

Fiscal Year (FY) 2018 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Final Rule (CMS-1677-F)

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On August 2, 2017, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that updates Medicare payment and policies when patients are discharged from hospitals from October 1, 2017, to September 30, 2018. The final rule relieves regulatory burdens for providers; supports the patient-doctor relationship in healthcare; and promotes transparency, flexibility, and innovation in the delivery of care.

This fact sheet discusses only a major overview of the final rule. Providers are encouraged to review details included in The final rule (CMS-1677-F) from the Federal Register at: <https://www.federalregister.gov/public-inspection>.

Rules

Medicare Program:

Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Long Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Elec

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Critical Access Hospitals:

Notice Regarding Changes to Instructions for the Review of the Critical Access Hospital (CAH) 96-Hour Certification Requirement

For inpatient CAH services to be payable under Medicare Part A, the statute requires that a physician certify that the individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH. Based on feedback from stakeholders, CMS has reviewed the CAH 96-hour certification requirement to determine if there are ways to reduce its burden on providers. In this final rule, CMS is reiterating the notification provided in the proposed rule that it will direct Quality Improvement Organizations (QIOs), Medicare Administrative Contractors (MACs), the Supplemental Medical Review Contractor (SMRC), and Recovery Audit Contractors (RACs) to make the CAH 96-hour certification requirement a low priority for medical record reviews conducted on or after October 1, 2017. This means that absent concerns of probable fraud, waste, or abuse, CAHs should not expect to receive medical record requests from QIOs, MACs, RACs, or the SRMC related to the 96-hour certification requirement.

Hospital-Acquired Conditions (HAC) Reduction Program

The HAC Reduction Program helps to encourage hospitals to reduce the incidence of hospital-acquired conditions by requiring the Secretary to impose a payment reduction of one percent for applicable hospitals that rank in the worst-performing quartile. In the FY 2018 IPPS/LTCH PPS final rule, CMS is finalizing two changes to existing HAC Reduction Program policies:

1. Specifying the dates of the data period used to calculate hospital performance for the FY 2020 HAC Reduction Program; and
2. Updating the Extraordinary Circumstance Exception policy

In addition, CMS is also responding to comments received on adoption of additional measures, accounting for social risk factors, and inclusion of disability and medical complexity in the CDC NHSN measures.

Hospital Readmissions Reduction Program (HRRP)

The HRRP requires a reduction to a hospital's base operating DRG payment to account for excess readmissions associated with selected applicable conditions. For the FY 2018 IPPS/LTCH PPS final rule, CMS is implementing changes to the payment adjustment factor in accordance with the 21st Century Cures Act. CMS will assess penalties based on a hospital's performance relative to other hospitals with a similar proportion of patients who are dually eligible for Medicare and full-benefit Medicaid. Specifically, CMS is finalizing the following:

- Defining the proportion of full benefit dual-eligible beneficiaries as the proportion of dual-eligible patients among all Medicare fee-for-service and Medicare Advantage stays during the 3-year period that corresponds to the performance period;
 - Stratifying hospitals into five peer groupings; and
 - Adopting a change to the payment adjustment formula calculation methodology

In addition, CMS is specifying the applicable time period and the methodology for the calculation of aggregate payments for excess readmissions for FY 2018 and updating the program's Extraordinary Circumstance Exception policy.

Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs for Eligible Hospitals, Critical Access Hospitals (CAHs), and Eligible Professionals (EPs)

In 2011, the Medicare and Medicaid EHR Incentive Programs were established to encourage eligible professionals, eligible hospitals, and CAHs to adopt, implement, upgrade (AIU), and demonstrate meaningful use of certified EHR technology (CEHRT).

Changes to Clinical Quality Measures (CQMs)

In the FY 2018 IPPS/LTCH PPS final rule, for eligible hospitals and CAHs that report CQMs electronically for the EHR Incentive Programs, CMS is finalizing the following policies:

