

Medicare Program; Inpatient Psychiatric Facilities PPS Proposed Payment Update: RY 2007; Beginning July 1, 2006

Provisions of the Proposed Rule (p. 164)

CMS Proposes the Following:

- Changes are applicable to IPF discharges occurring during the rate year beginning July 1, 2006 through June 30, 2007.
- Proposing to adopt the labor market area definitions, which may have significant impact of the wage index applied to IPFs & associated payments. Proposing other new policies and making changes to existing ones
- To update payments for IPF facilities using a market basket reflecting the operating and capital cost structures for the RPL market basket.
- To develop cost weights for benefits, contract labor, and blood and blood products using the FY 2002-based IPPS market.
- To provide weights and proxies for the FT 2002-based RPL market basket.
- To indicate the methodology for the capital portion of the FY 2002-based RPL market basket.
- To update the outlier threshold amount to maintain total outlier payments at 2% of total estimated payments.
- To use source code "D" to identify IPF patients who have been transferred to the IPF from the same hospital or CAH.
- To retain the 17% adjustment for IPFs located in rural areas, the 1.31 adjustment for IPFs with qualifying ED, the 0.5150 teaching adjustment to the Federal per diem base rate, and the DRG adjustment factor currently being paid to IPFs for discharges occurring during RY 2007.
- To update the payment rate for ECT
- To update the DRG listing and comorbidity categories to reflect the ICD-9-CM revisions effective October 1, 2005
- See page 165-168 for specific text revisions

II. Overview for Updating the IPF PPS

1. Proposed Updates to the IPF PPS (p. 16)

CMS is not adopting the new labor market definitions (developed by OMB & adopted by IPPS), rather they intend to use the MSAs developed by OMB in 1993 for the wage index under IPF PPS. *CMS believes that the adoption of the new labor market area definitions may have significant impact on the wage index applied to IPFs and associated payments. CMS will assess the implications of the new MSA definitions on IPFs before proposing to adopt them.* (p.17)

2. Transition Period for Implementation of the IPF PPS (p. 17)

For the 2nd Transition year, beginning January 1, 2006, the TEFRA Rate percentage is 50% and the IPF PPS Federal Rate Percentage is also 50%. For the 3rd Transition year, beginning January 1, 2007, the TEFRA Rate percentage is **25%** and the IPF PPS Federal Rate percentage is **75%**. *Note: The payment update CMS is proposing would be effective for discharges occurring on or after July 1, 2006 through June 30, 2007. There are **no new proposals to the transition approach** established in the IPF PPS final rule.*

III. Proposed Updates to the IPF PPS: RY 2007

Revision of Standardization Factor (p. 26)

Issue: The computer code incorrectly assigned non-teaching status to most teaching facilities when it simulated the IPF PPS payments used for the final rule, therefore, total IPF PPS payments were **underestimated** by **1.36%**. This incorrect estimated payment total was used in calculating the IPF PPS standardization factor, which indicates the proportion by which the IPF PPS per diem payment rate and the ECT rate must be reduced in order to make total IPF PPS payments equal to estimated total TEFRA payments (assuming IPFs continued to be paid solely under TEFRA for the first PPS payment year. The per diem rate and the ECT rate should have been reduced by **0.8254** instead of 0.8367.

Resolution: CMS proposes to amend the Federal per diem base rate using the standardization factor of **0.8254**; the base rate should have been **\$568.17** for the implementation year of the IPF PPS. It is this base rate that CMS is proposing to update using the market basket rate of increase of **4.5%** and the budget neutral wage index factor of **1.00156**. Applying these factors yields a proposed Federal per diem base rate of **\$594.66** for RY 2007. (p. 27)

Update of the Federal per Diem Base Rate (p. 27)

Market Basket for IPFs Reimbursed under the IPF PPS; Proposed IPF Market Basket Index

CMS proposes to update PPS payments using a RPL market basket- excluding children's and cancer hospitals. CMS also proposes to rebase and revise the market basket used to update the IPF PPS. P.31

Proposed Methodology for Operating Portion of the RPL Market Basket (p. 31)

CMS proposes to limit our sample to hospitals with a Medicare average length of stay (LOS) within a comparable range of the total facility average LOS.

