facilities. Provisions include a market basket update of 4.5 percent, as well as updates to the payment rates, diagnosis-related groups, labor market areas and outlier fixed-loss threshold amount. The final rule can be viewed at: www.access.gpo.gov/su_docs/fedreg/a060509c.html. Changes will take effect July 1.

Our Take:

The final rule makes routine updates to the IPF PPS and includes few policy changes of note. In comments on the proposed rule, the AHA had urged CMS to wait until it can review 2005 claims before raising the outlier threshold. We also asked for a three-year hold-harmless provision for rural hospitals that will be reclassified as urban under the new Core-Based Statistical Areas because these areas will be negatively affected by the loss of the 17 percent rural adjustment. However, CMS did not adopt these changes in the final rule.

What You Can Do:

Share this advisory with your senior management team, chief financial officer and key physician leaders in preparation for the changes becoming effective on July 1.

Further Questions:

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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

On May 9, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* the Medicare inpatient psychiatric facilities (IPF) prospective payment system (PPS) final rule for rate year (RY) 2007. It makes updates to the payment rates, diagnosis-related groups (DRGs), labor market areas and outlier fixed-loss threshold amount, among other policies, and can be viewed at: www.access.gpo.gov/su_docs/fedreg/a060509c.html. Changes become effective July 1.

AT ISSUE

Transition Period

As previously established, CMS will phase 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 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 January 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 will implement the new 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 systems. 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 will update the PPS portion of payments, while the inpatient-excluded hospital market basket will continue to update the TEFRA portion of payments. CMS analyses demonstrate that, historically, the new RPL market basket would have tracked closely with the excluded-hospital market basket. In fact, for RY 2007 the rate of increase for both is estimated to be 3.4 percent. However, because CMS is moving from a calendar year to a rate year, the estimated market basket rate of increase will be 4.5 percent to account for the longer time period. After policy changes and adjustments for budget neutrality are made, the average increase in payments is estimated to be 4.0 percent.

Payment rates. In setting the federal per-diem rate last year, CMS inadvertently miscoded most teaching hospitals, which lead to higher-than-anticipated spending in RY 2006. To correct for this prospectively, CMS will adjust last year's federal per-diem rate downward and then apply the 4.5 percent market basket to arrive at the fiscal year (FY) 2007 per-diem rate. Had the teaching hospitals been correctly coded last year, the federal per-diem base rate would have been $568.17 rather than $575.95. Thus, the market basket will be applied to $568.17, resulting in a federal per-diem rate of $595.09 for RY 2007. Note that CMS is not making any retroactive changes to payment to correct for this error.

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 set the labor-related share at 75.66 percent (compared to 72.027 percent under the excluded market basket for RY 2006). This change will benefit hospitals or units with area wage indices over 1.0 and negatively impact those with indices below 1.0.

Wage Index

The wage index adjusts payments to reflect the differences in labor costs across geographic areas. CMS will base the RY 2007 IPF PPS wage index on the 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 indices 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, the agency will fully implement the new labor market definitions in RY 2007. CMS asserts that a blend of payments similar to that implemented under the inpatient PPS is unnecessary under the IPF PPS because payments are already being blended during the transition, and the TEFRA portion of payments is not wage adjusted.

Hold-harmless for certain urban hospitals re-designated as rural. By adopting the new CBSAs, a small number of hospitals that were classified as rural in RY 2006 under the IPF PPS now will be classified as urban. Because these hospitals will lose the 17 percent rural adjustment to the PPS portion of payments, the AHA asked that CMS implement a three-year hold-harmless provision. This would have been similar to the hold-harmless provision established under the inpatient PPS for rural hospitals that became urban resulting in a significant drop in their wage indices. However, CMS did not adopt the recommended change in the final rule.

Payment Adjustments

CMS will not make 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 final rule incorporates 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 total increase versus 19 percent for hospitals without EDs). CMS adjusts for the presence of an ED, rather than for admissions made through the department, to avoid creating 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 inpatient DRG payments capture the costs associated with maintaining an ED. Thus, in this final rule CMS notifies the field of 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 will not pay 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" will be used and the ED adjustment will be paid.

Cost of living adjustment. The cost of living adjustments for Hawaii and Alaska will not change for RY 2007. However, 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 electro-convulsive therapy (ECT) services to help cover the higher costs of caring for these patients. CMS will increase the payment rate for ECT in RY 2007 to $256.20 from $247.96. While CMS had proposed to calculate the ECT rate based on the latest hospital median cost data adjusted by the budget neutrality factors, CMS instead decided to use the 2005 IPF PPS rates updated by market basket to establish the RY 2007 rates. This methodology is more consistent and predictable. Note that in order to receive additional payment, 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.

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. For RY 2007, CMS will raise the outlier fixed-dollar loss threshold amount to $6,200 to ensure that it will not spend more than the 2 percent of total payments set aside for such cases. The AHA remains very concerned that CMS will not spend the full 2 percent set aside due to shortcomings in the methodology.

Physician Certification

During the first year of the PPS, CMS required physician certification of medical necessity upon admission and recertification by day 18. However, there has been confusion regarding the conditions of participation for inpatient acute-care facilities versus inpatient psychiatric facilities. In the final rule, CMS adopts a proposal to make the physician certification requirements consistent between the two. Thus, physician certification will be required at admission (or shortly thereafter), and recertification will be required by day 12. The timing of subsequent recertification will depend 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, 4.0 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	4.0%
Freestanding government-owned	15.6%
Freestanding non-profit	6.0%
Freestanding for-profit	8.7%
Hospital-based unit	2.3%
Rural	3.2%
Urban	4.1%

NEXT STEPS

Comments

Changes become effective July 1. We recommend you share this advisory with your IPF members as soon as possible in preparation.