At Issue
On May 1, the Centers for Medicare & Medicaid Services (CMS) issued its inpatient psychiatric facility (IPF) prospective payment system (PPS) proposed rule for fiscal year (FY) 2015. Comments are due to CMS by June 30. A final rule will be released by Aug. 1, and changes will take effect Oct. 1. This proposed rule affects freestanding IPFs, as well as IPF distinct-part units of acute care and critical access hospitals.

The rule would increase IPF rates by 2.1 percent in FY 2015 compared to FY 2014, after accounting for inflation and other adjustments. Specifically, the proposed rule includes an initial market basket update of 2.7 percent for IPFs that submit data on quality measures, as well as a productivity cut of 0.4 percentage points and an additional market basket cut of 0.3 percentage points, as mandated by the Affordable Care Act. The proposed rule also includes an increase of 0.1 percentage points resulting from an updated outlier threshold.

CMS also proposes several changes to the IPF quality reporting (IPFQR) program. CMS proposes two new measures for the FY 2016 IPFQR: one measure would require IPFs to attest to how they use electronic health records; the other would require IPFs to provide information on whether they collect patient experience information using standardized surveys. For FY 2017, CMS proposes four new measures: two assess the proportion of patients and health care personnel receiving influenza vaccination, and two measure whether IPFs screen for and offer counseling and medications for tobacco use. CMS also proposes updates to the program’s data collection and reporting processes.

Our Take:
The AHA is evaluating all of the proposed changes to ensure IPFs receive appropriate payments for providing care to Medicare beneficiaries. However, we are concerned that some of CMS’s proposed quality measures have neither received endorsement from the National Quality Forum for use in the IPFQR nor are fully supported for use in the IPFQR by the Measure Applications Partnership. Moreover, several proposed measures focus on areas that may not be central to the quality of inpatient psychiatric care.

What You Can Do:
Please share this advisory with your senior management team. Ask your chief financial officer to examine the potential impact of the proposed payment changes on your Medicare revenue, and your chief quality officer to assess the value and feasibility of the IPFQR’s proposed measures.

Further Questions:
Please contact Joanna Hiatt Kim, vice president of payment policy, at (202) 626-2340 or jkim@aha.org.
BACKGROUND

On May 1, the Centers for Medicare & Medicaid Services (CMS) issued its inpatient psychiatric facility (IPF) prospective payment system (PPS) proposed rule for fiscal year (FY) 2015. The rule would increase IPF rates by 2.1 percent in FY 2015 compared to FY 2014, after accounting for inflation and other adjustments. Specifically, the proposed rule includes an initial market basket update of 2.7 percent for those IPFs that submit data on quality measures. The rule also would make a productivity cut of 0.4 percentage points and an additional market basket cut of 0.3 percentage points, as mandated by the Affordable Care Act (ACA). The proposed rule also includes an increase of 0.1 percentage points resulting from an updated outlier threshold.

Comments are due to CMS by June 30. A final rule will be released by Aug. 1, and changes will take effect Oct. 1. A detailed summary of the proposed rule follows.

AT ISSUE

IPF PPS Rate Update

The market basket is an input price index that measures price changes over a fixed period of time. To construct the market basket index, price proxies, such as the U.S Consumer Price Index (CPI), are used to estimate the price changes for a mix of goods and services purchased by hospitals. The rate of increase in the inpatient rehabilitation facility, IPF and long-term care hospital market basket, which is known as the RPL market basket, is 2.7 percent for FY 2015. However, CMS proposes to make a 0.4 percentage point reduction to this market basket update for productivity, as well as an additional 0.3 percentage point reduction, as mandated by the ACA. Thus, the net proposed market basket update for FY 2015 is 2.0 percent.

The proposed per diem rates for FY 2015 under this 2.0 percent market basket update are as follows:
As required by law, IPFs that do not report on specific quality measures would receive an update of the market basket minus 2.0 percentage points, or 0.0 percent for FY 2015. (See “Inpatient Psychiatric Facility Quality Reporting” for more information.)

The proposed per diem rates for FY 2015 under this 0.0 percent market basket update are as follows:

<table>
<thead>
<tr>
<th>Federal Per Diem Base Rate</th>
<th>$ 713.40</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labor Share (0.69538)</td>
<td>$ 496.08</td>
</tr>
<tr>
<td>Non-labor Share (0.30462)</td>
<td>$ 217.32</td>
</tr>
</tbody>
</table>

Cost-of-living Adjustment (COLA) for IPFs in Alaska and Hawaii
The IPF PPS includes a COLA payment adjustment for IPFs located in Alaska and Hawaii. Under this adjustment, the non-labor related portion of the federal per diem base rate is multiplied by the applicable COLA factor, thereby increasing the IPF’s total payment rate. CMS proposes to adopt the same methodology used to determine the COLA factors in the inpatient PPS for the IPF PPS. Under this methodology, CMS would compare the growth in the CPIs in Alaska and Hawaii relative to the growth in the overall CPI, as published by the Bureau of Labor Statistics, to update the COLA factors for these states.

