INPATIENT PSYCHIATRIC FACILITY SERVICES PAYMENT SYSTEM

*payment***basics**

Revised: October 2014

Medicare beneficiaries with serious mental illnesses or alcohol- and drug-related problems may be treated in inpatient psychiatric facilities (IPFs), either freestanding hospitals or specialized hospital-based units.[1] The services furnished by IPFs are intended to meet the urgent needs of those experiencing an acute mental health crisis. Medicare payments to IPFs are estimated to be $4.4 billion in 2012. On average, Medicare beneficiaries account for about 24 percent of psychiatric facilities' discharges. In 2012, 301,000 beneficiaries had about 451,000 Medicare discharges from IPFs. About 1,590 facilities submitted Medicare cost reports in 2012.

To be admitted to an IPF, patients generally have to be considered a risk to themselves—either intentional or as the result of impaired self-care—or to others. As is the case for stays in general acute care hospitals, beneficiaries treated in IPFs are responsible for a deductible—$1,216 in 2014—for the first admission during a spell of illness, and for a copayment—$304 per day—for the 61st through 90th days. Beneficiaries treated for psychiatric conditions in IPFs are covered for 90 days of care per spell of illness, with a 60-day lifetime reserve.[2] Over their lifetimes beneficiaries are limited to 190 days of treatment in freestanding psychiatric hospitals.[3]

Defining the care Medicare buys

Under the prospective payment system (PPS) for IPF care, Medicare pays for the per diem routine, ancillary, and capital costs associated with furnishing covered inpatient psychiatric services. A base per diem payment is adjusted to account for differences in the cost of care related to specified patient and facility characteristics. The PPS was implemented in January 2005. Prior to that time, Medicare paid IPFs (under the Tax Equity and Fiscal Responsibility Act of 1982, or TEFRA) for furnishing care to Medicare beneficiaries on the basis of their average costs per discharge, as long as they did not exceed the facility-specific limit that was adjusted annually.

Setting the payment rates

The base payment rate for each patient day in an IPF is based on the national average daily routine operating, ancillary, and capital costs in IPFs in 2002. For fiscal year (FY) 2015, the base payment rate is $728 per day. The base rate is adjusted to account for patient and facility characteristics that can be collected from administrative data and that are associated with significant cost differences (Figure 1). The patient characteristics include:

- **Age**—In general, payment increases with increasing patient age over 45.
- **Diagnosis**—Patients are assigned to one of 17 psychiatric Medicare severity diagnosis related groups (MS–DRGs), such as psychoses, depressive neuroses, and degenerative nervous system disorders. Medicare assigns a weight to each of the MS–DRGs reflecting the average costliness of cases in that group compared with that for the most frequently reported psychiatric diagnosis in FY 2002 (MS–DRG 885, psychosis).
- **Comorbidities**—This adjustment recognizes the increased costs associated with 17 specific patient conditions—such as renal failure, diabetes, and cardiac conditions—that are secondary to the patient's principal diagnosis and that require treatment during the stay.
- **Length of stay**—Per diem payments decrease as patient length of stay increases (Table 1).

Facility-based adjustments include:

