CliftonLarsonAllen

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CMS Releases 2018 Proposed Rule for Inpatient Prospective Payment System Hospitals

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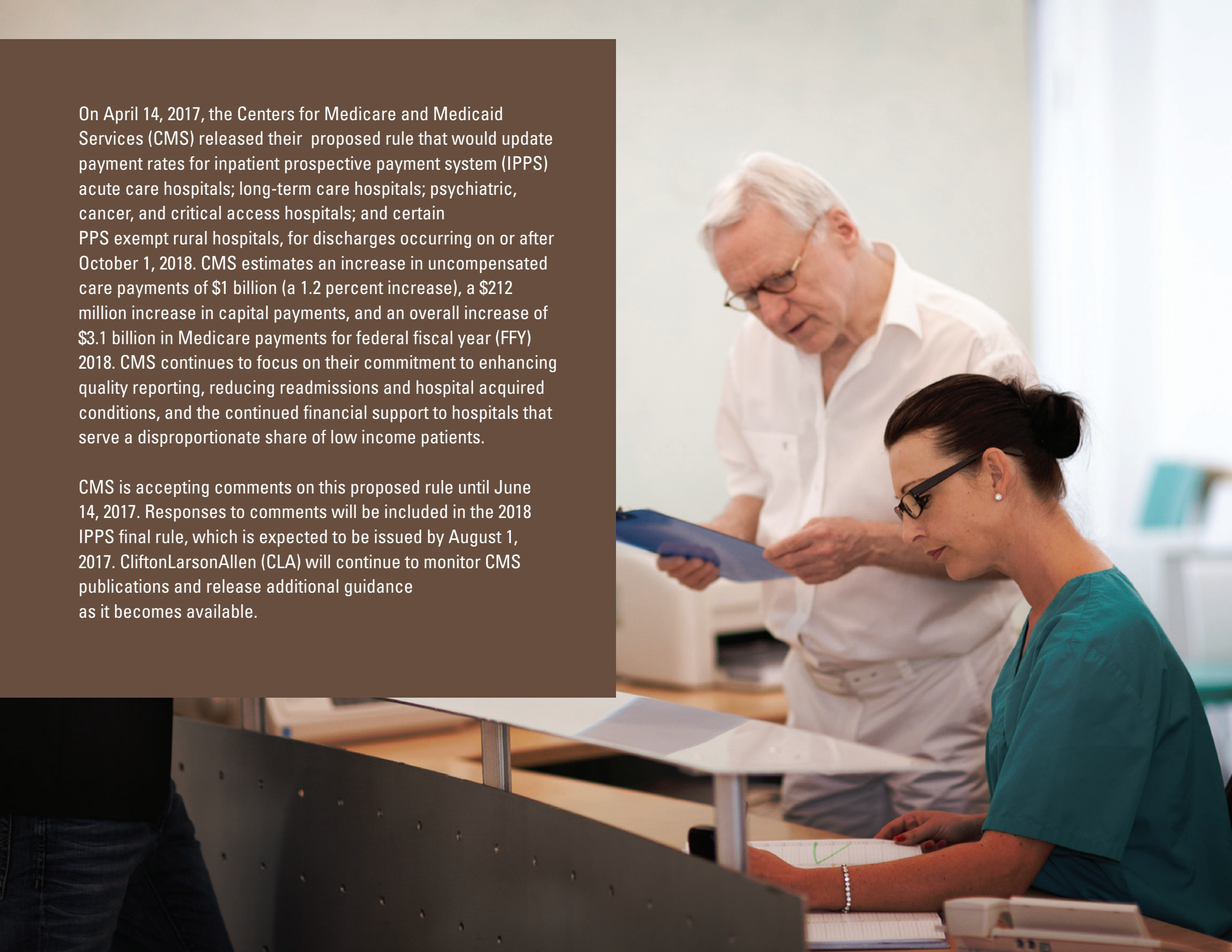
On April 14, 2017, the Centers for Medicare and Medicaid Services (CMS) released their proposed rule that would update payment rates for inpatient prospective payment system (IPPS) acute care hospitals; long-term care hospitals; psychiatric, cancer, and critical access hospitals; and certain PPS exempt rural hospitals, for discharges occurring on or after October 1, 2018. CMS estimates an increase in uncompensated care payments of $1 billion (a 1.2 percent increase), a $212 million increase in capital payments, and an overall increase of $3.1 billion in Medicare payments for federal fiscal year (FFY) 2018. CMS continues to focus on their commitment to enhancing quality reporting, reducing readmissions and hospital acquired conditions, and the continued financial support to hospitals that serve a disproportionate share of low income patients.

