CMS Issues Its FY 2017 IPPS Final Rule: The Clock Strikes Midnight On The Two Midnight Rule's Payment Reductions

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On August 2, 2016, the Centers for Medicare & Medicaid Services ("CMS") issued its Fiscal Year ("FY") 2017 Inpatient Prospective Payment System ("IPPS") final rule. The rule was published in the Federal Register on August 22, 2016 and became effective on October 1, 2016.[1]

The comprehensive rule spans nearly 700 pages of the Federal Register and makes significant changes to many aspects of the IPPS.[2] While the scope of the rule is broad, this article focuses specifically on what we believe to be one of the most significant changes to the IPPS system, the elimination of the payment reductions associated with the "Two Midnight Rule."

The Two Midnight Rule was introduced as part of CMS' FY 2014 IPPS rule "[t]o reduce uncertainty regarding the requirements for payments to hospitals and [Critical Access Hospitals] under Medicare Part A related to when a Medicare beneficiary should be admitted as a hospital inpatient."[3]

Pursuant to the Two Midnight Rule when a physician expects a beneficiary to require care that crosses two midnights and admits the beneficiary based on that expectation, Medicare Part A payment is generally appropriate. Conversely, if the physician expects the beneficiary's hospital stay to be less than a period spanning two midnights, payment under Medicare Part A is generally inappropriate.[4] If a physician cannot reliably predict the beneficiary to require a hospital stay spanning more than two midnights "the physician should continue to treat the beneficiary as an outpatient and then admit as an inpatient if and when additional information suggests a longer stay or the passing of the second midnight is anticipated."[5]

When CMS adopted the Two Midnight Rule, CMS' actuaries anticipated that there would be an additional $220 million in expenditures due to a net increase in hospital inpatient encounters[6]. Accordingly, CMS exercised the Secretary's "broad authority" under 42 *U.S.C.* 11395 ww(d)(5)(I)(i) to impose a 0.2% reduction to the national capital federal rate in FY 2014 to offset the anticipated increase in expenditure.[7] That same reduction was applied to the national capital federal rate in FY 2015 and FY 2016 as well.

The adoption of the Two Midnight Rule came amid a rash of criticism from providers. Numerous comments were submitted which suggested that while the rule was phrased as a presumption it was setting a *per se* standard on admission based solely on length of stay and many commenters suggested there should be more flexibility in considering when an admission, regardless of length of stay, should be treated as an inpatient admission. The underlying concerns which resulted in these comments was how Recovery Audit Contractors ("RACs") would use the new rule when auditing claims. CMS rejected these concerns indicating that the rule required only a reasonable expectation by the admitting physician that the stay would span two midnights and that, if unforeseen circumstances resulted in a shorter stay, inpatient admission would still be appropriate.[8] However, the rule's revisions to the regulations mentioned only death and transfer as appropriate unforeseen circumstances which would support a shorter stay being appropriately billed as an inpatient admission.[9]

Additionally, and more importantly, commenters questioned whether the Secretary had the authority to implement the 0.2% reduction on inpatient payments. The commenters also questioned the validity of the Secretary's prediction, upon

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which the reduction was based, that the new policy would cause a net increase in inpatient cases at a cost of $220 million in 2014. To the contrary, the commenters believed the Two Midnight Rule would result in a net increase in outpatient, rather than inpatient, encounters. The notice of final rulemaking did not address these comments in detail except to say that the reductions were an appropriate use of the Secretary's statutory exceptions and adjustments authority.[10]

Provider criticism of the payment reductions associated with the implementation of the Two Midnight Rule did not end after its formal adoption. Indeed, following the formal adoption of the rule numerous hospitals filed timely reviews before the Provider Reimbursement Review Board (PRRB), challenging the 0.2% reduction. The PRRB granted the hospitals' requests for expedited judicial review, and thereafter lawsuits were filed by hospitals throughout the United States. Several of those suits were consolidated before the United States District Court for the District of Columbia under the caption *Shands Jacksonville Medical Center, et al. v. Burwell,* Consolidated Civil Case Nos. 14-263, 14-503, 14-536, 14-607, 14-976, 14-1477 (the "*Shands* Litigation").[11]

The hospitals in the *Shands* Litigation challenged the 0.2% reduction in compensation for inpatient services.[12] The hospitals raised three principal arguments: (1) the Medicare Act does not authorize the Secretary to make an across-the-board 0.2% reduction to compensation for inpatient services; (2) the Secretary failed to comply with the rulemaking requirements of the Administrative Procedures Act ("APA") by failing to disclose critical information about her methodology, failing to provide a meaningful response to substantial comments and failing to provide a reasoned basis for the final rule; and (3) the reduction was arbitrary and capricious.[13]

On September 21, 2015 the Court in the *Shands* Litigation found that the Secretary's failure to disclose critical assumptions made by the actuaries who calculated the alleged $220 million dollar increase in expenditures, which was relied upon to impose the 0.2% reduction, failed to meet the standards of the APA and thus deprived the public of a meaningful opportunity to comment on the proposed rule.[14] As a result, the Court remanded the matter back to the agency for further proceedings regarding the adequacy of the 0.2% reduction. However, the Court did not vacate the rule.[15]

After the matter was remanded, on December 1, 2015, CMS issued a public notice of the basis for the 0.2% reduction and its underlying assumptions.[16] As a result of the comments received to that public notice, in connection with the FY 2017 IPPS final rule, CMS eliminated the 0.2% reduction for FY 2017. Additionally, the Secretary invoked her powers under the Medicare Act to adjust the FY 2017 capital IPPS rate to address the effects of the 0.2% reduction to the national capital federal rates in effect for FY 2014, FY 2015, and FY 2016. To do so, CMS is implementing a one-time prospective adjustment of 1.006 in FY 2017 to the national capital Federal rate. This effectively eliminates the impact of the Two Midnight Rule reductions from 2014-2016.[17]

While it appears from the FY 2017 IPPS final rule that CMS has recognized the error of its ways in imposing the 0.2% reduction, CMS denies any error and continues to maintain that "the assumptions underlying the 0.2% reduction to the rates put in place beginning in FY 2014 were reasonable at the time we made them in 2013."[18]

Nevertheless, whether CMS recognized its error, or felt compelled to make this change as a result of the *Shands* Litigation, the end result is the same for hospitals throughout the country. They are no longer subject to the 0.2% reduction imposed by the FY 2014 IPPS final rule and the negative impact from that rule over the past three years has been eliminated.

Regardless of the reasons for CMS' turn around, this is a major victory for all hospitals impacted by the rule. The clock has struck midnight on the 0.2% reduction and tomorrow is a new day.

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Footnotes

[1] 81 *F.R.* 56761, et seq.
[2] *Id.*
[3] 78 *F.R.* 50495, 50506
[4] *Id.*
[5] *Id.* at 50945.
[6] *Id.* at 50746
[7] *Id.*
[8] *Id.* at 50943-50948 .
[9] 42 C.F.R. 412.3(e)(2).
[10] *Shands Jacksonville Medical Center v. Burwell,* 139 F.Supp.3d 240, 248 (D.C. Cir. 2015).
[11] *Id.* at 249-250.
[12] *Id.* at 244.
[13] *Id.* at 250.
[14] *Id.* 261-265.
[15] *Id.* at 267-271.
[16] 80 *F.R.* 75107
[17] 81 *F.R.* 57062
[18] *Id.* at 57059.