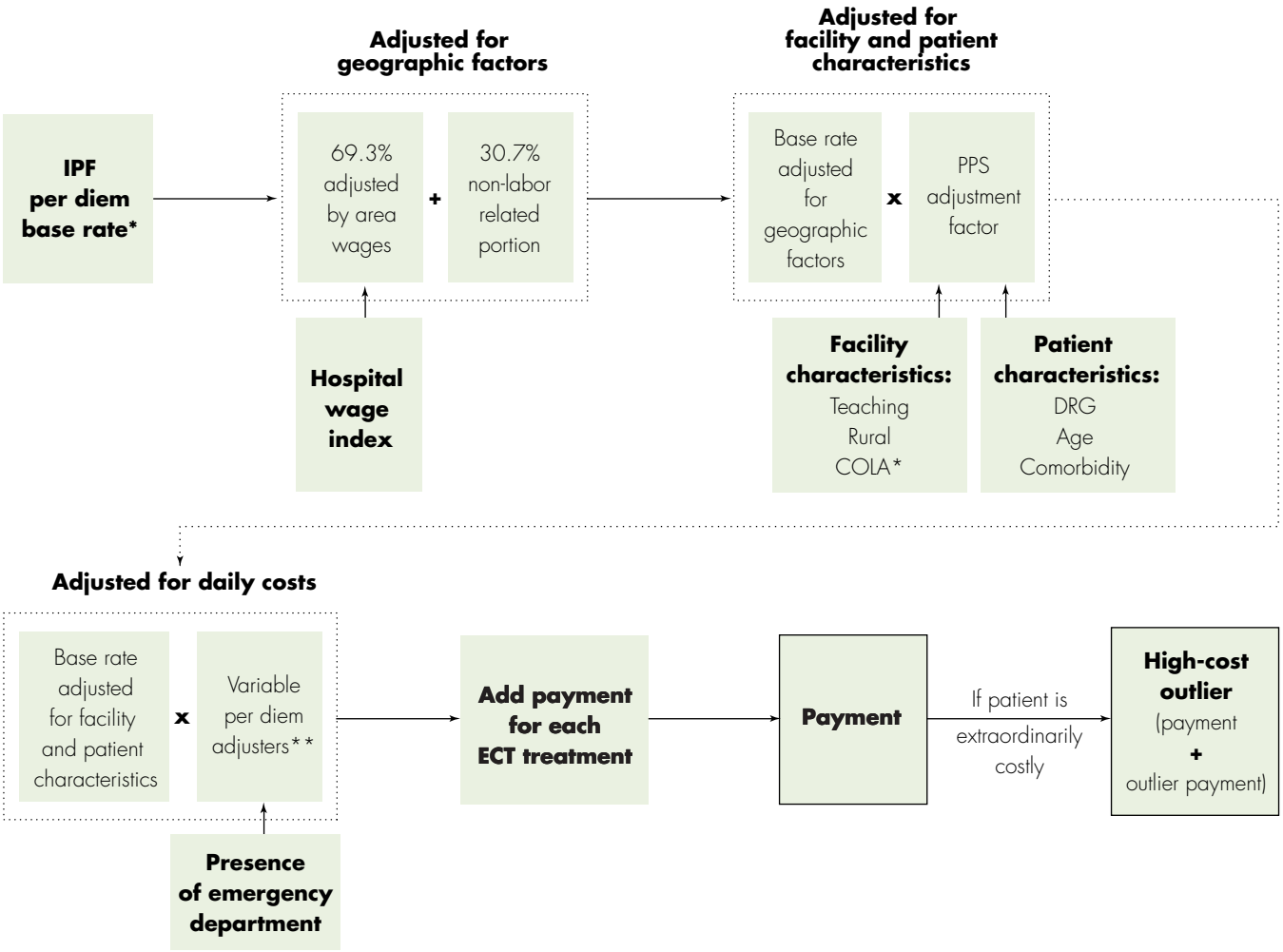
- **Wage index adjustment**—The labor-related share (69.3 percent) of the base

This document does not reflect proposed legislation or regulatory actions.

MEDPAC

425 I Street, NW
Suite 701
Washington, DC 20001
ph: 202-220-3700
fax: 202-220-3759
www.medpac.gov

Figure 1 Inpatient psychiatric facility services prospective payment system



Note: IPF (inpatient psychiatric facility), PPS (prospective payment system), COLA (cost of living adjustment), DRG (diagnosis related group), ECT (electro-convulsive therapy).
*A cost of living adjustment (COLA) to the non-labor related portion is made for facilities in Alaska and Hawaii.
**The variable per diem adjuster is higher for the 1st day when an emergency department is present. The adjuster declines from 1.31 with an emergency department and 1.19 without an emergency department to 0.92 over time. Table 1 shows the adjuster.

per diem payment is adjusted by an area wage index to reflect the expected differences in local market prices for labor.