CMS is accepting comments on this proposed rule until June 14, 2017. Responses to comments will be included in the 2018 IPPS final rule, which is expected to be issued by August 1, 2017. CliftonLarsonAllen (CLA) will continue to monitor CMS publications and release additional guidance as it becomes available.



Proposed IPPS payment changes

The proposed rule will increase net payment rates for hospital acute care inpatient services by 1.6 percent. A summary of the adjustments are as follows:

- Inflationary update: 2.9%
  - ACA market basket update: -.75%
  - Multifactor productivity update: -.4%
  - Sunsetting of the two-midnight adjustment: -.6%
  - ATRA adjustment (21st Century Cures Act): +.45%
- Net increase in IPPS payment: 1.6%

Wage index

Hospitals that do not participate in the hospital inpatient quality reporting program (IQR) or submit required quality data will be subject to a one-fourth reduction to the market basket rate (0.725 percent). Hospitals that are not an electronic health records (EHR) meaningful user will be subject to a three-fourths reduction to the market basket rate (2.175 percent).

CMS makes a separate payment for capital that is not varied by the wage index. The national average capital payment is $451.37.

Table 1A. Proposed National Adjusted Operating Standardized Amounts; Labor/Nonlabor ([8.3 Percent Labor Share/31.7 Percent Nonlabor Share if Wage Index Is Greater Than 1] — FY 2018)

Hospital Submitted Quality Data and Is a Meaningful EHR User (Update = 1.75 percent)		Hospital Submitted Quality Data Is NOT a Meaningful EHR User (Update = -0.425 percent)		Hospital Did NOT Submit Quality Data and Is a Meaningful EHR User (Update = 1.025 percent)		Hospital Did NOT Submit Quality Data and Is NOT a Meaningful EHR User (Update = -1.15 percent)	
Labor-related	**Nonlabor-related**	**Labor-related**	**Nonlabor-related**	**Labor-related**	**Nonlabor-related**	**Labor-related**	**Nonlabor-related**
$3,822.07	$1,773.93	$3,740.37	$1,736.01	$3,794.84	$1,761.29	$3,713.14	$1,723.37

Table 1B. Proposed National Adjusted Operating Standardized Amounts, Labor/Nonlabor [(62 Percent Labor Share/38 Percent Nonlabor Share if Wage Index Is Less Than or Equal to 1) — FY 2018]

Hospital Submitted Quality Data and Is Meaningful EHR User (Update = 1.75 percent)		Hospital Submitted Quality Data Is NOT Meaningful EHR User (Update = -0.425 percent)		Hospital Did NOT Submit Quality Data and Is a Meaningful EHR User (Update = 1.025 percent)		Hospital Did NOT Submit Quality Data and Is NOT a Meaningful EHR User (Update = -1.15 percent)	
Labor-related	**Nonlabor-related**	**Labor-related**	**Nonlabor-related**	**Labor-related**	**Nonlabor-related**	**Labor-related**	**Nonlabor-related**
$3,469.52	$2,126.48	$3,395.36	$2,081.02	$3,444.80	$2,111.33	$3,370.64	$2,065.87

Source: CMS

Indirect medical education payment

Medicare also makes an add-on payment percentage to the diagnosis-related group (DRG) payment if the hospital has an intern and resident program. This percentage is calculated as the number of full-time equivalent interns and residents when compared to staffed PPS beds. This is meant to compensate hospitals for the additional indirect costs a teaching hospital incurs. There are no proposed changes for 2018 to this payment.

Disproportionate share hospital payment methodology change

The ACA mandated that CMS change the manner in which it makes additional payments to Disproportionate Share Hospitals (DSH), which is meant to compensate hospitals that have a disproportionate share of Medicaid patients. The theory is that these hospitals do not have the ability to gain back the loss they incur on Medicaid patients with what they receive from commercially insured patients. CMS estimates an increase in uncompensated care for DSH hospitals of $1 billion for 2018, which brings the total uncompensated care funds distributed to DSH hospitals to approximately $6.9 billion.

