PUBLICATION

CMS Releases the 2017 IPPS and LTCH PPS Final Rule, Including MOON Requirements [Ober|Kaler]

2016

On August 2, 2016, CMS issued its final rule addressing new payment rates and policies under both the Hospital Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) for Fiscal Year (FY) 2017. As we stated in our previous article summarizing key provisions from the proposed rule [PDF], CMS noted the 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 patients."

This final rule will be published in the Federal Register on August 22, 2016, and affects discharges occurring on or after October 1, 2016.

Below is a brief overview of some of the key provisions of the final rule.

1. IPPS Payment Rate – Increase of 0.95%

CMS increased the FY 2017 operating payment rates by 0.95% (rather than the proposed 0.90%) for general acute care hospitals that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful electronic health record (EHR) users. This final percent increase reflects:

- The projected market basket update of 2.7% (rather than the proposed 2.8%), with additional -0.3% and -0.75% adjustments to account for productivity and those mandated by the Affordable Care Act;
- A 1.5% final recoupment reduction for documentation and coding overpayments from the transition to MS-DRGs as of FY 2008, as mandated by the American Taxpayer Relief Act of 2012; and
- A 0.8% increase to offset CMS's previous stance on its "two midnight" policy in which, in its FY 2014 IPPS/ LTCH PPS final rule, CMS estimated a 0.2% increase in IPPS expenditures and thus reduced IPPS hospitals' payment rates by 0.2%. CMS is permanently removing the -0.2% adjustment and reversing the effect of the -0.2% cut for FYs 2014, 2015, and 2016 by: (1) increasing the FY 2017 rates by 0.2% and (2) adding on a one-time increase of 0.6% to offset cuts made in FY 2014, 2015, and 2016. As noted in our previous article summarizing the proposed rule, this revision arose from the U.S. District Court for the District of Columbia's decision in *Shands Jacksonville Med. Ctr. v. Burwell (Shand's)*, D.D.C., No. 1:14-cv-00263 (Sept. 21, 2015), in which the Court concluded CMS's explanation of its 0.2% reduction was inadequate and ordered the agency to go through further notice and comment rulemaking. The discussion on this issue in the proposed and final rule constitutes "the final notice required by the [*Shand's*] Court. . . ." For more discussion on this issue, please refer to our previous article here.

2. New Notification Procedures for Outpatients Receiving Observation Services

In accordance with the Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act), hospitals and critical access hospitals (CAHs) must notify patients receiving observation services as outpatients for more than 24 hours of their status as outpatients (and not inpatients) and explain the

implications of such status. To satisfy this requirement, CMS has developed a standardized written notice, the Medicare Outpatient Observation Notice (MOON), which hospitals and CAHs must provide to a Medicare beneficiary who has been receiving observation services as an outpatient for more than 24 hours.

Under the rule, the MOON:

- must be delivered to the patient no later than 36 hours after observation services as an outpatient are initiated, but may be provided before the patient has received more than 24 hours of observation services (in limited circumstances);
- will inform beneficiaries of the reasons he or she is an outpatient receiving more than 24 hours of observation services and the implications of his or her status as an outpatient receiving such services (i.e., potential post-hospitalization skilled nursing facility services coverage and Medicare cost sharing); and
- must be orally explained to and acknowledged by (by signature) the individual receiving such notice.

Although the NOTICE Act's notification requirements were to be effective August 6, 2016, CMS has delayed implementation of such requirements until the MOON is finalized. **Public comments on the MOON will be due by September 1st.** Once finalized, hospitals and CAHs must fully implement the use of the MOON within 90 calendar days.

3. Medicare Uncompensated Care Payments – Revised Methodology

For FY 2017, CMS will distribute about $6 billion in uncompensated care payments, which is almost $400 million less than the FY 2016 distributions. To do so, CMS has finalized two proposed changes to its methodology. First, CMS will now use data from three cost reporting periods instead of one cost reporting period; and second, since Puerto Rico residents are not eligible for Medicare Supplemental Security Income (SSI) benefits, CMS will use a proxy to estimate inpatient days for Puerto Rican hospitals.

While CMS initially proposed to begin incorporating uncompensated care cost data from Worksheet S-10 into the new methodology by FY 2018, this proposal was not finalized due to public comments. CMS intends to engage in future rulemaking and begin incorporating such data no later than FY 2021.

4. Hospital Readmissions Reduction Program (HRRP) – Public Reporting

To account for excess readmissions associated with certain conditions, the HRRP requires a reduction in a hospital's base operating DRG payment. For FY 2017 and subsequent years, this reduction is based on a hospital's risk-adjusted readmission rate for certain conditions during a three-year period. CMS is updating its 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."

5. Hospital Inpatient Quality Reporting (IQR) Program – Changes to Measures for FY 2019

CMS has finalized, for the FY 2019 payment determination and subsequent years, its addition of four claims-based measures (three clinical based payment measures and one communication and coordination-of-care measure) and the removal of 15 electronic clinical quality and structural measures. Changes related to the electronic clinical quality measures (eCQMs) were also finalized.

Additionally, CMS finalized updates to its Extraordinary Circumstances Extensions/Exemptions (ECE) policy by extending the ECE request deadline for non-eCQM circumstances and establishing a separate deadline for ECEs related to eCQMs.

6. Hospital Acquired Conditions Reduction Program – New Reporting Requirements for Newly Opened Hospitals

CMS has finalized five changes in its Hospital-Acquired Condition (HAC) Reduction Program, which include those relating to newly opened hospitals' data submissions, Domain 1 scoring, performance periods for FYs 2018 and 2019, PSI 90: Patient Safety for Selected Indicators Composite Measures, and the Program scoring methodology (from decile-based scoring to a continuous scoring methodology).

7. LTC Payment Rate – Updates

For FY 2017, CMS is updating the LTCH PPS standard Federal rate by 1.75% for those LTCHs that successfully participate in the LTCH Quality Reporting Program. The update is based on the recent estimate of the LTCH PPS market basket (2.8%) with additional -0.3% and -0.75% adjustments to account for productivity and those mandated by the Affordable Care Act.

CMS will continue to implement changes required by 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). By doing so, CMS estimates LTCH PPS payments will decrease by 7.1% in FY 2017.

8. LTC Quality Reporting Program – New Measures

Pursuant to the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act), CMS finalized three new measures for the FY 2018 payment determinations and subsequent years (one assessment-based quality measure and three claims-based measures). Additionally, CMS will be adding four new measures to the LTCH Quality Reporting Program public reporting for fall 2017.