Assessing Medicare's payments for services provided in inpatient psychiatric facilities

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Outline of presentation

- Inpatient psychiatric facilities (IPFs)
- Characteristics of beneficiaries who use IPFs
- Medicare's IPF prospective payment system (PPS)
- Questions about the accuracy of the IPF PPS
- Measuring quality of IPF care

Inpatient psychiatric facilities (IPFs)

- Treat patients with serious behavioral health conditions who are experiencing acute crisis
- Freestanding hospitals or specialized units in acute care hospitals
- In 2016, ~1,600 IPFs submitted Medicare cost reports:
  - Provided ~409,000 stays to ~272,000 beneficiaries
  - Medicare payments: $4.3 billion
- Number of IPF cases per FFS beneficiary declining
  - Declined 1.4% per year, on average, between 2004 and 2014
  - Declined 3.9% per year, on average, between 2014 and 2016

Numbers are preliminary and subject to change.
Source: MedPAC analysis of MedPAR and cost report data from CMS.

IPFs, continued

- To be admitted, beneficiaries generally must be considered a risk to themselves—either intentional or as the result of impaired self-care—or to others
- Goal of care: Mood stabilization and restoration of ability to live independently
- IPFs provide supervision and behavioral management to reduce risk of harm to self and others
  - Individual and group therapy, psychosocial rehabilitation, illness management training, family therapy, drug therapy, electroconvulsive therapy (ECT), and other treatments

Fee-for-service IPF users in 2015

- 57% under age 65; 30% under age 49
- 44% are full dual-eligible; 11% partial duals
- 30% have more than one IPF stay during the year
- High level of use for other Medicare-covered services, including Part D drugs. On a per FFS beneficiary basis:
  - 3.1 outpatient ED visits (vs. 0.5 for all beneficiaries)
  - 40.4 E&M visits (vs. 6.6 for all beneficiaries)
  - 64.7 standardized Part D fills (vs. 35.8 for all beneficiaries)
- Total Medicare spending on all covered services:
  - $40,294 (vs. $11,809 for all beneficiaries)

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E&M (evaluation and management). Numbers are preliminary and subject to change.
Source: MedPAC analysis of Medicare beneficiary summary files from CMS.

Medicare's IPF prospective payment system (PPS)

- Per diem payment
  - Adjusted for patient characteristics
    - MS-DRG, age, comorbidities, length of stay
  - Adjusted for facility characteristics
    - Wage index, cost of living, teaching status, rural location, presence of ED
- Add-on payment for each electroconvulsive therapy (ECT) treatment
- Outlier pool = 2% of total payments

Most common types of cases in IPFs, 2015

Description	Number of cases	Share of all cases	% change, 2011-2015
Psychosis	306,212	73%	-6.6%
Organic disturbances & mental retardation	29,034	7%	7.5
Substance abuse or dependency	27,682	7%	8.9
Degenerative nervous system disorders	26,439	6%	-28.6
Depressive neurosis	13,476	3%	-11.7
All other	16,001	4%	-11.0
All IPF cases	418,844	100%	-7.1

Results are preliminary and subject to change.
Source: MedPAC analysis of MedPAR data from CMS.

IPF Medicare margins, 2016

	% of IPFs	% of discharges	Margin
All IPFs	100%	100%	-2.4%
Freestanding			
Not for profit	4%	6%	-6.6%
For profit	17%	30%	29.2%
Hospital-based			
Not for profit	41%	36%	-18.5%
For profit	15%	15%	-6.2%

Government-owned IPFs are not shown but are reflected in the aggregate margin.
Results are preliminary and subject to change.

Source: MedPAC analysis of Medicare cost report data from CMS.