CMS proposes changes to the methodology for how each DSH hospital's percentage of the total uncompensated care is calculated. Currently this is calculated as a percentage of a hospital's Medicaid patient days compared to all hospital Medicaid patient days. The proposed change would look at a hospital's uncompensated care as shown by the Medicare cost report worksheet S-10, as a percentage of uncompensated care calculated from the cost reports for all DSH hospitals.

The proposed change also calls for 75 percent of each hospital's DSH payment to be withheld. Each hospital has the ability to gain back this lost payment based upon the hospital's uncompensated care as a percentage of total uncompensated care across the United States. CMS retains a portion of the DSH funding if there is a projected increase in commercially insured patients due to the ACA.

Expiration of the Medicare dependent hospital program

The Medicare dependent hospital program supports rural hospitals whose Medicare patients make up more than 50 percent of their overall volume. The program allows payments that are based upon 50 percent of the hospital's cost per discharge, and 50 percent of the federal DRG payment per discharge. This provision was scheduled to sunset on September 30, 2012, but was extended by Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) for five years. These hospitals will now be paid under the federal rate per discharge effective October 1, 2017.

These hospitals will need to apply for sole community hospital (SCH) status by September 1. SCH hospitals must be no closer than 30 miles from the nearest acute care hospital in order to obtain SCH status. SCH status will allow the hospital to obtain cost based reimbursement from Medicare and Medicaid.

Clinical quality measures

The proposed reporting period for clinical quality measures is the first three quarters of 2018. In 2017, hospitals must report quality measures for two self-selected quarters, including reporting on at least six self-selected clinical quality measures. There are 31 different clinical quality measures from which a provider may choose.

Readmissions program

The proposed rule adjusts the penalty for excess readmissions based on socioeconomic status. Hospitals will be placed in one of five peer groups, and the hospital's readmission adjustment will be calculated based on the specific hospital's readmissions compared to their peer group average.

Medicare and Medicaid electronic health record incentive programs

CMS created funding to encourage hospitals, ambulatory surgery centers (ASC), and physicians to convert to certified EHRs and report data electronically to CMS. This proposed rule adjusts the EHR reporting period from a full year to any continuous 90-day period. A facility or eligible professional (EP) that is able to bill Medicare Part B, takes the funding, and does not report their required data back to Medicare will receive a 2 percent reduction in payments. Hospitals will not be penalized if their EHR technology was decertified under the Office of the National Coordinator's (ONC) Health IT Certification Program.

The proposed rule also implements a policy for no payment adjustments if an EP (physician, nurse practitioner, or other professional) furnishes more than 75 percent of their services in an ASC and does not report their required data.

Hospital value-based purchasing program

The proposed rule would remove the current eight indicators for patient safety from the safety domain beginning FFY 2019. CMS will adopt a 10-indicator composite measure for reporting beginning in FFY 2023. The 10 proposed indicator composite measures for FFY 2023 are as follows:

- PSI 03 Pressure Ulcer Rate
- PSI 06 Iatrogenic Pneumothorax Rate
- PSI 09 Perioperative Hemorrhage or Hematoma Rate
- PSI 10 Postoperative Acute Kidney Injury Requiring Dialysis Rate
- PSI 11 Postoperative Respiratory Failure Rate
- PSI 12 Perioperative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT) Rate
- PSI 13 Postoperative Sepsis Rate
- PSI 14 Postoperative Wound Dehiscence Rate
- PSI 15 Unrecognized Abdominopelvic Accidental Puncture/Laceration Rate

The tenth indicator is a hospital-level, risk standardized payment associated with a 30-day episode of care for pneumonia measure for the efficiency and cost reduction domain. This indicator would begin in FFY 2022.

PPS-exempt cancer hospital quality reporting program

Related to the quality reporting program for cancer centers, CMS is proposing to add four measures, remove three previously adopted measures, and implement

revisions to the Extraordinary Circumstances Exceptions (ECE) policy. The ECE exempts a provider from reporting quality measures due to:

- Natural disasters
- Infrastructure changes
- Insufficient internet access
- Vendor issues

Newly participating hospitals may be given extra time to bring an IQR program up for reporting. Extension requests may be extended from 30 to 90 days due to CMS data issues. This extension request will bring cancer hospitals up to the acute care hospitals 90-day timeline.

