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CMS Publishes 2018 Payment Rate Updates

The *Centers for Medicare and Medicaid Services* (CMS) recently released their final rules for *fiscal year* (FY) 2018 payment and policy updates for the: (1) *Medicare Physician Fee Schedule* (MPFS);[1] (2) the *Medicare Inpatient Prospective Payment System* (IPPS);[2] (3) the *Hospital Outpatient Prospective Payment System* (OPPS); and, (4) the *Ambulatory Surgical Center* (ASC) *Payment System.*[3] Whereas the IPPS became effective on October 1, 2017,[4] the MPFS, OPPS, and ASC Payment System will become effective on January 1, 2018.[5] In this *Health Capital Topics* article, changes to these final rules will be discussed.

The final changes made to MPFS for FY 2018 include:

(1) *Increases to the Medicare Conversion Factor (CF)*: A positive adjustment of 0.41 percent will be applied to the MPFS CF used to calculate payments for physician services.[6] This positive adjustment is higher than the 2017 CF adjustment of 0.32 percent.[7] Additionally, the CF used to calculate payments for anesthesia services includes additional adjustments for practice expense and malpractice;[8]

(2) *Modifications to Reporting Requirements for the Physician Quality Reporting System (PQRS)*: CMS now only requires six measures to be reported under the PQRS, rather than nine;[9] and,

(3) *Adjustments to the Value-Based Payment Modifier (VM)*: Physician groups of ten or more who do not meet the minimum PQRS criteria will only be penalized with a downward payment adjustment of -2.0 percent, rather than the previously proposed -4.0 percent.[10] Non-physician practitioners, solo physician practitioners, or physician groups of nine or fewer will experience downward payment adjustments of -1.0 percent, rather than the previously proposed -2.0 percent, for unsatisfactory participation.[11] Practices that have successfully participated in the PQRS will not experience any downward payment adjustments, and may even experience a positive payment adjustment for lowering practice costs and providing higher quality care.[12]

Both the reduction in PQRS reporting requirements, as well as the reduced downward payment adjustments for failing to meet minimum PQRS standards, are a part of the "*Patients Over Paperwork*" initiative launched by CMS in an effort to reduce provider burden, increase efficiencies, and improve patient care.[13] As CMS Administrator Seema Verma articulated in a press release on November 2, 2017, "*These rules move the agency in a new direction and begin to ease that burden by strengthening the patient-doctor relationship, empowering patients to realize the value of their care over volume of tests, and encouraging innovation and competition within the American healthcare system.*"[14] Although the *American Medical Association* (AMA) has not commented on the final rule, they responded to the proposed rule stating, "*The AMA is encouraged by many of the proposed changes and applauds the Administration for working with the AMA to address physician concerns.*"[15] Specifically, the AMA affirmed their support for the proposed modifications to the PQRS and the VM requirements.[16]

Additionally, CMS finalized several updates to the IPPS, including:

(1) *Payment Rate Updates:* For FY 2018, CMS is implementing an overall increase of 1.2 percent for hospital payments.[17] CMS also estimates that Medicare payments to inpatient psychiatric facilities will increase by one percent, or $45 million total, for FY 2018;[18]

(2) *Disproportionate Share Hospital (DSH) Payment*[19] *Adjustment Updates*: For FY 2018, Medicare DSH uncompensated care payments to hospitals will increase by $800 million[20] for a total of $6.8 billion in DSH payments.[21] Starting in 2018, there will be a three-year transition to use Worksheet S-10 data (also known as uncompensated care data) to calculate the amount and distribution of DSH payments to hospitals.[22] This three-year transition was implemented after numerous stakeholders voiced concerns regarding the accuracy and consistency of Worksheet S-10 data to calculate uncompensated care payments;[23] and,

(3) *Changes to the Electronic Health Record (EHR) Incentive Program:* The EHR Incentive Program was established by CMS to promote the adoption, implementation, upgrade, and demonstration of *meaningful use* of certified EHR technology by healthcare providers.[24] Currently, the program has three stages, including a Modified Stage 2 that was included to ease reporting requirements for providers.[25] The final rule for 2018 established

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that hospitals and *critical access hospitals* (CAH) can choose to use either Modified Stage 2 EHR reporting or Stage 3 EHR reporting for the *EHR Incentive Program*, instead of just Stage 3 EHR reporting.[26] CMS finalized this rule as a way to allow for flexibility among providers who may need additional time to implement updated EHR technology.[27] Further, hospitals are now only required to report EHR data for 90 continuous days, rather than a full year.[28]