- For Calendar Year (CY) 2017:
 - a. Reporting period: For eligible hospitals and CAHs reporting CQMs electronically that demonstrate meaningful use for the first time in 2017 or that have demonstrated meaningful use in any year prior to 2017, the reporting period will be **one self-selected quarter** of CQM data in CY 2017.
 - b. CQMs: If an eligible hospital or CAH is only participating in the EHR Incentive Program or is participating in both the EHR Incentive Program and the Hospital IQR Program, the eligible hospital or CAH will report on at least **four (self-selected)** of the available CQMs.
- For CY 2018:
 - a. Reporting period: For eligible hospitals and CAHs reporting CQMs electronically that demonstrate meaningful use for the first time in 2018 or that have demonstrated meaningful use in any year prior to 2018, the reporting period will be **one self-selected quarter** of CQM data in CY 2018. For the Medicare EHR Incentive Program only, the submission period for reporting CQMs electronically will be the **two months** following the close of the calendar year, ending February 28, 2019.
 - b. CQMs: For eligible hospitals and CAHs participating only in the EHR Incentive Program or is participating in both the EHR Incentive Program and the Hospital IQR Program, the eligible hospital or CAH will report on at least **four (self-selected)** of the available CQMs.

- c. For eligible hospitals and CAHs that **report CQMs by attestation** under the Medicare EHR Incentive Program as a result of electronic reporting not being feasible and for eligible hospitals and CAHs that report CQMs by attestation under their State's Medicaid EHR Incentive Program, they are required to report on **all 16 available CQMs for the full CY 2018 (consisting of four quarterly data reporting periods)**. We also established an **exception to this full-year** reporting period for eligible hospitals and CAHs demonstrating meaningful use for the first time under their State's Medicaid EHR Incentive Program. Under this exception, the CQM reporting period is any **continuous 90-day period** within CY 2018.

Additionally, in the final rule, for the eligible professionals (EPs) in the Medicaid EHR Incentive Program, CMS is finalizing the following changes:

1. Reporting Periods: For 2017, CMS is modifying the CQM reporting period for EPs in the Medicaid EHR Incentive Program to be a minimum of a **continuous 90-day period** during calendar year 2017.
2. CQMs: For 2017, CMS is aligning the specific CQMs available to EPs participating in the Medicaid EHR Incentive Program with those available to professionals participating in the Merit-based Incentive Payment System.

Changes to the Medicare and Medicaid EHR Incentive Programs

For 2018, CMS is finalizing the modification to the EHR reporting periods for new and returning participants attesting to CMS or their state Medicaid agency **from the full year to a minimum of any continuous 90-day period during the calendar year.**

CMS is finalizing the addition of a new exception from the Medicare payment adjustments for EPs, eligible hospitals, and CAHs that demonstrate through an application process that compliance with the requirement for being a meaningful EHR user is not possible because their certified EHR technology has been decertified under ONC's Health IT Certification Program.

CMS is also finalizing an exception to the 2017 and 2018 Medicare payment adjustments for ambulatory surgical center (ASC)-based EPs and defining ACS-based EPs as those who furnish 75 percent or more of their covered professional services in an ASC, using Place of Service (POS) code 24 to identify services furnished in an ASC.

CMS is adopting final policies to allow healthcare providers to use either 2014 Edition CEHRT, 2015 Edition CEHRT, or a combination of 2014 Edition and 2015 Edition CEHRT, for an EHR reporting period in 2018. This policy is based on the ongoing monitoring of progress on the deployment and implementation status of EHR technology certified to the 2015 Edition, as well as feedback by stakeholders expressing the need for more time and resources are needed for the transition process.

Hospital Inpatient Quality Reporting (IQR) Program

In the FY 2018 IPPS/LTCH PPS final rule, CMS is refining two previously adopted measures as follows:

1. Replacing the pain management questions in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey to focus on the hospital's communications with patients about the patients' pain during the hospital stay beginning with surveys administered in January 2018. In response to stakeholder feedback, public display of hospital performance data on these refined questions will be delayed for one year so that hospitals may gain more experience with the refined questions.
2. Updating the risk adjustment methodology used in the Stroke 30-Day Mortality measure to include the use of stroke severity codes (based on the NIH Stroke Scale).

CMS is adopting the Hospital-Wide All-Cause Unplanned Readmission Hybrid Measure as a voluntary measure for the CY 2018 reporting period that uses both claims and electronic health record data for measure calculation. Furthermore, CMS received public comments on potential new quality measures for future inclusion in the Hospital IQR Program, accounting for social risk factors in the program and confidential and public reporting of measure rates for certain measures stratified by patients' dual eligibility status, which are being taken under consideration for development of policies and future rulemaking.

