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Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Final Rule Policy and Payment Changes for Fiscal Year (FY) 2017

Today, the Centers for Medicare & Medicaid Services (CMS) issued a final rule to update fiscal year (FY) 2017 Medicare payment policies and rates under the Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS). The final rule, which would apply to approximately 3,330 acute care hospitals and approximately 430 LTCHs, would affect discharges occurring on or after October 1, 2016.

The IPPS pays hospitals for services provided to Medicare beneficiaries using a national base payment rate, adjusted for a number of factors that affect hospitals' costs, including the patient's condition and the cost of hospital labor in the hospital's geographic area.

This rule finalizes policies that continue a commitment to increasingly shift Medicare payments from volume to value. The Administration has set measurable goals and a timeline to move the Medicare program, and the health care system at large, toward paying providers based on the quality, rather than the quantity of care they give patients. The final rule includes policies that advance that vision and is one of several final rules that reflect a broader Administration-wide strategy to create a health care system that results in better care, smarter spending, and healthier people.

This fact sheet discusses major provisions of the final rule.

Background

CMS pays acute care hospitals (with a few exceptions specified in the law) for inpatient stays under the IPPS and long-term care hospitals under the LTCH PPS. Under these two payment systems, CMS generally sets payment rates prospectively for inpatient stays based on the patient's diagnosis and severity of illness. A hospital receives a single payment for the stay based on the payment classification – MS-DRGs under the IPPS and MS-LTC-DRGs under the LTCH PPS – assigned at discharge.

By law, CMS is required to update payment rates for IPPS hospitals annually, and to account for changes in the costs of goods and services used by these hospitals in treating Medicare patients, as well as for other factors. This is known as the hospital "market basket." Payment rates to LTCHs are typically updated annually according to a separate market basket based on LTCH-specific goods and services.

Changes and Updates in FY 2017 Policies

Changes to Payment Rates under IPPS

The final increase in operating payment rates for general acute care hospitals paid under the IPPS that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful electronic health record (EHR) users is approximately 0.95 percent. This reflects the projected hospital market basket update of 2.7 percent adjusted by -0.3 percentage point for multi-factor productivity and an additional adjustment of -0.75 percentage point in accordance with the Affordable Care Act. This also reflects a 1.5 percentage point reduction for documentation and coding required by the American Taxpayer Relief Act of 2012 and an increase of approximately 0.8 percentage points to remove the adjustment to offset the estimated costs of the Two Midnight policy and address its effects in FYs 2014, 2015, and 2016.

Hospitals that do not successfully participate in the Hospital IQR Program and do not submit the required quality data will be subject to a one-fourth reduction of the market basket update. Also, the law requires that any hospital that is not a meaningful EHR user will be subject to a three-fourths reduction of the market basket update in FY 2017.

CMS projects that the rate increase, together with other final changes to IPPS payment policies, will increase IPPS operating payments by approximately 1.0 percent and that changes in uncompensated care payments will decrease

IPPS operating payments by 0.4 percent. Other continued additional payment adjustments will include: a 1.0 percent reduction for hospitals in the lowest performing quartile under the Hospital Acquired Condition Reduction Program; payment adjustments for excess readmissions under the Hospital Readmissions Reduction Program; and incentive payments and reductions under the Hospital-Value Based Purchasing Program. In sum, CMS projects that total Medicare spending on inpatient hospital services, including capital, will increase by about $746 million in FY 2017.

This projected increase in spending includes an estimated $350,000 increase in FY 2017 payments to hospitals located in Puerto Rico under the final policy to make IPPS payments for capital-related costs based solely on the national capital Federal rate (rather than the current blend of the national capital Federal rate and Puerto Rico-specific capital rate), consistent with the recent statutory change in the payment methodology for operating IPPS payments to those hospitals.

IPPS Rate Adjustments for Documentation and Coding and Two Midnight Policy

In the FY 2017 IPPS final rule, CMS is finalizing two adjustments in addition to its annual rate update for inpatient hospital payments.

First, CMS is finalizing the last year of recoupment adjustments required by the American Taxpayer Relief Act of 2012 (ATRA). Section 631 of ATRA requires CMS to recover $11 billion by FY 2017 to fully recoup documentation and coding overpayments related to the transition to the MS-DRGs that began in FY 2008. For FYs 2014, 2015, and 2016, CMS implemented a series of cumulative -0.8 percent adjustments. For FY 2017, CMS calculates that $5.05 billion of the $11 billion requirement remains to be addressed. Therefore, CMS is finalizing a -1.5 percent adjustment to complete the statutorily-specified recoupment.