Wage Index
An IPF’s wage index is calculated using the inpatient PPS wage index for the labor market area in which the IPF is located, without taking into account geographic reclassifications, floors and other adjustments made to the wage index under the inpatient PPS. In the FY 2015 inpatient PPS proposed rule, CMS proposes to update the labor market areas used for the inpatient PPS area wage index using the most recent areas that were issued by the Office of Management and Budget (OMB) on Feb. 28, 2013. However, CMS bases the IPF PPS wage index on the inpatient PPS wage index from the prior year, which in this case is FY 2014; therefore, the FY 2015 IPF PPS wage indexes will not reflect the new OMB labor markets. However, CMS anticipates that the labor market changes would be reflected in the FY 2016 IPF PPS wage index.

ICD-10-CM/PCS Conversion
The Protecting Access to Medicare Act of 2014 delayed adoption of the ICD-10 codes sets until at least Oct. 1, 2015. Recently, the Department of Health and Human Services announced that Oct. 1, 2015 will, in fact, be the new implementation date.
this rule, the agency proposes to convert to ICD-10-CM codes for the 17 IPF PPS comorbidity categories for which the IPF PPS provides a comorbidity adjustment.

CMS also proposes to remove site-unspecified codes in instances when a more specific code is available or when the clinician should be able to identify a more specific diagnosis based on clinical assessment. CMS specifically proposes the elimination of 153 ICD-10-CM codes for nonspecific conditions. The areas are:

- Oncology – 93 ICD-10-CM site-unspecified codes;
- Gangrene – 6 ICD-10-CM site-unspecified codes; and
- Severe Musculoskeletal and Connective Tissue – 54 ICD-10-CM codes.

**Outlier Payments**

CMS proposes an outlier fixed-dollar loss threshold amount of $10,125 for FY 2015, a decrease from the FY 2014 threshold of $10,245. While the IPF PPS aims to make outlier payments equal to 2 percent of total estimated aggregate IPF payments for a given fiscal year, CMS estimates that it will pay out only 1.9 percent in FY 2014. It believes that the decreased threshold in FY 2015 would increase outlier payments from 1.9 percent to the intended 2.0 percent.

**Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program**

Beginning with FY 2014 payments, IPFs and separately licensed, distinct-part psychiatric units in acute care hospitals that are paid under the IPF PPS are required to participate in the IPFQR program. Eligible facilities must comply with all IPFQR data submission requirements and deadlines to avoid a 2 percent reduction to their annual payment update.

CMS proposes two new measures for the FY 2016 IPFQR program, and four new measures for FY 2017. CMS also proposes updates to the program’s data collection and reporting processes.

FY 2016 Measurement Proposals. CMS proposes to add two structural measures to the FY 2016 IPFQR program. Structural measures require only that providers attest to whether they perform certain activities thought to be associated with higher quality care. In contrast to process and outcome measures, structural measures do not require the collection or aggregation of patient information from medical records or claims data. In the proposed rule, CMS indicates that the use of structural measures will provide useful information while mitigating the burden of abstracting patient data.

However, the AHA is concerned that the two proposed measures are neither endorsed by the National Quality Forum (NQF), nor supported for use in the IPFQR program by the Measure Applications Partnership (MAP). The ACA requires that measures for most CMS quality reporting and payment programs – including the IPFQR – be reviewed by the multi-stakeholder MAP before they are proposed for programs. Each proposed measure is briefly summarized below.
IPF Assessment of Patient Experience. CMS proposes to require IPFs to submit, as part of FY 2016 measure reporting, information about whether they routinely conduct patient experience surveys using a standardized tool, and which survey tool is used. CMS indicates that this data would be used to help inform future efforts to implement a single patient experience survey for all IPFs. CMS had finalized this measure for voluntary submission in the FY 2014 inpatient PPS final rule; however, CMS now proposes to require IPFs to submit this information.

IPF Use of an Electronic Health Record (EHR). IPFs do not currently participate in CMS’s EHR Incentive Program, and are not subject to the reporting or EHR certification requirements in that program. However, in the proposed rule, CMS states its belief that the use of EHRs by IPFs can help improve patient care, support information exchange during care transitions and potentially facilitate the use of electronically specified clinical quality measures (eCQMs). Moreover, CMS indicates that it, along with the Office of the National Coordinator for Health Information Technology (ONC), is considering how to expand EHR certification into behavioral health and other care settings (e.g., post-acute care) not currently participating in the EHR Incentive Program. ONC is responsible for developing EHR certification requirements for the EHR Incentive Program. CMS indicates that ONC's recent proposed rule on Voluntary 2015 EHR Certification provides a potential mechanism to “accommodate” certification programs for providers, such as IPFs, that are not currently in the Medicare EHR Incentive Program.