CMS is proposing to use those cost reports for IRFs and LTCHs whose Medicare average LOS is within 15% (higher or lower) of the total facility average LOS for the hospital. They propose 15% because it includes those LTCHs and IRFs whose Medicare LOS is within approximately 5 days of the facility LOS. However they are proposing to use a less stringent measure of Medicare LOS for IPFs whose average LOS is within 30 or 50% of the total facility average LOS. By using this less stringent edit, it allows CMS to increase their sample size by over 150 cost reports and produce a cost weight more consistent with the overall facility. (p. 33)

On page 36, Table 2 summarizes the choice of the proxies we propose to use for the operating portion of the market basket. On page 56, Table 3 illustrates the proposed CMS FY 2002- based RPL Market Basket Capital Vintage Weights

The proposed rate year, (beginning July 1, 2006) update for the IPF PPS using the proposed FY 2002-based RPL market basket and Global Insight's 3rd quarter 2005 forecast would be **4.5%**. This reflects increases in both the operating and capital portions of the market basket from the 18-month period (January 1, 2005 through June 30, 2006)

Proposed Labor-Related Share (p. 58)

Due to the variations in costs and geographic wage levels, CMS proposes that payment rates under the IPF PPS continue to be adjusted by a geographic wage index. This wage index would apply to the labor-related portion of the proposed Federal per diem base rate.

The proposed labor-related share for RY 2007 would be the sum of the proposed RY 2007 relative importance of each labor-related cost category, and would reflect the different rates of price change for these cost categories between the base year (FY 2002) and RY 2007. The sum of the proposed relative importance for RY 2007 for operating costs would be **71.845**. The portion of capital that is influenced by the local labor market would be estimated to be **46%**. Since the relative importance for capital would be **8.866%** (RY 2007) of the proposed FY 2002-based RPL market basket in RY 2007, CMS is proposing to take **46%** of 8.866% to determine the proposed labor-related share of capital for RY 2007. The result would be **4.078%**, which will be added to **71.845%** for the operating cost amount to determine the total proposed labor-related share for RY 2007. Therefore, the labor-related share proposed to use for IPF PPS in RY 2007 would be **75.923%**.

On page 60, Table 5 illustrates the proposed RY 2007 relative importance labor-related share using the proposed FY 2002-based RPL market basket and the FY 1997-based excluded hospital with capital market basket. Note: the revised and rebased labor-related share would benefit those hospitals with a wage index greater than or equal to 1.0.

IPFs Paid based on a Blend of the Reasonable Cost-based Payment (p. 61)

The reasonable cost-based payments, subject to TEFRA limits, are determined on a FY basis. For purposes of the update factor for FY 2006, the portion of the IPF PPS transitional blend payment based on reasonable costs was determined by updating the IPF's TEFRA limit by the FY 2002-based excluded hospital market basket (3.8%)

IV. Update of the IPF PPS Adjustment Factors

Proposed Patient-Level Adjustment (p. 66)

CMS provided payment adjustments for the following payment-level characteristics in the IPF PPS final rule: DGR assignment for the patient's principal diagnosis, selected comorbidities, patient age, and variable per diem adjustments.

Proposed Adjustment for DRG Assignment

IPFs that are distinct part psychiatric units of acute care hospitals and CAHs may only admit patients who have a principal diagnosis in the DMS-IV-TR.

Only claims with diagnoses that group to one of these psychiatric DRGs would receive a DRG adjustment.

CMS proposes that the DRG adjustment factors currently being paid to IPFs would remain the same for discharges occurring during the rate year July 1, 2006 through June 30, 2007. (p. 72)

Table 8; p. 72, illustrates FY 2006 Proposed DRGs that are currently being paid and adjustment factors that CMS is proposing to adopt in RY 2007.

Text adjustment on p. 73

Proposed Payment for Comorbid Conditions (p. 73)

CMS is proposing that the comorbidity adjustment factors currently in effect would remain in effect for RY 2007. In addition, CMS believes it is essential to maintain the same diagnostic coding set for IPFs that is used under the IPPS for providing the same psychiatric care. Therefore, CMS proposes to use the most current FY 2006 ICD codes. (p. 75)

Table 9, lists the update FY 2006 new ICD diagnosis codes that impact the comorbidity adjustment under the IPF PPS and Table 10, lists the invalid ICD codes no longer applicable for the comorbidity adjustment.