Second, CMS is taking action regarding the -0.2 percent adjustment it implemented in the FY 2014 IPPS/LTCH PPS final rule to account for an estimated increase in Medicare expenditures due to the Two Midnight Policy. Specifically, in the FY 2014 IPPS/LTCH PPS final rule, CMS estimated that this policy would increase expenditures and accordingly made an adjustment of

-0.2 percent to the payment rates. CMS believes the assumptions underlying the -0.2 percent adjustment were reasonable at the time they were made. Additionally, CMS does not generally believe it is appropriate in a prospective payment system to retrospectively adjust rates. However, in light of recent review and the unique circumstances surrounding this adjustment, for FY 2017, CMS is permanently removing this adjustment and also its effects for FYs 2014, 2015, and 2016 by adjusting the FY 2017 payment rates. This will increase FY 2017 payments by approximately 0.8 percent.

Medicare Uncompensated Care Payments

CMS distributes a prospectively determined payment amount to Medicare disproportionate share hospitals based on their relative share of uncompensated care nationally. As required by the Affordable Care Act, this amount is equal to an estimate of 75 percent of what otherwise would have been paid as Medicare disproportionate share hospital payments prior to the Affordable Care Act, adjusted for decreases in the rate of uninsured individuals and other factors. In this rule, CMS is distributing almost $6 billion in uncompensated care payments in FY 2017, a decrease of approximately $400 million from the FY 2016 amount.

For FY 2017, CMS is finalizing a policy of continuing to distribute these funds using a proxy for uncompensated care based on insured low income days, which include inpatient days for patients eligible for Medicaid and inpatient days for patients entitled to Medicare and Supplemental Security Income (SSI). CMS is also finalizing two changes to this methodology. First, CMS will use data from three cost reporting periods instead of one cost reporting period to limit major fluctuations in uncompensated care payments from year-to-year. Second, CMS will apply a proxy to estimate Medicare SSI inpatient days for Puerto Rico hospitals since residents of Puerto Rico are not eligible for SSI benefits.

CMS proposed to begin incorporating uncompensated care cost data from Worksheet S-10 of the Medicare cost report in the methodology for distributing these funds starting in FY 2018. In light of public comment, we are not finalizing this proposal. Instead, our intent is to engage in future rulemaking and begin to incorporate Worksheet S-10 data into the computation of Factor 3 no later than FY 2021. We intend to make certain modifications and clarifications to the cost report instructions for Worksheet S-10, as well as implement review protocol for the Medicare Administrative Contractors (MACs) to use in reviewing Worksheet S-10.

CMS-1632-F & IFC –Finalization of the Extension of the MDH Program and Low-Volume Hospital Adjustment Provided by the MACRA

On August 17, 2015, CMS issued an interim final rule with comment period (IFC) implementing the extension of the temporary changes to the criteria and payment adjustment for low-volume hospitals and the Medicare-dependent hospital (MDH) program for discharges occurring from April 1, 2015 through September 30, 2017, as provided by sections 204 and 205 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) of 2015 (Pub. L. 114-10). Under these extensions, a hospital can qualify as a low-volume hospital if it is located more than 15 road miles from another hospital and has fewer than 1,600 Medicare discharges, and special payment protections are retained for Medicare-dependent, small rural hospitals. We are finalizing this IFC in the FY 2017 IPPS/LTCH PPS final rule.

Notification Procedures for Outpatients Receiving Observation Services

Enacted August 6, 2015, the Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act) requires hospitals and Critical Access Hospitals (CAH) to provide notification to individuals receiving observation services as outpatients for more than 24 hours explaining the status of the individual as an outpatient, not an inpatient,

and the implications of such status.

- Hospitals and CAHs are required to furnish a new proposed CMS-developed standardized notice, the Medicare Outpatient Observation Notice (MOON), to a Medicare beneficiary who has been receiving observation services as an outpatient for more than 24 hours. Under the final rule, hospitals and CAHs may deliver the MOON to individuals receiving observation services as an outpatient before such individuals have received more than 24 hours of observation services. The notice must be provided no later than 36 hours after observation services are initiated or, if sooner, upon release;
- The MOON will inform more than one million beneficiaries annually of the reason(s) they are an outpatient receiving observation services and the implications of such status with regard to Medicare cost sharing and coverage for post-hospitalization skilled nursing facility (SNF) services; and
- An oral explanation of the MOON must be provided, ideally in conjunction with the delivery of the notice, and a signature must be obtained from the individual, or a person acting on such individual's behalf, to acknowledge receipt. In cases where such individual or person refuses to sign the MOON, the staff member of the hospital or CAH providing the notice must sign the notice to certify that notification was presented.

The standardized notice, the MOON, is going through the Paperwork Reduction Act process, thus affording the public an opportunity to comment on the MOON. The 30-day public comment period begins when the final rule is published.