Based on these developments, CMS proposes a structural measure intended to assess how IPFs currently use EHRs. IPFs would be asked to attest to one of the following statements that “best describes the [IPF’s] highest level typical use of an EHR system during the reporting period:

- The facility most commonly used paper documents or other forms of information exchange (e.g., email) NOT involving transfer of health information using EHR technology at times of transitions in care.
- The facility most commonly exchanged health information using non-certified EHR technology (i.e., not certified under the ONC HIT Certification Program) at times of transitions in care.
- The facility most commonly exchanged health information using certified EHR technology (certified under the ONC HIT Certification Program) at times of transitions in care.”

FY 2017 Measurement Proposals. CMS proposes four new measures for the FY 2017 IPFQR program. All four measures are NQF-endorsed.

Influenza Vaccination (IMM-2). CMS proposes to add the same chart-abstracted patient influenza vaccination measure to the IPFQR that is currently in the hospital inpatient quality reporting (IQR) program. The measure assesses the percentage of patients
discharged during influenza season (i.e., October through March) who are screened for flu vaccine status and vaccinated, if indicated. The measure excludes patients who die prior to discharge, have lengths of stay greater than 120 days, are transferred to another acute care hospital, or leave against medical advice. **While this measure is NQF-endorsed, the MAP only conditionally supported it for the IPFQR.** The MAP indicated that the measure’s NQF endorsement is not specific to IPFs and, therefore, recommended that the measure undergo additional testing before being adopted for the IPFQR program. Nevertheless, CMS indicates that the measure specifications are adequate to ensure accurate data collection in IPFs.

**Healthcare Personnel (HCP) Influenza Vaccination.** CMS proposes to add the same HCP flu vaccination measure to the IPFQR that it uses in a number of other quality reporting programs. The measure assesses the percentage of HCP working in a facility for at least one day during flu season (i.e., between Oct. 1 and Mar. 31) who have received the flu vaccine. Measure data would be reported using the Centers for Disease Control and Prevention’s (CDC) National Healthcare Safety Network (NHSN) beginning with the 2015-2016 flu season. The measure’s detailed specifications and data collection protocol are available on the CDC’s website. CMS’s proposed data collection and submission processes timeframes are outlined in the next section of this advisory.

CMS has added the HCP flu vaccination measure to several quality reporting programs; in particular, the hospital IQR and outpatient quality reporting (OQR) programs. In response to concerns previously raised by the AHA and others about the burden of separately collecting and reporting HCP flu vaccination status for inpatient and outpatient settings, CMS proposes that IPFs collect and report a single vaccination count per CMS Certification Number (CCN). That single count would include both inpatient and outpatient settings covered under that CCN. **However, IPF units that use CCNs different from their acute-care hospital’s CCN would be expected to report their own HCP flu vaccination rate.** Additional details are provided in Operational Guidance developed by the CDC.

**Tobacco Use Screening (TOB-1).** The proposed chart-abstracted measure assesses the proportion of patients screened within the first three days of admission for tobacco use (i.e., cigarettes, smokeless tobacco, pipe and cigar) within the previous 30 days. CMS states that tobacco use is the single-largest contributor to disease in the country, and indicates that a tobacco screening measure would “encourage the uptake of tobacco cessation treatment and attendant benefits” for IPF patients. CMS originally intended to propose a different tobacco use measure; however, at the recommendation of the MAP, it instead proposes TOB-1.

**Tobacco Use Treatment Provided or Offered (TOB-2/TOB-2a).** The proposed chart-abstracted measure is a single measure reported as two rates. The overall rate (TOB-2) reflects the proportion of patients identified as tobacco users who **receive or refuse** counseling to quit, and **receive or refuse** Food and Drug Administration-approved tobacco cessation medications within the first three days following admission. The
second rate (TOB-2a) is a subset of TOB-2, and assesses the proportion of tobacco use patients who actually receive medication and counseling. TOB-2/TOB-2a is part of the same measure set as TOB-1; the patient population (i.e., patients who are tobacco users) for TOB-2/TOB-2a is actually identified through the collection of TOB-1.

Data Collection and Reporting Requirements. CMS proposes several updates to the data collection and reporting requirements for the IPFQR program.