Specifically, since diagnosis code 585 is no longer valid, CMS proposes to eliminate it from the comorbidity category, "Renal Failure, Chronic". In addition, CMS is proposing to provide comorbidity adjustments for 585.3, "Chronic kidney disease, Stage III (moderate)," 585.4, "Chronic kidney disease, Stage IV (severe)," 585.5, "Chronic kidney disease, Stage V," 585.6, "End Stage renal disease," and 585.9, "Chronic kidney disease, unspecified." CMS does not propose a comorbidity adjustment for 585.1 "Chronic kidney disease, Stage I" and 585.2, "Chronic kidney disease, Stage II (mild)," because they believe that these conditions are less costly to treat on a per diem basis because patients with these conditions are either asymptomatic or may have only mild symptoms. These conditions represent a minimal to mild decrease in kidney function that is almost completely compensated such that the only finding is typically an abnormal laboratory test. (p. 77) The 17 comorbidity categories for which we are proposing to provide an adjustment, their respective codes including the new FY 2006 ICD codes, and their respective adjustment factors are described in Table 11 on page 79.

Proposed Patient Age Adjustments (p. 80)

CMS is proposing to adopt the patient age adjustment currently in effect. These adjustment factors are displayed in Table 12 on page 81.

Proposed Variable per Diem Adjustments (p. 81)

For the rate year beginning July 1, 2006, CMS is proposing to adopt the variable per diem adjustment factors currently in effect.

Proposed Revision of the IPF PPS Labor Market (p. 91)

CMS proposes to revise the labor market area definitions used under the IPF PPS based on the OMB's CBSA designations, effective for IPF PPS discharges occurring on or after July 1, 2006.

CMS is proposing not to adopt Micropolitan Areas as independent labor market area under the IPF PPS. However, they are proposing that Micropolitan Areas, under the CBSA-based labor market area definition, would be considered part of the statewide rural labor market area. CMS is proposing that the statewide rural wage index would be determined using acute-care IPPS hospital wage data from hospitals located in non-MSA areas and that statewide rural wage index would be assigned to IPFs located in those non-MSA areas.

Implementation of the Proposed Revised Labor Market Areas under the IPF PPS (p. 107-115)

The IPF PPS wage index adjustment is made by multiplying the labor-related share of the IPF PPS standard Federal per diem rate by the applicable wage index value, and the proposed IPF PPS labor related-share is **75.923%**. Consequently, for most IPFs, only **38%** of the standard Federal per diem base rate is affected by the wage index adjustment and the proposed revision to the labor market area definitions based on OMB's new CBSA-based designations would only have a minimal impact on IPF PPS payments. CMS does not believe it is necessary to propose a transition policy for the proposed revision to the IPF PPS labor market area definitions.

Therefore, CMS is not proposing a transition under the IPF PPS from the current MSA-based labor market areas designations to the new CBSA-based labor market designations. Instead, they propose to adopt the new CBSA-based labor market area definitions beginning with the July 1, 2006 IPF PPS rate year without a transition period.

CMS is not proposing a hold harmless policy or an "out-commuting" adjustment under the IPF PPS from the current MSA-based labor market area designations to the new CBSA-based labor market area designations. In addition, CMS proposes to keep the rural adjustment at **17%**.

Wage Index Budget Neutrality (p. 115)

CMS proposes to calculate the budget-neutral wage index adjustment factor in 3 steps.

1. Calculate the total amount of the estimated IPF PPS payments for the implementation year using the labor-related share and wage indices from FY 2005 (based on MSAs)
2. Calculate the total amount of estimated IPF PPS payments for RY 2007 using the proposed labor-related share and wage indices from FY 2006 (based on CBSAs)
3. Divide amount found in step 1 by the amount calculated in step 2 which yields a RY 2007 budget-neutral wage adjustment of **1.00156**.

