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CMS RELEASES FY 2017 HOSPITAL INPATIENT PPS FINAL RULE

This bulletin is 5 pages.

The Centers for Medicare & Medicaid Services (CMS) on Aug. 2 issued its hospital inpatient prospective payment system (PPS) and long-term care hospital (LTCH) PPS final rule for fiscal year (FY) 2017. Select highlights of the final rule related to the inpatient PPS follow. Highlights of the final rule related to the LTCH PPS will be covered in a separate Special Bulletin.

The rule is a mixed bag for hospitals and the patients they serve. We are pleased CMS reversed the effects of the 0.2 percent payment reduction that was part of the original “two-midnight” policy. We also commend the agency for pausing the incorporation of Worksheet S-10 data in order to improve its accuracy and consistency in determining the cost of treating uninsured patients. However, we are disappointed that CMS finalized an unjustified cut to reimbursement rates for hospital services. In addition, while CMS reduced its proposed requirements on reporting electronic clinical quality measures (eCQMs), much more work needs to be done to ensure that the measures are valid and reliable before broad-scale implementation.

Inpatient PPS Payment Update: The final rule will increase inpatient PPS rates by 0.95 percent in FY 2017, after accounting for inflation and other adjustments required by law. Specifically, the update includes an initial market-basket update of 2.7 percent, less 0.3 percentage points for productivity, 0.75 percentage points mandated by the Affordable Care Act (ACA) and 1.5 percentage points in response to the American Taxpayer Relief Act of 2012 (ATRA). In addition, CMS finalizes a 0.8 percent positive adjustment related to the two-midnight policy. Table 1 below details the factors CMS includes in this update.
Table 1: Impacts of FY 2017 CMS Final Policies

<table>
<thead>
<tr>
<th>Policy</th>
<th>Average Impact on Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Market-basket update</td>
<td>2.7%</td>
</tr>
<tr>
<td>Productivity cut mandated by ACA</td>
<td>- 0.3%</td>
</tr>
<tr>
<td>Additional cut mandated by ACA</td>
<td>- 0.75%</td>
</tr>
<tr>
<td>Documentation and coding cut for FYs 2010, 2011 and 2012 mandated by ATRA</td>
<td>- 1.5%</td>
</tr>
<tr>
<td>Two-midnight policy adjustments</td>
<td>+ 0.8%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>+0.95%</strong></td>
</tr>
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</table>

The ACA, ATRA and two-midnight policy adjustments will be applied to all hospitals. Additionally, hospitals not submitting quality data will be subject to a one-quarter reduction of the initial market basket (for a new market-basket rate of 2.025 percent) and, thus, will receive an update of 0.275 percent. Hospitals that were not meaningful users of electronic health records (EHRs) in FY 2015 will be subject to a three-quarter reduction of the initial market basket (for a new market-basket rate of 0.675 percent) and, thus, will receive an update of -1.075 percent. Hospitals that fail to meet both of these requirements will be subject to a full reduction of the initial market-basket rate (for a new market-basket rate of 0 percent), thus receiving an update of -1.75 percent.

**Two-midnight Policy**: CMS finalizes two adjustments that will reverse the effects of the 0.2 percent cut it unlawfully instituted when implementing the two-midnight policy in FY 2014. Specifically, the agency finalizes a permanent adjustment of 0.2 percent to remove the cut prospectively for FYs 2017 and onward; as well as a temporary, one-time adjustment of 0.6 percent to address the retroactive impacts of this cut for FYs 2014, 2015 and 2016.

This change represents an important, hard-fought victory for hospitals and health systems. The AHA successfully challenged CMS’s implementation of this cut in federal court and convinced CMS to restore the resources that hospitals are lawfully due.

**ATRA**: The rule finalizes a cut of 1.5 percentage points to inpatient PPS payments that will fulfill the requirement of ATRA. Specifically, ATRA requires CMS to recoup what the agency claims is the effect of documentation and coding changes from FYs 2010 through 2012 that CMS says do not reflect real changes in case mix. The agency indicates that this cut, combined with the effects of the previous cuts of 0.8 percentage points in FYs 2014, 2015 and 2016, will allow the agency to fulfill the $11 billion ATRA recoupment requirement within the statutory four-year timeline. These recoupment cuts will be restored to the standardized amount beginning in FY 2018.
The AHA is extremely disappointed that the cut finalized by CMS is nearly two times what Congress specified in ATRA, as well as in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The AHA will urge the agency to restore the full amount allowed by law to the standardized amount in FY 2018.

Disproportionate Share Hospital (DSH) Payment Changes: The ACA required changes to the way in which DSH payments are made to hospitals, beginning in FY 2014. Under the new payment formula, hospitals initially receive 25 percent of the Medicare DSH funds they would have received under the former statutory formula (described as “empirically justified” DSH payments). The remaining 75 percent flows into a separate funding pool for DSH hospitals. This pool will be reduced as the percentage of uninsured declines and will be distributed based on the proportion of total uncompensated care each Medicare DSH hospital provides.

In FY 2017, CMS will further decrease the amount of the 75-percent pool to reflect additional decreases in the percentage of uninsured. Specifically, the agency estimates that DSH payments will decrease by $400 million compared to FY 2016. This calculation is based on estimates from the Congressional Budget Office that the rate of uninsured will decrease from 11 percent to 10 percent between calendar years (CY) 2016 and 2017.