Added Measures for Cancer Hospitals		Removed Measures for Cancer Hospitals	
NQF #		NQF #	
0210	Proportion of patients who died from cancer receiving chemotherapy in the last 14 days of life	0223	Adjuvant chemotherapy is considered or administered within four months of diagnosis to patients under the age of 80 with American Joint Committee on Cancer (AJCC) (lymph node positive) colon cancer
0213	Portion of patients who died from cancer admitted to the ICU in the last 30 days of life	0559	Combination chemotherapy is considered or administered within four months of diagnosis for women under the age of 70 with AJCC or Stage II or III hormone receptor negative breast cancer
0215	Proportion of patients who died of cancer not admitted to hospice	0220	Adjuvant hormonal therapy
0216	Proportion of patients who died from cancer admitted to hospice for less than three days		

Inpatient psychiatric facility quality reporting program

Inpatient Psychiatric Facility Quality Reporting Program (IPFQR) is a system established by the ACA. CMS is proposing to add one measure — medication continuation following inpatient psychiatric discharge — beginning with the 2020 payment determination and continuing for subsequent years. CMS is also proposing to align the IPFQR Program's ECE policy to align with other program's ECE provisions. Present IPFQR reporting indicators are as follows:

Proposed and Previously Finalized Measures for the FFY 2020 Payment Determination and Subsequent Years		
NQF #	Measure ID	Measure
640	HBIPS–2	Hours of physical restraint use
641	HBIPS–3	Hours of seclusion use
560	HBIPS–5	Patients discharged on multiple antipsychotic medications with appropriate justification
576	FUH	Follow-up after hospitalization for mental illness
1661	SUB–1	Alcohol use screening
1663	SUB–2 and SUB–2a	Alcohol use brief intervention provided or offered and SUB–2a Alcohol use brief intervention
1664	SUB–3 and SUB–3a	Alcohol and other drug use disorder treatment provided or offered at discharge and SUB–3a Alcohol and other drug use disorder treatment at discharge
1651	TOB–1	Tobacco use screening
1654	TOB–2 and TOB–2a	Tobacco use treatment provided or offered and TOB–2a Tobacco use treatment
1656	TOB–3 and TOB–3a	Tobacco use treatment provided or offered at discharge and Tob-3a Tobacco use treatment at discharge
1659	IMM–2	Influenza immunization
647	N/A	Transition record with specified elements received by discharged patients (discharges from an inpatient facility to home or self-care or any other site of care)
648	N/A	Timely transmission of transition record (discharges from an inpatient facility to home/self-care or any other site of care)
N/A	N/A	Screening for metabolic disorders
431	N/A	Influenza vaccination coverage among health care personnel
N/A	N/A	Assessment of patient experience of care
N/A	N/A	Use of an electronic health record
2860*	N/A	Thirty-day all-cause unplanned readmission following psychiatric hospitalization in an inpatient psychiatric facility
N/A	N/A	Medication continuation following inpatient psychiatric discharge**

* Since this measure was finalized in the FY 2017 IPPS/LTCH PPS final rule (57239 through 57246), NQF endorsement has been received.

** New measure proposed for the FY 2020 payment determination and subsequent years.

Source: CMS

The proposed rule also changes the annual data submission period for IPFQR to align the end of the period with the deadline for a notice of participation (NOP) or withdrawal from the program.

Long-term care hospital prospective system changes

CMS is proposing to update the long-term care hospital (LTCH) standard federal payment rate by 1 percent, consistent with the MACRA. This increase is applicable to LTCH patients that meet certain clinical criteria under the dual rate LTCH payment system required by the *Pathway for SGR Reform Act of 2013*.

Overall, based upon the proposed changes, CMS projects that LTCH payments will decrease by 3.75 percent (approximately $173 million) in FFY 2018, which is largely due to the continued phase-in of the dual (site neutral) rate system. In addition, CMS is evaluating whether the 25 percent threshold is still needed. The 25 percent rule states that LTCHs will have payments reduced if the facility admits more than 25 percent of its patients from an on-site or neighboring hospital.

Long-term care hospital quality reporting program

Under the proposed rules, LTCH rates would be reduced by 2 percent if they do not report and submit specified quality measures. Beginning in 2020, LTCH's also must report standardized patient assessment data related to five specified patient assessment categories.

