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## Medicare Inpatient Prospective Payment System

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April 26, 2016

### Payment Rule Brief — PROPOSED RULE

Program Year: FFY 2017

### Overview and Resources

On April 27, 2016, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2017 proposed payment rule for the Medicare Inpatient Prospective Payment System (IPPS). The proposed rule reflects the annual updates to the Medicare fee-for-service (FFS) inpatient payment rates and policies. In addition to the regular updates to wage indexes and market basket, this proposed rule includes:

- The final rate reduction amount (-1.5%) for the Coding Offset adjustment, as mandated by the American Taxpayer Relief Act of 2012 (ATRA);
- Updates to the program rules for the Value-Based Purchasing (VBP) and Hospital-Acquired Condition (HAC) programs;
- Updates to the payment penalties for non-compliance with the Electronic Health Record (EHR) Incentive Program;
- Updates to the Medicare Disproportionate Share Hospital (DSH) payment policies, as mandated in the Affordable Care Act of 2010 (ACA); and
- Implementation of a notification process for Medicare patients placed in observation for at least 24 hours.

Program changes would be effective for discharges on or after October 1, 2016 unless otherwise noted.

A copy of the proposed rule *Federal Register* (FR) and other resources related to the IPPS are available on the CMS website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Proposed-Rule-Home-Page.html>. Comments on all aspects of the proposed rule are due to CMS by June 17 and can be submitted electronically at <http://www.regulations.gov> by using the website's search feature to search for file code "1655-P".

An online version of the rule is available at <https://federalregister.gov/a/2016-09120>. Page numbers noted in this summary are from the Display Copy of the proposed rule.

A brief summary of the major hospital IPPS sections of the proposed rule is provided below.

## IPPS Payment Rates

Display Copy pages 547-555, 788-803, and 1,308-1,390

The table below lists the federal operating and capital rates proposed for FFY 2017 compared to the rates currently in effect for FFY 2016. These rates include all marketbasket increases and reductions as well as the application of an annual Budget Neutrality factor. These rates do not reflect any hospital-specific adjustments (e.g. penalty for non-compliance under the Inpatient Quality Reporting (IQR) Program and EHR Meaningful Use Program, quality penalties/payments, DSH, etc.).

	Final FFY 2016	Proposed FFY 2017	Percent Change
<b>Federal Operating Rate</b>	<b>\$5,467.53</b>	<b>\$5,511.79</b>	<b>+0.81%</b>
<b>Federal Capital Rate</b>	<b>\$438.75</b>	<b>\$446.35</b>	<b>+1.7%</b>

The table below provides details for the annual updates to the inpatient federal operating, hospital-specific, and federal capital rates for FFY 2017.

	Federal Operating Rate	Hospital- Specific Rates	Federal Capital Rate
Marketbasket (MB) Update/Capital Input Price Index	<b>+2.8%</b>	<b>+2.8%</b>	<b>+1.2%</b>
ACA-Mandated Reductions 0.5% productivity reduction and 0.75% pre-determined reduction	<b>-1.25 percentage points (PPTs)</b>	<b>-1.25 PPTs</b>	—
Forecast Error Adjustment	—	—	<b>-0.3 PPT</b>
American Taxpayer Relief Act (ATRA)-Mandated <u>Retrospective</u> Documentation and Coding Adjustment	<b>-1.5%</b>	—	—
2-Midnight Rule Prospective Adjustment	<b>+0.2%</b>	<b>+0.2%</b>	<b>+0.2%</b>
2-Midnight Rule Temporary Retrospective Adjustment	<b>+0.6%</b>	<b>+0.6%</b>	<b>+0.6%</b>
Annual Budget Neutrality Adjustment	<b>-0.02%</b>	<b>-0.02%</b>	<b>+0.02%</b>
<b>Net Rate Update</b>	<b>+0.81%</b>	<b>+2.34%</b>	<b>+1.73%</b>

- Effects of the Inpatient Quality Reporting (IQR) and EHR Incentive Programs** (Display Copy pages 1,311-1,317):  
 Beginning in FFY 2015, the IQR MB penalty changed from -2.0 percentage points to a 25% reduction to the full MB, and the EHR Meaningful Use (MU) penalty began its phase-in over three years, starting at 25% of the full MB. In FFY 2017, the EHR MU penalty will be capped at 75% of the MB; hence, beginning FFY 2017, the full MB update will be at risk between these two penalty programs. A table displaying the various update scenarios for FFY 2017 is below:

	Neither Penalty	IQR Penalty	EHR MU Penalty	Both Penalties
Net Rate Federal Rate Update (from above)	<b>+1.55%</b>	<b>+1.55%</b>	<b>+1.55%</b>	<b>+1.55%</b>
Penalty for Failure to Submit IQR Quality Data (25% of the base MB Update of 2.8%)	—	<b>-0.7 PPT</b>	—	<b>-0.7 PPT</b>
Penalty for Failure to be a Meaningful User of EHR (75% of the base MB Update of 2.8%)	—	—	<b>-2.1 PPT</b>	<b>-2.1 PPT</b>
<b>Adjusted Net Rate Update</b>	<b>+1.55%</b>	<b>+0.85%</b>	<b>-0.55%</b>	<b>-1.25%</b>

CMS has released an initial list of 133 non-compliant hospitals that would be penalized under the IQR for FFY 2017. CMS also estimates that 179 hospitals will be penalized for non-compliance under EHR MU for FFY 2017. In FFY 2016, 178 hospitals were penalized under the EHR MU Program, while 55 were non-compliant under IQR. Generally, successful participation in both programs is based on data collection two years prior to the payment adjustment year.