- **Rural location adjustment**—IPFs in rural areas are paid 17 percent more than urban IPFs.
- **Teaching adjustment**—Teaching hospitals have an adjustment based on the ratio of interns and residents to average daily census.
- **Cost of living adjustment**—IPFs in Alaska and Hawaii are paid up to 25 percent more than IPFs located in other areas, reflecting their disproportionately higher costs.
- **Emergency department adjustment**—IPFs with qualifying emergency departments are paid about 10 percent more for their patients' first day of the stay.

IPFs also receive an additional payment for each electroconvulsive therapy (ECT) treatment furnished to a patient. In FY 2015, the ECT payment is $314.

Patients who are readmitted to the IPF within three days of discharge are considered to have an interrupted stay. In such cases, Medicare treats the readmission as a continuation of

the original stay, with lengths of stay adjustments applied accordingly.

Outlier payments—The IPF PPS has an outlier policy for cases that have extraordinarily high costs, drawn from an outlier pool of 2 percent of total payments. Medicare makes outlier payments when an IPF's estimated total costs for a case exceed the total payment amount for the case plus a fixed loss amount ($8,755 in FY 2015, adjusted for the facility characteristics outlined above). Medicare will cover 80 percent of the costs above this threshold for days 1 through 9, and 60 percent of the costs above the threshold amount for the remaining days. The different risk-sharing rates are intended to counteract the financial incentives to keep outlier cases longer than may be necessary.

Payment updates

There is no mechanism in law for updating payments to IPFs. CMS has stated that it intends to update the IPF payment rates based on the most recent estimate of the Rehabilitation, Psychiatric, and Long-Term Care (RPL) market basket index (which measures the price increases of goods and services inpatient rehabilitation facilities, inpatient psychiatric facilities, and LTCHs buy to produce patient care). The Patient Protection and Affordable Care Act of 2010 requires that any annual update to the IPF payment rates in fiscal years 2012 through 2019 be reduced by an adjustment for productivity. In addition, beginning in FY 2015, the annual update to the base payment amount will be reduced by 2 percentage points for any IPF that fails to submit required quality data. ■

Table 1 The adjusted rate for IPFs is higher for earlier days of a patient's stay

Day of patient's stay	Per diem adjustment
1 Facility:	
with a full-service emergency department	1.31
without a full-service emergency department	1.19
2	1.12
3	1.08
4	1.05
5	1.04
6	1.02
7	1.01
8	1.01
9	1.00
10	1.00
11	0.99
12	0.99
13	0.99
14	0.99
15	0.98
16	0.97
17	0.97
18	0.96
19	0.95
20	0.95
21	0.95
22 or more	0.92

Note: IPF (inpatient psychiatric facility). The per diem adjustment is applied to the base rate that is already adjusted for geographic, facility, and patient characteristics.

Source: Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2014. Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System—Update for Fiscal Year Beginning October 1, 2014 (FY 2015). *Federal Register* 79, no. 151 (August 6): 45985.

1 Beneficiaries are also treated for psychiatric or alcohol- and drug-related conditions in regular beds in acute care hospitals. When this happens, the acute care hospital is paid under the acute care inpatient prospective payment system.

2 The number of inpatient benefit days in the first benefit period is reduced for individuals who are in a Medicare participating IPF on their first day of entitlement to Medicare Part A. Beneficiaries are liable for a higher copayment for each lifetime reserve day—$608 per day in 2014.

3 This restriction, which was intended to limit the federal government's role in paying for long-term custodial care of beneficiaries with mental illnesses, applies only to services furnished in freestanding IPFs. The limitation does not apply to inpatient psychiatric services furnished in a specialized psychiatric unit of an acute care hospital, nor does it apply to psychiatric stays paid for under the acute care hospital prospective payment system.