The Centers for Medicare & Medicaid Services (CMS) April 27 issued a proposed rule for the inpatient psychiatric facility (IPF) prospective payment system (PPS) for fiscal year (FY) 2019. CMS will accept comments on this rule through June 26. Key takeaways from the rule follow.

**Proposed IPF PPS Payment Provisions**
- CMS estimates IPF payments to increase by 0.98 percent, equivalent to $50 million, in FY 2019.
- The 0.98 percent payment update is a reflection of a 2.8 percent market basket update minus the productivity adjustment of 0.80 percent, the 0.75 percent reduction mandated by the Affordable Care Act, and a 0.27 percent outlier fixed-dollar loss threshold amount.
- The resulting labor-related share for FY 2019 would be 74.9 percent.
- CMS proposes to update the federal per diem base rate to $782.01 (an increase from the previous rate of $771.35).

**Proposed IPF Quality Reporting Program (IPFQR) Provisions**
CMS provides background on its Meaningful Measures initiative, wherein the agency is reviewing measures currently in use in the various quality reporting programs to determine how to reduce burden on providers and the agency itself by streamlining reporting requirements. In this rule, CMS reviews the criteria it uses to evaluate measures for removal on a case-by-case basis, and proposes to add an additional criterion: a measure may be considered for removal if the costs (i.e., administrative burden, compliance, duplication of efforts, and government maintenance of measure) outweigh the benefits to patients.

CMS proposes to remove eight measures from the IPQFR. These measures and the rationale for their removal include:

- **Influenza Vaccination Coverage Among Healthcare Personnel:** information collection for this measure is burdensome, as it requires registration and use of the National Healthcare Safety Network (NHSN) system, which is not used by IPFs for any other measure.
- **Alcohol Use Screening (SUB-1):** CMS is moving away from using chart-abstracted measures; in addition, IPFs routinely demonstrate high performance on this measure and are likely to continue to provide this screening without the measure.
• Tobacco Use Screening (TOB-1): IPF performance is uniformly high and unvarying (the measure is “topped out”).
• Hours of Physical Restraint Use (HBIPS-2): CMS monitors the use of physical restraints in several other ways, including surveys regarding compliance with Medicare’s Conditions of Participation, rendering this measure unnecessary as it only addresses one element of the approach to minimize the use of physical restraint.
• Hours of Seclusion Use (HBIPS-3): Same rationale as for previous measure.
• Tobacco Use Treatment Provided or Offered at Discharge and Tobacco Use Treatment at Discharge (TOB-3 and TOB-3a): The same data that is reported for this measure is captured in the required transition record received by discharged patients, rendering it duplicative.
• Use of an Electronic Health Record (EHR): This structural measure only assesses whether EHR technology is used, not whether patient outcomes improve; in addition, performance has been static for the past two program years.
• Assessment of Patient Experience of Care: Similar rationale as for previous measure; this measure was originally intended to inform future development of experience of care measures, and CMS believes it has collected enough information from this measure.

Removing these eight measures would leave the IPFQR with 10 measures. CMS is engaging with a multi-stakeholder group to begin the development of new quality measures. Topics for new quality measures include but are not limited to standardized depression assessments (e.g. PHQ-9) and patient-reported outcome measures on change in function.

CMS proposes to no longer require non-measure data (i.e., sample size counts for measures for which sampling is performed) beginning with data reported during the summer of calendar year 2019 (FY 2020 payment determination).

Other Provisions
• CMS is releasing a Request for Information (RFI) to obtain feedback on solutions to better achieve interoperability of healthcare data between providers. Specifically, CMS is asking for feedback regarding the possibility of revising Conditions of Participation as a way to increase sharing of electronic data.
• CMS proposes to update out-of-date regulation language, including replacing references to ICD-9 with ICD-10. These updates will not change any policies.
• CMS requests public comment on differences in IPF costs, patient mix, and provision of drugs and lab services to better inform the refinement process.

Next Steps
The AHA will be submitting comments on CMS’s proposed rule. Contact Caitlin Gillooley, AHA associate director, at 202-626-2267 or cgillooley@aha.org, with any questions.