- Functional status
- Cognitive function
- Special services, treatments, and interventions
- Medical conditions and co-morbidities
- Impairments

In this rule, CMS proposes to replace the current pressure ulcer measure with an updated version, along with two companion measures related to ventilator weaning beginning with the 2020 LTCH quality reporting period:

- Changes in skin integrity post-acute care: pressure ulcer/injury
- Compliance with spontaneous breathing trial (SBT) by day two of the LTCH stay
- Ventilator liberation rate

CMS is also planning to begin publicly reporting these new measures on the LTCH Compare website beginning in the fall of 2018 for the updated measure and by the fall of 2020 for the two new measures.

CMS is also proposing to remove two measures:

- Percent of residents or patients with pressure ulcers that are new or worsened (NQF # 0678)
- All cause unplanned readmission measure for 30 days post-discharge from LTCHs

Critical access hospital 96-hour certification requirement

For services payable under Medicare Part A, a physician is required to certify that a patient may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to a critical access hospital (CAH). Based upon feedback from stakeholders, CMS is providing notice to the supplemental medical review contractor and all quality improvement organizations, Medicare administrative contractors, and recovery audit contractors to make the CAH 96-hour certification requirement a low priority for medical record reviews on or after October 1, 2017. This means that unless there are concerns of probable fraud, waste, or abuse of the coverage requirement, these contractors will not conduct medical record reviews for this provision.

Application and re-application procedures for national accrediting organizations

Currently, accrediting organizations (AO) do not make their survey reports publicly available. CMS is proposing to revise the application and re-application process for AOs by requiring to post provider/supplier survey reports and plans of corrections from CMS-approved accreditation programs on their website.

Termination notices

CMS feels that newspapers have become an outdated means of communications and proposes to eliminate newspaper notices for the Medicare termination of ASCs, federally qualified health centers, rural health clinics, and organ procurement organizations.

Rural community hospital demonstration project

Rural hospitals with more than 25 beds were able to apply to be in a demonstration project if they were too large to be a CAH. CAHs are eligible for cost-based reimbursement rather than being paid under the DRG. The selected hospitals in the project could access the cost-based reimbursement initially for five years. Section 15003 of the 21st Century Cures Act requires a second five-year extension for hospitals participating in the Rural Community Hospital Demonstration Project. The statute also requires that within 120 days of enactment, a request for applications is issued to find those hospitals that want to participate in this demonstration program for the new five year extension. A maximum number of 30 hospitals would be accepted into the program.

The Medicare Modernization Act requires this provision to be budget neutral. IPPS rates were reduced to allow for this budget neutrality provision.

CMS' request for information

CMS requests feedback from providers on how Medicare can become more innovative, flexible, and transparent. In particular, CMS requests comments on how to re-design the payment system, streamline reporting, make the delivery system less bureaucratic and complex, and reduce the burden for clinicians, providers, and patients in order to make the system more effective, simple, and cost effective.

They also are requesting feedback on data sharing that would enhance patient care and support the physician-patient relationship to enhance more patient-centered care, thereby improving quality and reducing hospital inpatient costs.

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About CliftonLarsonAllen

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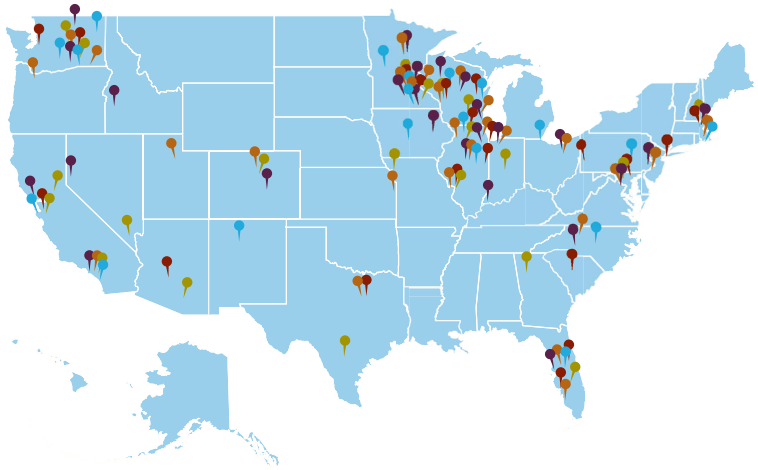

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