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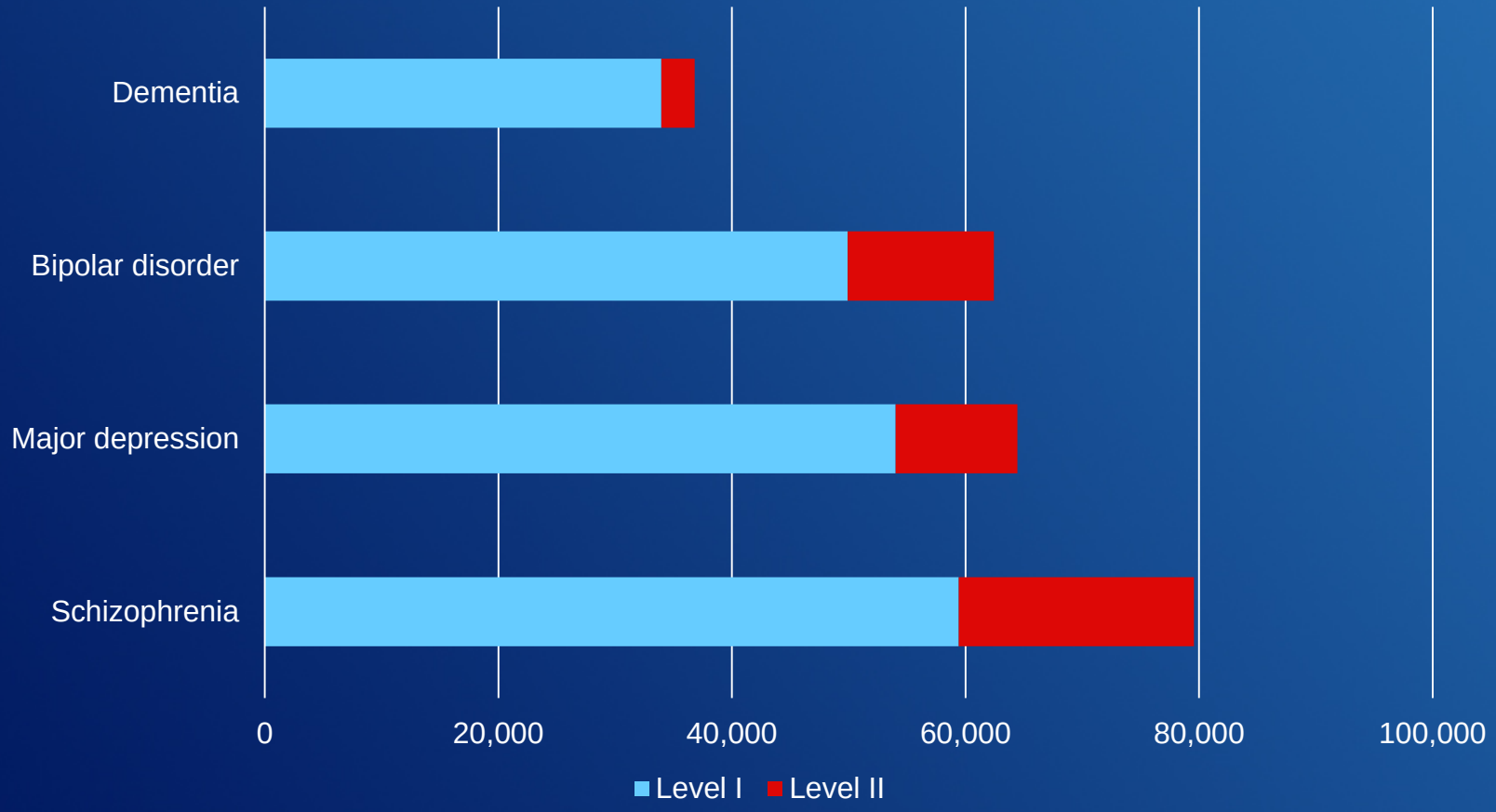
Very low costs in some IPFs raises questions about accuracy of PPS and program integrity

- Variation in margins may indicate that Medicare's payments do not track closely to patient costs
  - Payments for patients requiring high levels of staff time may be too low; payments for other patients may be too high
- IPF PPS payments vary relatively little
  - Per diem payments; 73% of cases are in one MS-DRG
- Studies in the US and other countries suggest that per diem costs of IPF care are relatively homogenous
  - But studies generally do a poor job of capturing complexity of disease
  - CMS administrative data captures little variation in cost of staff time

