The Centers for Medicare & Medicaid Services (CMS) on July 31 issued a final rule for the inpatient psychiatric facility (IPF) prospective payment system (PPS) for fiscal year (FY) 2019. Key takeaways from the rule follow.

**Final IPF PPS Payment Provisions**
CMS estimates IPF payments will increase by 1.1 percent, equivalent to $50 million, in FY 2019. The 1.1 percent payment update is a reflection of a 2.9 percent market-basket update minus the productivity adjustment of 0.80 percentage points, the 0.75 percentage point reduction mandated by the Affordable Care Act, and a 0.24 percentage point outlier fixed-dollar loss threshold amount.

Thus, the federal per diem base rate will be $782.78 (an increase from the previous rate of $771.35). The resulting labor-related share for FY 2019 is 74.8 percent.

**Final IPF Quality Reporting Program (IPFQR) Provisions**
In line with CMS’s Meaningful Measures initiative, the agency finalizes its proposal to add an additional criterion with which to evaluate measures for removal. Measure Removal Factor 8 will read “the costs associated with a measure outweigh the benefit of its continued use in the program.”

In June, CMS had proposed to remove eight measures from the IPQFR. In this rule, CMS finalized the removal of five of these measures. Removing these five measures will leave the IPFQR with 13 measures. CMS is engaging with a multi-stakeholder group to begin the development of new quality measures for psychiatric facilities. The measures that will be removed from the IPFQR for the FY 2020 payment year 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”).
- **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.

CMS did not finalize its proposal to remove three measures in response to what the agency called “overwhelming public comment that emphasized their importance for patient safety and health issues specific to the population.” The table below shows these measures, the rationale cited in the proposed rule for the measures’ proposed removal, and the rationale cited to retain the measures:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Rationale for Removal</th>
<th>Rationale for Retention</th>
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<tbody>
<tr>
<td>Hours of Physical Restraint Use (HBIPS-2)</td>
<td>Measures are topped out; CMS monitors the use of physical restraints/ seclusion in several other ways, including surveys regarding compliance with Medicare’s Conditions of Participation (CoPs), rendering these measures unnecessary as they only address one element of the approach to minimize the use of physical restraint.</td>
<td>Measures allow critical data to continue to be publicly reported and used by patients to select an IPF, ensuring that IPFs continue to proactively track and strive for improvement; CoPs do not provide benchmark data or information to consumers.</td>
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<tr>
<td>Hours of Seclusion Use (HBIPS-3)</td>
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<tr>
<td>Tobacco Use Treatment Provided or Offered at Discharge and Tobacco Use Treatment at Discharge (TOB-3 and TOB-3a)</td>
<td>The same data that is reported for this measure is captured in the required transition record received by discharged patients, rendering it duplicative.</td>
<td>Providers only document tobacco use treatment in the discharge records if it is provided, which does not capture whether the treatment is appropriately provided; thus, the benefits of specifically measuring this aspect of care are greater than CMS initially determined.</td>
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CMS also finalized its proposal to no longer require facilities to report 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). Finally, CMS will update out-of-date regulation language, including replacing references to ICD-9 with ICD-10. These updates will not change any policies.

**Further Questions**
Contact Caitlin Gillooley, associate director, at cgillooley@aha.org, with any questions.