In addition, CMS is finalizing a number of changes in relation to the reporting of electronic clinical quality measures (eQMs):

1. Modifying, by further reducing what was proposed, the previously finalized eQm reporting requirements for the CY 2017 reporting period/FY 2019 payment determination and the CY 2018 reporting period/FY 2020 payment determination, such that hospitals would be required to select and submit **four** of the available eQMs included in the Hospital IQR Program measure set and provide **one, self-selected calendar quarter** of data, in alignment with the electronic reporting requirements for CQMs in the EHR Incentive Program for hospitals
2. Increasing flexibility for eQm certification requirements such that for the CY 2018 reporting period/FY 2020 payment determination, hospitals will be able to use: (1) the

2014 Edition of CEHRT, (2) the 2015 Edition of CEHRT, or (3) a combination of both the 2014 and 2015 Editions of CEHRT

3. Requiring that a hospital using EHR technology certified to the 2014 Edition or 2015 Edition, or a combination thereof, have its EHR technology certified to all 15 eQMs that are available to report in the Hospital IQR Program; requiring use of the most recent version of the eQIM electronic specifications; and specifying that eQMs would not need to be recertified each time it is updated to a more recent version. These policy changes are being made in alignment with the CQM electronic reporting policies for the Medicare and Medicaid EHR Incentive Programs.
4. Modifying the previously finalized validation process for eQIM data to reduce the number of cases required to be submitted and to include additional policies related to the exclusion criteria for hospital and case selection and the data submission requirements for participating hospitals; requiring submission of at least 75 percent of sampled eQIM measure medical records in a timely and complete manner
5. Formalizing the educational review process for chart abstracted measures and using this process to correct quarterly scores for any of the first three quarters of validation in order to compute final confidence intervals.

Lastly, CMS is aligning its Extraordinary Circumstances Exceptions (ECE) policy with other quality reporting programs and is making conforming updates to 42 CFR 412.140(c)(2).

Hospital Value-Based Purchasing (VBP) Program

The Hospital VBP Program adjusts payments to hospitals for inpatient services based on their performance on an announced set of measures. In the FY 2018 IPPS/LTCH PPS final rule, CMS is finalizing its proposals to implement updates to the Hospital VBP Program, including the removal of one measure and adoption of two measures. Specifically, CMS is finalizing its proposals to:

1. Remove the current 8-indicator Patient Safety for Selected Indicators measure from the Safety domain beginning with the FY 2019 program year and replace it with the 10-indicator Patient Safety and Adverse Events Composite measure, which is a modified version of the removed measure beginning with the FY 2023 program;
2. Adopt a payment measure associated with 30-day episodes of care for pneumonia patients for the Efficiency and Cost Reduction domain beginning with the FY 2022 program year; and
3. Update the weighting of measures in the Efficiency and Cost Reduction domain to reflect the addition of the new condition-specific payment measures along with the overall Medicare Spending per Beneficiary measure beginning with the FY 2021 program year.

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 2018 IPPS/LTCH PPS final rule, CMS is finalizing its proposals to adopt four new measures, remove three previously-adopted measures, and implement revisions to the PCHQR Extraordinary Circumstances Exceptions (ECE) Policy. Specifically, CMS is adopting four measures that assess end-of-life care:

1. Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (NQF #0210);
2. Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life (NQF #0213);
3. Proportion of Patients Who Died from Cancer Not Admitted to Hospice (NQF #0215); and
4. Proportion of Patients Who Died from Cancer Admitted to Hospice for Less than Three Days (NQF #0216).

CMS is also removing three cancer-specific, chart-abstracted process measures:

1. Adjuvant Chemotherapy is Considered or Administered Within four Months (120 Days) of Diagnosis to Patients Under the Age of 80 with AJCC III (Lymph Node Positive) Colon Cancer (NQF #0223);
2. Combination Chemotherapy is Considered or Administered Within four Months (120 Days) of Diagnosis for Women Under 70 with AJCC T1c, or Stage II or III Hormone Receptor Negative Breast Cancer (NQF #0559); and
3. Adjuvant Hormonal Therapy (NQF #0220)

Inpatient Psychiatric Facility Quality Reporting Quality Reporting (IPFQR) Program

In the final rule, CMS is not finalizing the Medication Continuation following Inpatient Psychiatric Discharge measure. CMS is updating the IPFQR Program's extraordinary circumstances exception (ECE) policy to align with other CMS programs' ECE provisions. CMS is also changing the annual data submission timeframes for Notices of Participation (NOP) and withdrawals from the Program and its policy to provide precise dates defining the end of the data submission period. Finally, CMS is adopting factors by which it would evaluate measures to be removed from or retained in the IPFQR Program.