Overall, for FY 2018, acute care hospitals expect to see a $2.4 billion increase in total Medicare spending on inpatient hospital payments, due to both payment rate increases and other payment adjustments.[29] The Trump Administration is confident that these updates will benefit hospitals, with Verma stating:

> "*This final rule will help provide flexibility for acute and long-term care hospitals as they care for Medicare's sickest patients…Burden reduction and payment rate increases for acute care hospitals and long-term care hospitals will help ensure those suffering from severe injuries and illnesses have access to the care they need*."[30]

While the *American Hospital Association* (AHA) approved of mandates related to the EHR Incentive Program, it expressed concerns regarding certain parts of the final rule, with the AHA Executive Vice President, Tom Nickels, stating, "*[W]e continue to have concerns over the accuracy and consistency of the 'Worksheet S-10' data [i.e., uncompensated care data] that CMS will use to determine the cost of treating uninsured patients."*[31]

Updates made to Medicare OPPS for FY 2018 include:

(1) *Payment Rate Updates*: For FY 2018, ASCs and *hospital outpatient departments* (HOPDs) will receive smaller increases in payment adjustments than originally proposed, with ASCs receiving a payment adjustment increase of 1.2 percent[32] (compared to the proposed 1.9 percent increase),[33] and HOPDs receiving a payment adjustment increase of 1.35 percent[34] (compared to the proposed 1.75 percent increase);[35]

(2) *Total Knee Arthroplasty (TKA) Reimbursement Changes:* TKA surgeries have been removed from the inpatient-only reimbursement list and are now covered under OPPS;[36] however, they were not added to the procedures reimbursable under the ASC Payment System.[37] Further, CMS is currently discussing whether total ankle arthroplasty, total hip arthroplasty, and partial hip arthroplasty surgical procedures should be reimbursable under the ASC Payment System.[38] Despite the fact that several procedures were not removed from the inpatient-only list of reimbursable items, and the fact that TKA is still not reimbursable under the ASC Payment System, the removal of TKA from the inpatient-only list is a crucial step to eventually having TKA and similar procedures covered under the ASC Payment System.[39]

(3) *The Addition of New Procedures Reimbursable to ASCs:* Beginning in 2018, CMS will reimburse ASCs under the ASC Payment System for: (a) total artificial disc arthroplasties; (b) second level total artificial disc arthroplasty; and, (c) total hysterectomy for uterus greater than 250 grams;[40] and,

(4) *Voluntary Participation of the Consumer Assessment of Healthcare Providers and Systems Outpatient and Ambulatory Surgery Survey* (*OAS CAHPS) Program:* The OAS CAHPS is a program aimed at gathering data from Medicare beneficiaries regarding their care episodes at ASCs,[41] similar to those surveys conducted at hospitals. CMS originally proposed for this program to have mandatory ASC participation starting in 2018; however, plans to implement this program have been delayed.[42]

While the Trump Administration, including Verma, insist that these final rules can help increase patient access to healthcare services,[43] Bill Prentice, CEO of the *Ambulatory Surgery Center Association* (ASCA), expressed discontent with the changes, stating:

> "*Yet again, ASC payments fall farther behind those of hospital outpatient departments because CMS continues to use an inflation factor — the CPI-U — that doesn't focus on the costs of goods and services in the healthcare market… CMS insists on waiting for a perfect replacement to the CPI-U while a good one, the hospital market basket, is available.*"[44]

However, other final changes have managed to garner support from the ASCA, with Kara Newbury, JD, regulatory counsel for the ASCA, explaining "*The removal of total knee arthroplasty from the inpatient-only list is an important step to seeing this procedure covered in the ASC setting in the future.*"[45] The ASCA also stated support for voluntary OAS CAHPS participation.[46]

Overall, there have been mixed sentiments regarding the 2018 MPFS, IPPS, OPPS, and ASC payment system updates. Stakeholder groups such as the AMA, AHA, and ASCA generally approve of CMS mandates that lessen provider burden,[47] which policy is a main goal of the Trump Administration.[48] However, many healthcare providers have expressed discontent over the amount of the payment rate updates,[49] as increases in payment rates have stagnated over the past several years.[50] As the growth in payment rates may continue to stagnate in subsequent years, providers may need to find ways to reduce costs and increase efficiencies in order to survive and thrive in this changing healthcare reimbursement environment.

(Continued on next page)

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