CMS also finalizes its proposal to continue using inpatient days of Medicaid patients plus inpatient days of Medicare Supplemental Security Income (SSI) patients to determine the amount of uncompensated care each hospital provides in FY 2017. However, CMS did not finalize its proposal to incorporate Worksheet S-10 data into the computation of uncompensated care payments beginning in FY 2018. In response to concerns expressed by AHA and others, CMS says it will institute certain additional quality control and data improvement measures, including an audit process, to the Worksheet S-10 instructions and data prior to moving forward with its use. The agency indicates that it expects to re-propose a policy of incorporating Worksheet S-10 data into the computation of uncompensated care costs no later than FY 2021.

The AHA commends the agency for pausing the incorporation of Worksheet S-10 data in order to improve its accuracy and consistency in determining the cost of treating uninsured patients. Among other actions, the AHA will continue to urge CMS to adopt a broad definition of uncompensated care that includes Medicaid shortfalls and discounts to the uninsured and fully accounts for graduate medical education expenditures.

Notification Procedures for Outpatients Receiving Observation Services: CMS finalizes its proposal, with modifications, to implement the Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act, which requires hospitals and critical access hospitals (CAHs) to provide a written and oral notification to Medicare beneficiaries receiving observation services as outpatients for more than 24
hours. Hospitals and CAHs will be required to furnish a new CMS-developed standardized notice, the Medicare Outpatient Observation Notice (MOON), to a Medicare beneficiary or enrollee who has been receiving observation services for more than 24 hours.

Citing timing issues associated with approval process of the MOON, the agency will delay implementation of the NOTICE Act beyond the Aug. 6, 2016 statutory deadline by at least four months. The AHA is pleased that hospitals will have additional time to comply with the NOTICE Act and that CMS makes a number of the other changes recommended by the AHA.

**Hospital-Acquired Conditions (HAC) Reduction Program**: As mandated by the ACA, the HAC Reduction Program imposes a 1 percent reduction in total Medicare payments for hospitals scoring in the top quartile of national HAC rates. For the FY 2018 program, CMS adopts a new scoring methodology in which hospitals will receive “z-scores” for each measure that compares performance to the national mean. This departs from the existing HAC scoring methodology in which CMS assigns hospitals points based on their decile of performance on each measure. CMS also finalizes the adoption of an updated version of the claims-based patient safety indicator (PSI) composite measure.

**Hospital Readmissions Reduction Program (HRRP)**: The HRRP penalizes hospitals for having “excess” readmissions rates when compared to expected rates. The agency finalizes only minor updates to the HRRP, and will continue to impose a maximum payment penalty of 3 percent of base Medicare payments in FY 2017, as required by the ACA. As previously finalized, CMS will add a coronary artery bypass graft (CABG) readmission measure to the FY 2017 program. In addition, CMS will implement its previously finalized expansion of the patient population included in the pneumonia readmissions measure. CMS estimates these changes will result in aggregate readmission penalties of $528 million in FY 2017, an increase of $108 million compared to FY 2016 penalties.

As the financial stakes for readmissions performance continue to rise, the AHA is dismayed that CMS has once again failed to adopt any sociodemographic adjustment for the HRRP. We remain especially concerned that hospitals caring for patients from low-income communities will be disproportionately penalized. We continue to strongly support legislation that would require CMS to incorporate sociodemographic adjustment in the HRRP.

**Inpatient Quality Reporting (IQR) Program**: For the FY 2019 IQR program, CMS adopts significant changes to the requirement that hospitals report certain electronic clinical quality measures (eCQMs). Specifically, CMS finalizes the removal of 13 eCQMs that are deemed topped out or cannot be represented adequately in the eCQM form. CMS finalizes the requirement that hospitals electronically submit data for eight self-selected eCQMs among the 15 eCQMs available for the IQR. Hospitals would
submit four quarters of data by an annual submission deadline. The eCQM data would be collected during the CY 2017 reporting period and submitted to CMS in early 2018. CMS also will begin validation of eCQM data collected during the CY 2018 report.

While the AHA agrees with CMS’s removal of certain eCQMs, we believe that requiring electronic submission of data for eight eCQMs for a full year is premature given the hospital field’s eCQM experience to date. We strongly disagree with CMS’s policy decision, which appears to prioritize reporting through a particular data collection mechanism (i.e., eCQMs) over ensuring that the quality data reported are accurate, meaningful and used to improve care.

CMS’s other finalized policies for the FY 2019 IQR program include the removal of two measures of participation in registry reporting and the addition of four new measures. Three of the four new measures assess episode-based payments for specific clinical procedures, while the other measure assesses excess acute care days (including emergency department and observation use) within 30 days of discharge for pneumonia.

**Value-based Purchasing (VBP) Program:** As required by the ACA, CMS will fund the budget-neutral FY 2017 VBP program by reducing base operating diagnosis-related group payment amounts to participating hospitals by 2 percent. CMS estimates the pool of available VBP funds will be $1.8 billion for FY 2017. For the FY 2021 VBP program, CMS will add episode-based payment measures for heart attack and heart failure, and will adopt an updated version of the pneumonia mortality measure. For the FY 2022 VBP program, CMS will add a CABG 30-day mortality rate measure.

**Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program:** Among other changes, CMS will add two new measures to the IPFQR program for the FY 2019 payment determination. Specifically, CMS finalizes SUB-3, Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge (NQF #1664), and Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an IPF (which is not yet endorsed by the National Quality Forum). The AHA opposed the inclusion of both measures and believes the readmission measure in particular should be postponed until it has been adjusted for sociodemographic factors.

**NEXT STEPS**
The final rule will be published in the Aug. 22 Federal Register, and the policies and payment rates will take effect Oct.1. Watch for a more detailed analysis of the final rule in the coming weeks.

If you have further questions, contact Priya Bathija, AHA senior associate director of policy, at (202) 626-2678 or pbathija@aha.org.