March 14, 2024

Psych Payment Rule: 2025 Outlook

Refinement Possible but Big Shifts Unlikely (till 2026-27), Policies in the Mix

Relevant Companies

UHS ACADIA HEALTHCARE

Our Take & Next Up

The proposed 2025 IPF rule is due in April and despite Congressionally-mandated analysis of the somewhat dated PPS, we do not foresee major draconian pay updates for psych hospitals (near-term). There was a legislative mandate to study the Inpatient Psychiatric Payment rule (IPF) PPS for the last two years – acuity, resource allocation and cost. CMS issued a white paper in 2022; MedPAC released a report in June 2023. We believe that many of the dated findings do not necessarily convey the current behavioral health landscape (post COVID). MedPAC has discussed its policy requests for the IPF and we highlight them below, but we note that these are wish list legislative ideas for Congress; CMS would be unable to implement many of these without a change in the law. Mental health "wins" are also discussed, with the historical context for major agency pay changes (IRF, SNF) which took 1-3 years before proposal & enactment.

Key Points

We believe that CMS will provide light policy reform proposals in its March/April proposed 2025 IPF Medicare payment regulation. The IPF PPS is under review at OMB here. The mandated reforms are supposed to be "budget neutral" (or $0 overall) which could create code winners & losers, for sure. We believe this because:

(1) CMS has not performed any external TEP (technical expert panels) of late to collect their own data, and particularly more recent data
(2) CMS typically takes time (2-3 years) to review salient data before proposing a bold reform idea, such as the creation of new DRGs (diagnosis related groups, or other coding intensity practices)
(3) We believe that anything more controversial would be a RFI (request for information) on more appropriate co-morbidities or case-mix in the 2025 rule
(4) We do not believe CMS will take into account MedPAC recommendations in this rule, as those are bigger payment shifts that would require an act of Congress (e.g., 190 day limit removal)

Better behavioral health – in all forms – is a bipartisan supported policy topic of significant public health need. We do not envision the agency lowering the boom on psych providers in this post COVID environment.

Policies in the mix (in other parts of the DC policy ecosystem) include an extension of telemental benefits, substance abuse treatment flexibility, potentially lifting the IMD exclusion (Medicaid) which allows Medicaid to reimburse for care in inpatient setting with 16+ beds (Medicaid has not covered for over 50 years). In tandem, CMMI introduced in January a behavioral health pilot for 8 years in 8 states (here) to better integrate physical and mental health needs in Medicare & Medicaid.

MedPAC has taken up IPF payment policy discussions over the last ~2 years of public sessions with a slew of recommendations that are largely geared toward Congress. These would be helpful, but don't look out for them in the proposed '25 CMS payment rule as they require Congress. MedPAC slides from its most recent meeting can be found here.

- *Reevaluating and potentially remove the lifetime limit of 190 days for freestanding IPFs.* This addresses the challenges faced by beneficiaries who reach this limit and require ongoing care.
- *Given the low uptake of MA plans that offer additional IPF coverage, suggest initiatives to improve awareness among beneficiaries* regarding the coverage options available to them, especially those exceeding the 190-day limit.
- *Measures to enhance the monitoring of the quality of care in both IPFs and general acute care hospitals providing scatter-bed stays*. This could involve the development of a standardized quality reporting program.
- *Consider the differences in diagnoses between IPFs and general acute care hospitals.* A comprehensive analysis of the appropriateness of care settings for different psychiatric conditions is needed.

The psych community has had some policy "wins" of late, positively. See our Minibus with Healthcare Provisions analysis here. Two specific policies are called out below in the March CR, with hospitals, physicians and community health center funding being provided.

- Permanent IMD exclusion for patients with SUD (substance use disorder, Medicaid)
- State Medicaid programs must cover all MAT (medication assisted therapies) for opioid use disorder

Historically, CMS took several years before proposing (major) pay reforms in post-acute (home health, Rehab & SNF). We think it would be premature for the agency to propose draconian policies without more recent case-mix, acuity, cost and trend analysis. However, if they do, mitigation is likely. We think it is more likely that small-ball reforms are proposed with a request for stakeholder input on other bigger ideas that restructure the IPF PPS.

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