Hospital-Acquired Condition (HAC) Reduction Program

The HAC Reduction Program creates an incentive for hospitals to reduce the incidence of hospital-acquired conditions by requiring the Secretary to make an adjustment to payments to hospitals that are in the worst performing quartile for hospital-acquired conditions. In the FY 2017 IPPS/LTCH PPS final rule, CMS is making five changes to existing HAC Reduction Program policies:

1. Establishing National Healthcare Safety Network (NHSN) CDC Healthcare Associated Infections (HAI) data submission requirements for newly opened hospitals;
2. Clarifying data requirements for Domain 1 scoring;
3. Establishing performance periods for the FY 2018 and FY 2019 HAC Reduction Program;
4. Adopting the refined PSI 90: Patient Safety for Selected Indicators Composite Measure (NQF # 0531); and
5. Changing the Program scoring methodology from the current decile-based scoring to a continuous scoring methodology.

Hospital Readmissions Reduction Program (HRRP)

The Hospital Readmission Reduction Program (HRRP) requires a reduction to a hospital's base operating DRG payment to account for excess readmissions associated with selected applicable conditions. For FY 2017 and subsequent years, the reduction is based on a hospital's risk-adjusted readmission rate during a three-year period for acute myocardial infarction (AMI), heart failure (HF), pneumonia, chronic obstructive pulmonary disease (COPD), total hip arthroplasty/total knee arthroplasty (THA/TKA), and coronary artery bypass graft (CABG) (pursuant to previous rulemaking). To align with other quality reporting programs and allow the posting of data as soon as possible, CMS is updating the public reporting policy so that excess readmission rates will be posted to the *Hospital Compare* website as soon as feasible following the hospitals' preview period.

Medicare and Medicaid EHR Incentive Programs

This rule also includes the requirements for eligible hospitals and CAHs reporting clinical quality measures (CQMs) for the Medicare and Medicaid EHR Incentive Programs. CMS finalized modifications to some of the CQM reporting and submission requirements, including the proposed removal of certain CQMs to align with the Hospital IQR Program.

Hospital Inpatient Quality Reporting (IQR) Program

The Hospital IQR Program is a pay-for-reporting program established by the Medicare Prescription Drug, Improvement, and Modernization Act. In the FY 2017 IPPS/LTCH PPS final rule, CMS is finalizing the addition of four new claims-based measures for the FY 2019 payment determination and subsequent years (three clinical episode-based payment measures and one communication and coordination-of-care measure). CMS is also finalizing the removal of 15 measures for the FY 2019 payment determination and subsequent years. Of these 15 measures, 13 are electronic clinical quality measures (eCQMs), two of which CMS is also removing in their chart-abstracted form, and two others are structural measures. CMS is also finalizing the refinement of two previously adopted measures beginning with the FY 2018 payment determination.

In addition, CMS is finalizing a number of changes in relation to eCQMs:

1. Requiring hospitals to report four quarters of data on an annual basis for eight of the available eCQMs included in the Hospital IQR Program measure set for the FY 2019 and FY 2020 payment determinations in order to align with the Medicare and Medicaid EHR Incentive Programs. This is a modification from the proposal, which proposed to require hospitals to submit on all available eCQMs (15 eCQMs) in the Hospital IQR Program;
2. Requiring several related technical eCQM submission requirements beginning with the FY 2019 payment determination; and
3. Expanding the current validation process to include the validation of eCQM data beginning in the spring of

CY 2018 for the FY 2020 payment determination.

Lastly, CMS is finalizing an update to its Extraordinary Circumstances Extensions/Exemptions (ECE) policy by:

1. Extending the ECE request deadline for non-eCQM circumstances from 30 to 90 calendar days following an extraordinary circumstance; and
2. Establishing a separate submission deadline of April 1 following the end of the reporting calendar year for ECEs related to eCQMs.

Hospital Value-Based Purchasing (VBP) Program

Established by the Affordable Care Act, the Hospital VBP Program adjusts payments to hospitals for inpatient services based on their performance on an announced set of measures. In the FY 2017 IPPS/LTCH final rule, CMS is finalizing updates to the Hospital VBP Program requirements and the expansion of the Hospital VBP Program measure set. Specifically, the rule finalizes expanding the number of hospital units to which two National Healthcare Safety Network measures apply beginning with the FY 2019 program year. In addition, CMS is finalizing expansion of the cohort used to calculate the 30-day pneumonia mortality measure beginning with the FY 2021 program year. CMS is also finalizing the addition of two condition-specific payment measures (one for acute myocardial infarction and one for heart failure) beginning with the FY 2021 program year and a 30-day mortality measure following CABG surgery beginning with the FY 2022 program year. The rule also finalizes changes to the policy that governs whether a hospital will be excluded from the program if it is cited for deficiencies that pose immediate jeopardy to the health and safety of patients.

PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program

The PCHQR Program collects and publishes data on an announced set of quality measures. In the FY 2017 IPPS/LTCH PPS final rule, CMS is finalizing one new measure for this program. Specifically, CMS is adding a measure of Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy. In addition to this measure, CMS is expanding the patient cohort of the previously finalized Radiation Dose Limits to Normal Tissues for Patients Receiving 3D Conformal Radiation Therapy measure. The new cohort will include breast and rectal cancer patients in addition to the previous cohort of lung and pancreatic cancer patients.

Inpatient Psychiatric Facility Quality Reporting Quality Reporting (IPFQR) Program

The IPFQR Program is a pay-for-reporting program established by the Affordable Care Act. In the final rule, CMS is finalizing a technical update to the previously finalized measure, Screening for Metabolic Disorder. CMS is also finalizing the addition of two new measures to the program beginning with the FY 2019 payment determination: (1) Thirty-day All-Cause Readmission Following Psychiatric Hospitalization in an IPF, which is a measure calculated from administrative claims data; and (2) SUB-3: Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and the subset measure SUB-3a: Alcohol & Other Drug Use Disorder Treatment at Discharge (NQF #1664). SUB-3/3a is a chart-abstracted measure that complements the previously adopted substance abuse measures in the IPFQR Program.

In addition, CMS is finalizing a policy to include the SUB-3/SUB-3a measure in the list of measures covered by the global sample for the FY 2019 payment determination and subsequent years. The agency is also finalizing that it will make the data for the IPFQR Program available as soon as possible and announce both the date of public display of the program's data and the 30 day preview period via sub regulatory methods. CMS is also finalizing that we will no longer specify how long before public display the preview period will be; this timeframe was previously finalized as 12 weeks. For the FY 2017 payment determination only, CMS is finalizing that, if it is technically feasible to display the data in December 2016, the Agency would provide data to IPFs for a two-week preview period that would start on October 1, 2016. Moreover, CMS is finalizing that, for the FY 2017 payment determination only, if CMS is able to display the data in December 2016, the Agency would ensure that IPFs have approximately 30 days for review by providing IPFs with their data as early as mid-September.

Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) Changes

In this final rule, CMS is updating the LTCH PPS standard Federal payment rate by 1.75 percent for FY 2017 for LTCHs that successfully participate in the LTCH Quality Reporting Program (LTCH QRP). This update is based on the most recent estimate of the revised and rebased LTCH PPS market basket (which is being adopted in this final rule) of 2.8 percent adjusted by -0.3 percentage point for multi-factor productivity and an additional adjustment of -0.75 percentage point in accordance with the Affordable Care Act. CMS is also continuing to implement the changes required by The Pathway for SGR Reform Act of 2013 that establish two different types of LTCH PPS payment rates depending on whether the patient meets certain clinical criteria. As a result of the continued phase-in of these changes, CMS projects that LTCH PPS payments will decrease by 7.1 percent, or approximately $363 million in FY 2017 CMS. Cases that qualify for the higher standard LTCH PPS payment rate under the revised system will see an increase in payments of 0.7 percent in FY 2017. In addition, CMS is streamlining its regulations regarding the 25 percent threshold policy, which is a payment adjustment made when the number of cases an LTCH admits from a single hospital exceeds a specified threshold (generally 25 percent).

Along with the FY 2017 IPPS/LTCH PPS final rule, CMS finalized an IFC to implement section 231 of the Consolidated Appropriations Act, 2016 that established a temporary exception from the site neutral payment rate for certain severe wound care discharges from certain LTCHs.

Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP)

Beginning in FY 2014, the applicable annual update for any LTCH that did not submit the required data to CMS is

reduced by two percentage points. The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) requires the continued specification of quality measures for the LTCH QRP, as well as resource use and other measures.

In order to satisfy the requirements of the IMPACT Act, CMS is finalizing one new assessment-based quality measure, and three claims-based measures for inclusion in the LTCH QRP:

1. Discharge to Community – Post Acute Care (PAC) LTCH QRP (claims-based);
2. Medicare Spending Per Beneficiary (MSPB) – PAC LTCH QRP (claims-based);
3. Potentially Preventable 30 Day Post-Discharge Readmission Measure for LTCHs (claims-based); and
4. Drug Regimen Review Conducted with Follow-Up for Identified Issues (assessment-based).

CMS is finalizing the addition of four new measures to LTCH QRP public reporting for fall 2017. We are additionally clarifying the previously finalized procedures for provider review and correction of performance data in advance of LTCH QRP public reporting, in order to ensure we are aligned with the Hospital IQR Program's policies and practices.

The final rule is available on the *Federal Register* at https://www.federalregister.gov/public-inspection.

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