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Final 2017 IPPS Rule Summary

Medicare Outpatient Observation Notice (MOON) – Last year Congress passed the *Notice of Observance Treatment and Implication for Care Eligibility Act or NOTICE Act* (the Act). The intent of the Act is to provide clarification to Medicare beneficiaries who are receiving outpatient observation services, but may assume they are inpatients of the hospital.

The Act requires a standardized written notification to be given to all Medicare-eligible patients who have received 24 or more hours of observation services.

The effective date of the Act is August 6, 2016. However, the written notice (lovingly referred to as the Medicare Outpatient Observation Notice or MOON) is a standard notice prepared by Centers for Medicare and Medicaid Services (CMS) and is undergoing the *Paperwork Reduction Act* approval process. Currently, the MOON is open for public comments. If you choose to comment on the proposed MOON, those comments are due by September 1, 2016. The effective date will be 90 days after the MOON is approved.

The MOON is required for *all* Medicare eligible beneficiaries who have received 24 or more hours of observation services, whether or not Medicare is paying for the service. Medicare eligible beneficiaries include beneficiaries with Medicare as secondary payor, Medicare beneficiaries who opted out of Part B coverage, and Medicare Advantage patients. Any Medicare eligible patient in observation for more than 24 hours must receive a copy of the MOON.

The MOON must be presented to the Medicare patient the earlier of either 36 hours of observation or at discharge. When presented, hospital personnel must verbally explain the MOON to the patient or the patient's representative. The patient or patient's representative will be required to sign that they understand the document, and it was explained to them. In cases where the patient and their representative refuse to sign, the hospital representative must write their name, title, date and time the MOON was presented, and sign their name. A copy of the signed MOON must be maintained in the patient's medical record.

The amount a Medicare beneficiary pays for inpatient stays versus outpatient observation is significant. The MOON has standard language discussing the differences in cost to a patient and it includes an area for the admitting physician to explain the clinical criteria on which they made the decision to place the patient in observation status. Because there are significant financial differences to a patient, the hospital must find the right person to explain the cost differences and the clinical decision for their outpatient observation status to the patient and their representative.

Three major items are discussed in the MOON:

1. Medicare only pays for skilled nursing services if the patient receives at least a three-day qualifying stay in an acute care setting. At the first 24 hours of observation, when the MOON is required, the patient will have already received care for what the patient may consider an inpatient day. However, the day they spent in observation does not count towards the three-day qualifying stay for Medicare to cover skilled nursing services. A Medicare beneficiary in this situation may have been in the same bed for three midnights, but would be financially responsible for any skilled level of care after discharge.
2. Medicare cost sharing is different for inpatients than it is for outpatients. This can affect a patient in a couple of ways:
    a. Patients with lengthy observation stays that are not subsequently admitted – The entire stay is subject to coinsurance.
        i. If the patient has have opted for Part B coverage, they pay 20% of the PPS payment in a PPS hospital and 20% of charges in a critical access hospital (CAH).
        ii. If the patient has have opted out of Part B coverage, they pay the entire charge amount.
    b. Lengthy (over 24-hours) observation stays that result in inpatient stays – The effect to the patient depends on the type of hospital.
        i. PPS hospitals: The outpatient services roll up into the inpatient stay, and that patient will only pay inpatient deductible (the observation will be part of the three-day look back).
        ii. CAHs: The patient is liable for outpatient services up until the time they are admitted. The patient will pay 20% of charges up until the time they are admitted and then the inpatient deductible.

The MOON will be available in English and Spanish. Hospitals are required to follow their normal translation process for patients speaking other languages.

The MOON must be given to a Medicare patient after 24 hours of observation services but before 36 hours of observation or discharge. The MOON can be given before the 24-hour mark; however, CMS discourages hospitals from providing the MOON to all observation patients.

To summarize – the MOON is a standardized document that must be given to Medicare beneficiaries in observation for more than 24 hours; implementation is later this year. The draft copy of the MOON is included in this mailing. Please remember all comments are due to CMS by September 1, 2016.

Uncompensated Care Costs – The Medicare cost report calculates the cost of uncompensated care. Portions of the uncompensated care cost data were used in the electronic health records incentive calculation. CMS has also compared this data to the uncompensated care cost data reported on not-for-profit hospitals' IRS Form 990.

The uncompensated care cost calculated on cost reports beginning in federal fiscal year 2017 will be used to set federal fiscal year 2021 uncompensated care payments (UCC).

The details of how the calculation will look will be set in future rulemaking. Currently, the Medicare cost report calculates the unreimbursed cost of providing services to Medicaid patients, patients qualifying for charity care (both insured and uninsured), and the cost of non-Medicare bad debts. The actual cost used in the UCC calculation will be one or more of the three calculated uncompensated costs.

CMS will outline the exact calculation and provide clarifying instructions to the Medicare cost report in future rulemaking.

Because the uncompensated care cost from the Medicare cost report will be used to calculate future UCC payments, it is recommended to work with the data now to ensure the best information from the systems.

Currently, the UCC payment calculation is based on Medicaid and Medicare SSI days. Therefor theoretically, in states that expanded Medicaid, hospitals receive larger payments than hospitals in states that chose not to expand Medicaid.

Under the proposed method, and depending what cost items are included in the uncompensated care costs calculation (charity, bad debt, Medicaid, or any combination of those costs), a hospital in a state that chose not to expand Medicaid will receive higher UCC payments because they will have larger uninsured populations.

This phenomenon makes the switch to UCC cost data challenging as hospitals will feel passionately about whichever side best suits their situation. The UCC payment calculation is a budget-neutral calculation and therefore, some hospital's payments will increase, and others will decrease proportionally.

Finally, CMS finalized its proposal to average three years worth of data to set UCC payments starting with federal fiscal year 2017. Federal fiscal year 2017 UCC payments will be based on Medicaid days from 2011, 2012, and 2013 and Medicare SSI days from 2012, 2013, and 2014. The three-year average is meant to smooth UCC payments between hospital years. Hospitals have until August 31, 2016, to review the days' data on the CMS website.

Low-volume Payments – Regulations allow for an additional payment to PPS hospitals that care for lower volumes of inpatients. The *Affordable Care Act* allowed for additional hospitals to qualify for these payments for a two-year period.

The *Medicare Access and CHIP Reauthorization Act* further extends the expanded low-volume hospital definition through September 30, 2017. The low-volume add-on payments are based on inpatient services and follow the federal fiscal year.

PPS hospitals with fewer than 1,600 Medicare discharges and located 15 or more miles from the next hospital qualify for the low-volume payment add-on.

A qualifying hospital must submit a letter to its Medicare Administrative Contractor (MAC) that includes support that there is not another Subsection(d) hospital within 15 miles of the qualifying hospital. A qualifying hospital's Medicare discharge information is based on MedPar files.

The request to continue this payment add-on is due to your MAC by September 1, 2016, for the 2017 federal fiscal year.

FCHIP Demonstration Project – Certain CAHs are involved in an alternative payment demonstration project. The project provides added reimbursement for certain services, but in total, must be budget-neutral.

CMS finalized a rule stating if the demonstration project is not budget-neutral, CMS will recoup the added payment amount from all critical access hospitals.

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