Capturing complexity in the IPF PPS

- 3M Health Information Systems (under contract to MedPAC) created inpatient mental health groups using 2011 data:
  - 22 clinically homogenous groups of base mental health conditions (e.g., schizophrenia, bipolar disorder, alcohol disorder) based on DRG assignment
  - 16 groups sub-divided into mental health complexity levels based on the ICD-9-CM code. Level II more complex than Level I, e.g.:
    - "paranoid- type schizophrenia, chronic" = Level I; "paranoid type schizophrenia, acute exacerbation" = Level II
  - ➢ Yielded 41 mental health groups

80% of IPF episodes fell into 1 of 4 base mental health conditions; 19% of these were complex



Level II episodes were more complex than Level I episodes. Results are preliminary and subject to change.
Source: 3M analysis of 2011 claims data from CMS.

Incomplete or missing information about ancillary services

- IPFs must apportion costs for each ancillary department unless they have an "all-inclusive" rate
  - 188 all-inclusive rate IPFs in 2016; accounted for 11% of all Medicare IPF days
- Growing number of IPFs report no drug costs even though they are not all-inclusive rate providers ("non-reporters")
  - 190 non-reporting IPFs in 2016, up from 50 in 2007
  - 96% are freestanding; 80% are for profit
  - Accounted for 21% of all Medicare IPF days in 2016
- Overall, 30% of IPF claims have no charges for drugs
- CMS expects most IPF patients to need ancillary services and supplies such as drugs
  - 97% of hospital-based IPF claims have charges for drugs

Why no reported drug costs?

- Billing outside of the IPF payment bundle?
  - CMS has found no evidence of inappropriate Part D billing
- Providers rolling up ancillary costs with routine costs?
  - Not clear that this is allowed under Medicare rules
  - If so, we might expect that total per diem costs of non-reporters would be similar to their peers

Unadjusted per diem costs, 2016	
Non-reporters	All other freestanding IPFs
$546	$745

- Low costs could indicate provider efficiency, patient mix with very low care needs, or stinting on care

Medicare's IPF Quality Reporting (IPFQR) program

- Approved provider-reported measures include:
  - Hours of physical restraint/seclusion use
  - Patients discharged on multiple antipsychotics
  - Substance use treatment offered and provided
  - Flu immunization
  - Timely transmission of transition record to subsequent care provider
- Claims-based measures:
  - Follow-up after IPF discharge
  - Thirty-day all-cause readmission rates

Not all beneficiaries who used IPFs had follow-up care after discharge, 2011

Mental health group	No Medicare Part A or B claims within 30 days after discharge
Alcohol disorder I	24%
Schizophrenia I	17%
Schizophrenia II	15%
Bipolar disorder I	12%
Major depression I	11%
Dementia I	5%

Level II diagnoses were considered more complex than Level I diagnoses.
Results are preliminary and subject to change.
Source: 3M analysis of 2011 claims data from CMS.

Beneficiaries who used IPFs had high rates of potentially preventable readmissions, 2011

	Potentially preventable readmissions	
Mental health group	Within 30 days of IPF discharge	Within 90 days of IPF discharge
Schizophrenia II	21%	36%
Schizophrenia I	19%	34%
Bipolar disorder I	17%	29%
Alcohol disorder I	15%	26%
Major depression I	14%	24%

Potentially preventable readmissions included any potentially preventable readmission to any hospital setting (including acute care) within 30 or 90 days. Level II diagnoses were considered more complex than Level I diagnoses. Results are preliminary and subject to change.
Source: 3M analysis of 2011 claims data from CMS.

Summary

- IPF users are a vulnerable, high-needs population with heavy service use
- Potential program integrity issue
  - Substantial minority of IPFs do not report any drug or lab costs
- Quality measures suggest that beneficiaries may not get adequate post-discharge care