Measure Specifications for FY 2017 Proposed Measures. CMS proposes that IMM-2, TOB-1 and TOB-2/TOB-2a be collected using the specifications in the Specifications Manual for National Hospital Inpatient Quality Measures that is maintained by The Joint Commission. CMS indicates it also would provide any additional information needed to collect and submit the measures using QualityNet. While the measure specifications permit the use of sampling to collect measure data, CMS does not explicitly state in the rule whether the measures can be collected using sampling. **The AHA will ask CMS to clarify in the final rule whether sampling is permitted for these measures.**

The HCP flu vaccination measure would be collected and reported using the CDC’s NHSN; the measure’s detailed specifications and data collection protocol are available on the CDC’s [website](http://www.cdc.gov).

Sampling Data. For data submitted for the FY 2017 IPFQR program, CMS proposes to update its data submission requirements for program measures that permit the use of sampling. The current IPFQR measures that permit sampling include the following:

- HBIPS-4: Patients discharged on multiple antipsychotic medications
- HBIPS-5: Patients discharged on multiple antipsychotic medications with appropriate justification
- HBIPS-6: Post discharge continuing care plan created
- HBIPS-7: Post discharge continuing care plan transmitted to next level of care provider upon discharge
- SUB-1: Alcohol use screening

Specifically, CMS proposes that IPFs submit aggregate population and sample size counts for Medicare and non-Medicare discharges by age group, diagnostic group and quarter. CMS indicates that this data will help it better understand the completeness of measure data, as well as provide insight on the impact the measures in the program are having for particular patient populations. **The AHA will ask CMS to clarify whether IPFs also would have to submit this data for the FY 2017 proposed measures (IMM-2, TOB-1 and TOB-2/TOB-2a).**

Data Reporting and Submission Timeframes. CMS proposes to use the IPFQR’s existing data reporting and submission timeframes for all its newly proposed measures, with the exception of the health care personal flu vaccination measure. In general, the IPFQR has a data reporting period of a full calendar year. The data must be submitted to CMS between July 1 and Aug. 15 of the calendar year in which the applicable
payment determination (i.e., fiscal year) begins. The agency also uses the same deadline for the submission of a Data Accuracy and Completeness Acknowledgement (DACA) form. CMS publicly reports IPFQR program measure data in April of each year, and provides IPFs with a 30-day preview period approximately 12 weeks before the data are publicly displayed. The data reporting and submission deadlines through FY 2017 are outlined in Table 1.

Table 1: IPFQR Data Reporting Periods and Submission Deadlines FY 2015 through FY 2017

<table>
<thead>
<tr>
<th>Program Year</th>
<th>Reporting Period</th>
<th>Data Submission and DACA Deadline</th>
<th>Public Display</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Apr. 1, 2014 – June 30, 2014</td>
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<tr>
<td></td>
<td>July 1, 2014 – Sept. 30, 2014</td>
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<td></td>
<td>July 1, 2015 – Sept. 30, 2015</td>
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The proposed data reporting and submission timeframes for the health care personnel flu vaccine measure differs from the other proposed measures. CMS proposes that IPFs collect data from Oct. 1, 2015 through March 31, 2016, with a reporting deadline of May 15, 2016. These data collection and timeframes are aligned with those of the hospital IQR and OQR programs.

Future Measurement Topics. CMS solicits comment on several measures and measurement topics it is considering for future years. The agency indicates that the following five measures are currently undergoing testing:

- Suicide Risk Screening completed within one day of admission;
- Violence Risk Screening completed within one day of admission;
- Drug Use Screening completed within one day of admission;
- Alcohol Use Screening completed within one day of admission; and
- Metabolic Screening.

All five measures also were included on the list of measures reviewed by the MAP in early 2014, and CMS indicates that it intends to propose one or more of them “in the near future.” However, the MAP did not support any of them, suggesting that none of the five measures met the needs of the program. CMS does not provide any details on the measures in the proposed rule. However, the measure specifications reviewed by the MAP are available on its website.
Lastly, CMS states that it intends to develop both an all-cause, all-condition 30-day readmission measure for discharges from IPFs, and a patient experience survey for use in psychiatric settings.

**NEXT STEPS**

Given the changes proposed in this rule, the AHA encourages IPF leaders to estimate the impact of the provisions on their facilities, particularly the quality provisions. Look for the AHA’s comment letter on the rule in the near future and consider submitting comments.

Submit Comments Electronically. Comments are due to CMS by June 30 and may be submitted electronically at: [www.regulations.gov](http://www.regulations.gov). Follow the instructions for “Comment or Submission” and enter the file code “CMS-1606-P” to submit comments on this proposed rule.

**FURTHER QUESTIONS**

Please contact Joanna Hiatt Kim, vice president of payment policy, at (202) 626-2340 or jkim@aha.org.