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CMS's Proposed IPPS and LTCH FY 2017 Rule: Key Takeaways [Ober|Kaler]

2016

On April 18, 2016, CMS released its proposed rule [PDF] addressing new payment rates and policies under both the Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS), for fiscal year (FY) 2017.

CMS stated the proposed rule is intended to reflect its "commitment to increasingly shift Medicare payments from volume to value," and to pay providers based on the "quality, rather than the quantity of care they give to patients." An overview of several of CMS's key proposed policies is provided below.

Comments are due June 17, 2016. CMS has stated it intends to release the final rule on August 1, 2016.

1. IPPS Payment Rate — Increase of 0.9%

CMS proposes to increase payment rates by 0.9 percent in FY 2017 for all IPPS hospitals that successfully participate in the Hospital Inpatient Reporting (IQR) Program and are meaningful users of electronic health records (EHR). The 0.9 percent increase reflects the sum total of:

- A -1.5 percent recoupment adjustment to the standardized amount of Medicare payments, as mandated by the American Taxpayer Relief Act (with rate adjustments related to the American Taxpayer Relief Act phased in since FY 2014).
- A 0.8 percent increase as a result of CMS reversing its stance on its "two midnight" policy. Previously, in the FY 2014 IPPS/LTCH PPS final rule, CMS estimated that its two midnight policy would result in a 0.2 percent increase in IPPS expenditures and, accordingly, reduced IPPS hospitals' payment rates by 0.2 percent. While CMS is indicating that it "believes the assumptions underlying [its] -0.2 percent adjustment were reasonable at the time they were made," it is now proposing to not only permanently remove the -0.2 adjustment, but also reverse the effect of the -0.2 percent cut for FYs 2014, 2015, and 2016. Accordingly, CMS is increasing rates for FY 2017 by 0.2 percent, plus adding on a one-time increase of 0.6 percent to offset cuts made in the three preceding fiscal years. This revision arose from a challenge by hospitals to the 0.2 reduction in *Shands Jacksonville Med. Ctr. v. Burwell [PDF]*, D.D.C., No. 1:14-cv-00263 (Sept. 2, 2015). The court in that case found CMS's initial explanation of the 0.2 percent reduction to be inadequate and ordered the agency to go through further notice and comment rulemaking. Please see our earlier discussion of this issue here.
- The projected hospital market basket update of 2.8 percent, with additional adjustments to account for productivity and adjustments mandated by the Affordable Care Act.

2. LTC Payment Rate - Updates

As a result of CMS's continued implementation of The Pathway for SGR Reform Act of 2013 (which established two separate types of LTCH PPS payment rates, depending on whether the patient meets certain clinical criteria), CMS projects in this proposed rule that payment rates for LTCHs in FY 2017 will decrease by 6.9 percent. That said, cases that qualify for the higher standard LTCH PPS payment rate will realize an increased payment rate of .3 percent for FY 2017.

In addition, CMS is proposing to revise and rebase the market basket used under the LTCH PPS to reflect a 2012 base year.

3. New Notification Procedures for Outpatients Receiving Observation Services

Pursuant to the Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act), hospitals and critical access hospitals (CAHs) must soon (effective August 6, 2016) provide notification to individuals receiving observation services as outpatients for more than 24 hours. While CMS will separately afford comment on the proposed notice letter for Medicare beneficiaries (referred to by CMS as the Medicare Outpatient Observation Notice, or "MOON"), CMS proposes that the notice be provided no later than 36 hours after observation services are initiated. In addition, CMS proposes that an oral explanation of the MOON must be provided and a signature must be obtained from the beneficiary.

4. Medicare Uncompensated Care Payments — Revised Methodology

CMS is proposing to distribute $400 million less in uncompensated care payments in FY 2017, as compared to FY 2016.

In addition, CMS proposes two changes to the methodology to determine how to distribute such funds. Fist, CMS would use data from three cost reporting periods instead of one cost reporting period; and second, CMS would apply a proxy to estimate Medicare Supplemental Security Income (SSI) inpatient days for Puerto Rican hospitals (residents of Puerto Rico are not eligible for Medicare SSI benefits).

5. Hospital Readmission Reduction Program — Public Reporting

The Hospital Readmission Reduction Program mandates that hospitals with excess readmissions for select conditions receive a reduction to their base operating DRG payment. Related to this program, and in an effort to align with other hospital quality reporting programs, CMS is proposing to clarify its reporting policy — specifically, that excess readmission rates will be posted to the Hospital Compare website "as soon feasible following the [hospital] preview period."

6. Hospital Inpatient Quality Reporting Program — Changes to Measures for FY 2019

As part of the Hospital Inpatient Quality Reporting (IQR) Program, CMS proposes to add four new claims-based measures, while removing 15 measures, for the FY 2019 payment determination and subsequent years. CMS also invites public comment on potential new quality measures for future inclusion in the Hospital IQR program.

In addition, CMS proposes to update its "Extraordinary Circumstances Extensions or Exemptions" (ECE) policy by extending the ECE request deadline.

7. Hospital Acquired Conditions Reduction Program — New Reporting Requirements for Newly Opened Hospitals

Currently, hospitals who rank amongst the top 25 percent of all applicable hospitals for prevalence of hospital-acquired conditions (HAC), receive a one percent payment reduction. CMS proposes five changes to its

current HAC Reduction Program: (a) establish NHSN CDC HAI data submission requirements for newly opened hospitals; (b) clarify data requirements for Domain 1 scoring; (3) establish performance periods for the FY 2018 and FY 2019 HAC Reduction Programs; (4) adopt the refined PSI 90: Patient Safety for Selected Indicators Composite Measure (NQF # 0531); and (5) modify the current scoring methodology from the current decile-based scoring to a continuous scoring methodology.

8. LTC Quality Reporting Program — New Measures

In accordance with the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) CMS proposes three new measures for the FY 2018 payment determinations and subsequent years. In addition, CMS states it will publicly report LTCH quality data beginning in fall 2016 on a CMS website. Only four quality measures will be initially reported.