Proposed Teaching Adjustment (p. 117-125)

CMS does not intend to rerun the regression analysis until they can analyze 1 year of IPF PPS claims and cost report data. Until that point, they propose to retain the **0.5150** teaching adjustment to the Federal per diem base rate. (p.125)

Proposed Cost of Living Adjustment for IPFs Located in Alaska and Hawaii (p. 125)

CMS proposes to obtain the COLA factors if OPM updates them and as updated by OPM. The COLA adjustment factor for Alaska (all areas) is 1.25. COLA adjustment factors in Hawaii are divided up between 5 regions; Honolulu County: 1.25; Hawaii County: 1.165; Kauai County: 1.2325; and Maui County and Kalawao County share the adjustment factor of: 1.2375.

Proposed Adjustment for IPFs with a Qualifying Emergency Department (ED) (p. 127)

CMS proposes to retain the current 1.31 adjustment factor for IPFs with qualifying EDs for the rate year beginning July 1, 2006.

Proposed New Source of Admission Code to Implement the ED Adjustment (p. 132)

The new source of admission code "D", beginning April 1, 2006, will be used by IPFs to identify patients who have been transferred to the IPF from the same hospital or CAH. Claims with source of admission code "D" would not receive the ED adjustment.

Other Payment Adjustments and Policies (p. 135)

Outlier Policy: Retaining the **2% outlier policy**; proposing **\$6200** as the fixed dollar loss threshold amount in the outlier calculation in order to maintain the 2% outlier policy.

Statistical Accuracy of CCRs: Not proposing any changes to the procedures for ensuring the statistical accuracy of CCRs in RY2007. However, CMS is proposing to update the national urban and rural CCRs for IPFs for RY 2007 based on the full calendar year 2005 CCRs entered in the Provider-Specific File. In addition, CMS proposes that the updated ceilings and national median CCRs would be based on CBSA-based geographic designations because the CBSAs are the geographic designations CMS is proposing to adopt for purposes of computing the proposed wage index adjustment to IPF payments beginning July 1, 2006.

Stop-Loss Provision: No new proposals to the stop-loss policy.

ECT Payment Adjustment: The ECT base rate is adjusted for wage and COLA differences in the same manner that we adjust the Federal per diem base rate. Therefore, in accordance with the update methodology CMS is proposing to update the ECT base rate using the pre-scaled pre-adjusted hospital median cost for ECT used for the CY 2006 update of the OPSS. They propose to pay the median cost for an ECT treatment, posted as part of the calendar year 2006 OPSS update, which is \$324.44. After applying the standardization factor and the wage index budget neutrality factor the adjusted proposed **ECT payment** for RY 2007 is **\$268.21**. (p. 149)

Physician Certification and Recertification: CMS proposes that all IPFs would meet the following physician certification and recertification timeframes. The initial physician certification would be required at the time of admission or as soon thereafter as is reasonable and the first recertification would be required as of the 12th day of hospitalization. Subsequent recertification would be required at intervals established by the hospital's UR committee, but no less frequently than every 30 days.

Provision of Therapeutic Recreation in IPFs: CMS proposes to remove the specific reference to recreation therapy, (CMS wishes to emphasize that recreation therapy is, and would continue to be, an accepted therapeutic intervention in psychiatric treatment. (p. 159)

VII. Regulatory Impact Analysis (p. 168)

CMS estimates the expenditures from the IPF PPS implementation year to the 2007 IPF PPS RY will be increased by **\$180 million**. The updates to the IPF labor-related share and wage indices are made in a budget neutral manner and thus have no effect on estimated costs to the Medicare program. Therefore the estimated increased cost to the Medicare program is the result of a combination of the updated IPF market baskets, which is offset by the transition blend and the revision of the standardization factor.

CMS notes that aspects of the transition, including the stop-loss policy and the transition to the **50/50 percent** blend in the 2007 IPF PPS RY and the transition to the 75/25 percent blend in the 2008 IPF PPS, were included in the 2004 final rule and therefore are not incremental to this rulemaking

The impact of the transition blend is approximately **.2%** (about **\$10 million**) **decrease** in overall payments for the 2007 IPF PPS RY. Therefore, the impact attributable to the policy changes proposed in this rulemaking, primarily the market basket

update and the standardization correction, is approximately **\$180 million** in the 2007 IPF PPS RY. Since costs to the Medicare program are estimated to be greater than \$100 million, this proposed rule is considered a major economic rule.

