Codify
BY AAPC

Eli's Rehab Report

Reimbursement: The IPPS 2017 Rule Impact Could Be Overwhelming

There's good news and bad for you.

Providers don't know whether to rejoice or weep. There's a blink-and-miss-it 0.9 percent increase for hospitals in the Hospital Inpatient Prospective Payment System (IPPS) and a whopping 6.9 percent dint in the Long Term Acute Care Hospital (LTCH) Proposed Rule for fiscal year (FY) 2017. If you offer therapy in any of the 3330 acute care hospitals and 430 LTCHs affected by this rule, you need to sit up and take notice.

"The Federal Register's (proposed and final rule) for IPPS, MPFS, and OPPS are enormously long," says **Duane C. Abbey, PhD,** president of **Abbey and Abbey Consultants Inc.,** in Ames, IA. "The only thing that hospitals (physicians and others) can do is to follow the key issues and then depend upon professional organizations to analyze, question and comment to the proposals. For IPPS this is basically the **American Hospital Association**."

Know How These Updates Might Affect You

The **Centers for Medicare & Medicaid Services** (CMS) has estimated that all in all, Medicare expenditures on inpatient services in hospitals will supposedly increase up to $539 million by FY 2017, along with an $800 million increase in payments to SNFs, and a $125 million increase for IRFs. Further, CMS has proposed to increase the operating payment rates by 0.9 percent for the general acute care hospitals under IPPS. To reap these benefits, hospitals should be meaningful electronic health record (EHR) users and should have successfully complied with the Hospital Inpatient Quality Reporting (IQR) Program.

"Other additional payment adjustments will include continued penalties for excess readmissions, a continued 1 percent penalty for hospitals in the worst performing quartile under the Hospital Acquired Condition Reduction Program, and continued bonuses and penalties for hospital-value based purchasing," says an April 18 fact sheet released by the CMS.

Comply or pay dearly: The 2.1 percent rise in SNF reimbursement is balanced by the additions to the quality-reporting measures required by the Improving Post-Acute Care Transformation (IMPACT) Act, which SNFs will need to report in 2018. These measures will "include data on discharge to community, Medicare spending per beneficiary, and potentially preventable 30-day readmissions," according to an April 22 press release from the **American Physical Therapy Association** (APTA).

"APTA will advocate for a physical therapy representative to serve on the technical expert panel that will review input" of the public comment on performance standards, performance periods, scoring methodology, and the development of confidential feedback reports sought by CMS, according to the APTA release.

IRFs Need to Report On 4 New Measures

While the IRFs face a slight dip 1.45 percent increase compared to the current 1.6 percent increase they face "more quality-reporting requirements around many of the same areas that will be required of SNFs (discharge, spending, readmissions, drug regimen review, etc.)," APTA says in the press release.

The two-midnight rule's inpatient cut is dropped: The decision to undo the proposed inpatient cut came on the heels of a court case in September 2015. Hospitals questioned a 0.2 percent reduction for inpatient claims, to adjust for

the expected increase in Medicare costs associated with the two-midnight rule. According to this rule, a hospital stay spanning two midnights or more can be billed as an inpatient stay. CMS's intention behind the 0.2 percent annual reduction was to discourage an increase in observation stays. Later, CMS decided to undo this annual reduction policy.

Explaining this complex interplay of policy versus reimbursement issues is not easy.

"CMS happens to think in terms of overall national statistics," Abbey says. "Hospitals tend to think at a much more local level, that is, what impact is there on a given individual hospital. This dichotomy comes out in many different forms. Thus, the impact of a change such as the 2-midnight rule may have a significant impact (or not) on a given hospital, but from CMS's perspective on a national basis, everything averages out on a statistical basis." Of course, it is not possible for CMS to assess individual hospital impacts, and it is the national overall impact that guides CMS's course of actions.

The implications for patients who don't qualify for SNF rehab, who haven't been inpatient at a hospital through two midnights, but are unable to take care of themselves at home due to fall-related fracture, needs to be thought through, APTA emphasizes in the release.

LTCH payments to dip: Long-term-care hospitals need to tread cautiously, as CMS proposes to reduce payments by 6.9 percent, translating to a cumulative amount of $355 million next year, based on a new site-neutral policy for less crucial cases. There is some potential good news, as the agency further proposes to streamline the 25 percent threshold payment adjustment imposed on an LTCH, when the number of cases admitted from a single hospital reaches over 25 percent, according to the CMS fact sheet.

As a result of the proposed changes, "... cases that qualify for the higher standard LTCH PPS payment rate will realize an increased payment rate of .3 percent for FY 2017," **Leslie Demaree Goldsmith** and **Samantha C. Flanzer** pointed out in an April 29 blog posting for **Ober Kaler**.

Resources: For the Long Term Care PPS, see www.cms.gov/medicare/medicare-fee-for-service-payment/longtermcarehospitalpps/index.html, for the APTA press release see www.apta.org/PTinMotion/News/2016/4/19/IPPSProposed2017/, for the Ober Kaler blog posting www.lexology.com/library/detail.aspx?g=994de258-0c2a-4874-b031-c72418ca582a and www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-04-18-2.html for the CMS fact sheet.