HHS considers that a substantial number of entities are affected if the rule impacts more than **5%** of the total number of small entities as it does in this rule. CMS included psychiatric hospitals (79 are non-profit hospitals) in the analysis since their total revenues do not exceed the **\$29 million threshold**. They also included psychiatric units of small hospitals, (hospitals with fewer than 100 beds), but did not include psychiatric units of larger hospitals in the analysis because CMS believes this proposed rule would not significantly impact total revenues of the entire hospital that supports the unit.

Based on the analysis of the **1063** psychiatric facilities that were classified as small entities, CMS estimates the combined impact of the IPF PPS will be a **4.6% increase** in payments in RY 2007 relative to their payments in the implementation year of the IPF PPS.

Under the new labor market definitions that we are proposing to adopt, CMS would no longer employ NECMAs to define urban areas in New England. Therefore, CMS defines a small rural hospital as a hospital with fewer than 100 beds that is located outside of an MSA.

CMS is proposing to continue to provide a payment adjustment of **17%** for IPFs located in rural areas. In addition CMS has established a 3-year transition to the new system to allow IPFs an opportunity to adjust to the new system.

The market basket update is based on a 15-month time period (from the midpoint of the IPF PPS implementation period to the midpoint of the 2007 rate year)

Anticipated Effects of the Proposed Rule (p. 174)

Out of 1,806 IPFs included in the analysis, a number of conclusions resulted...

The proposed revision to the standardization factor would result in a **0.3% decrease** in overall payments to IPFs. There are small distributional effects among different categories of IPFs. For example, rural government psychiatric hospitals would receive the largest decrease of **0.5%** while rural for-profit psychiatric hospitals with over 75 beds would receive a decrease of **0.4%** while psychiatric hospitals with fewer than 12 beds would receive the smallest decrease of **0.1%**. (p. 180)

Rural IPFs would experience a **0.2%** decrease in payments while urban IPFs would experience no change in payments. Rural government hospitals would receive the largest decrease of **0.3%** while rural non-profit hospitals would receive the largest increase of **0.3%**.

The proposed market basket update to the IPF PPS payment update would result in a **4.7% increase** in overall payments to IPFs. This reflects the current blend of the **4.8%** update for IPF TEFRA payments and the **4.5%** update for the IPF PPS payments.

The overall effect of the payment change in transition blend percentages, across all hospital groups, would be a **0.2% decrease** in payments to IPFs in RY 2007. (p.182)

There are distributional effects of these changes among different categories of IPS. The largest increases would be among government psychiatric hospitals with rural government hospitals receiving an **11.8% increase** and urban government hospitals receiving a **10.8% increase**. Alternatively, psychiatric hospitals and units with fewer than 12 beds would receive the **largest decreases of 3.8 and 4.5%** respectively.

In comparing CMS' estimates of proposed changes for RY 2007, to their estimates of payments in the implementation year (w/o proposed changes), the average **increase** for all IPFs is approximately **4.2%**. This increase includes the effects of the market basket updates resulting in a **4.7% increase** in total RY 2007 payments. It also includes a **0.3% decrease** in RY 2007 payments for the standardization factor revision.

Overall, the largest payment increase would be among government IPFs. Urban government psychiatric hospitals would receive a **15.6% increase** and rural government psychiatric hospitals would receive a 16.1% increase. Psychiatric hospitals with fewer than 12 beds would receive a 0.8% increase and psychiatric units with fewer than 12 beds would receive a 0.2% decrease.

Effect on the Medicare Program (p. 183)

CMS estimates that Medicare spending for IPF services over the next 5 years will be (in millions): **RY 2007: \$4,257**; RY 2008: \$4,382; 2009: \$4,559; RY 2010: \$4,762; RY 2011: \$4,979.

The current estimate of **increases** in the excluded hospital with capital market basket for RY 2007 was **3.6%**, and for RY 2008; 3.5%. CMS estimates that there would be a change in fee-for-service Medicare beneficiary enrollment: **-2.3% in RY 2007**; -1.0% in RY 2008; 0.3 percent in RY 2009 etc. (p. 184)

Effect on Beneficiaries (p. 186)

CMS believes that access to IPF services would be enhanced due to the patient and facility level adjustment factors, all of which are intended to adequately reimburse IPFs for expensive cases. The stop-loss policy is intended to assist IPFs during the transition. CMS also expects that paying prospectively for IPF services would enhance the efficiency of the Medicare program.