- **Retrospective Coding Adjustment** (*Display Copy pages 110-114*): CMS is proposing to apply a retrospective coding adjustment of -1.5% to the federal operating rate in FFY 2017. The coding offset rate reduction was authorized as part of the American Taxpayer Relief Act of 2012 (ATRA), which required inpatient payments to be reduced by \$11 billion (or -9.3%) over a 4-year period. To meet the ATRA requirements, CMS applied -0.8% coding adjustments in FFYs 2014 through 2016 and while originally it was expected that CMS would to apply a similar reduction in FFY 2017, CMS has determined that the existing reductions have only recovered \$5.95 billion of the \$11 billion called for in ATRA, due to decreasing inpatient volumes. CMS estimates that a reduction of 1.5% will be necessary in FFY 2017 in order to reach the \$11 billion target by the end of the fourth year. Each of these four annual reductions has been layered on top of the prior year's, thereby compounding the reductions in order to achieve the full recoupment over four years. Under ATRA, once the full recoupment had been accomplished, the base amount was to be restored.

***The positive adjustment to reverse the coding offset (now at 3.9%) and restore the federal base rates, was anticipated to take effect in FFY 2018; however, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), delays and phases-in this adjustment over 6 years (FFYs 2018-2023) in 0.5% increments, resulting in a total restoration of 3.0% and maintaining a base rate reduction of 0.9%. This is a larger impact than the previously anticipated 0.2% due to the increased value of the proposed coding offset adjustment for FFY 2017.***

- **2-Midnight Policy Adjustment** (*Display Copy pages 788-794*): In the FFY 2014 IPPS final rule, CMS adopted its 2-midnight policy for inpatient admissions and implemented a 0.2% prospective reduction to the IPPS rate to offset a predicted increase in expenditures resulting from this policy. The industry challenged the validity of CMS' reasoning for the reduction and in *Shands Jacksonville Medical Center, Inc. v. Burwell*, the Court ordered that the policy be remanded back to the Secretary "to correct certain procedural deficiencies in the promulgation of the 0.2 percent reduction and reconsider the adjustment." In response to the Court's decision, CMS is proposing to rescind the prospective adjustment - increasing the IPPS rates by 0.2% - and will restore the money previously recouped in FFYs 2014, 2015 and 2016 by applying a one-year adjustment of 0.6%. The 0.6% adjustment will drop off at the end of the FFY.
- **Effect of Sequestration** (*no FR page reference*): While the final rule does not specifically address the 2.0% sequestration reductions to all Medicare payments authorized by Congress and currently in effect through FFY 2025, sequester will continue unless Congress intervenes. Sequester is not applied to the payment rate; instead, it is applied to Medicare claims after determining co-insurance, any applicable deductibles, and any applicable Medicare secondary payment adjustments. Other Medicare payment lines such as graduate medical education (GME), bad debt, and EHR incentives are also affected by the sequester reductions. Payments from Medicare Advantage plans should not be automatically impacted by sequester.

## Wage Index

*Display Copy pages 485-545*

In FFY 2015, CMS updated the CBSA delineations used in the determination of the wage index. This change caused some shifts in the CBSA assignments for providers. For the nine hospitals that are located in counties that were formerly considered to be either urban or LUGAR, FFY 2017 is the final year of the three-year hold harmless provision.

For FFY 2017, CMS proposed several changes that will affect the wage index and wage index-related policies; the most significant changes are:

- **Core-Based Statistical Area Revisions** (*Display Copy pages 486-489*): On July 15, 2015, the Office of Management and Budget (OMB) issued revisions to three CBSAs that will be in effect for FFY 2017 rulemaking:
  1. Garfield County, OK previously classified as rural is now part of the new Enid, OK - CBSA 21420.
  2. The county of Bedford City, VA (SSA code 49088) has changed to town status and is now part of Bedford County (SSA code 49090). It remains a part of CBSA 31340- Lynchburg, VA.
  3. The name of CBSA 31420 - Macon, GA has been renamed as Macon-Bibb County, GA.
- **Imputed Rural Floor** (*Display Copy pages 509-513*): CMS is proposing to extend the imputed rural floor policy by one additional year, through September 30, 2017 while potential wage index reforms are explored.
- **“Lock-In” Date for Urban to Rural Reclassifications** (*Display Copy pages 525-528*): In order to process all rural redesignation requests in a timely fashion for the IPPS final rule, CMS is proposing to implement a “lock-in” date (i.e. deadline) for the second Monday in June of each year. In order to meet this deadline, CMS states that a hospital would need to file its application with the CMS Regional Office no later than 70 days prior to the second Monday in June of each year in order to provide the required 60 days for the CMS Regional Office to notify the hospital of the application’s approval/disapproval; and to allow processing and administrative time for the CMS Central Office to be notified of the reclassification. Approved applications received after this date would not be classified as rural until the following fiscal year.
- **Labor-Related Share** (*Display Copy pages 536-539*): The wage index adjustment is applied to the portion of the IPPS rate that CMS considers to be labor-related. For FFY 2017, CMS is proposing to continue to apply a labor-related share of 69.6% for hospitals with a wage index of 1.0 or more. By law, the labor-related share for hospitals with a wage index less than 1.0 will remain at 62%.
- **Treatment of Overhead and Home Office Costs** (*Display Copy pages 539-545*): CMS is seeking comments on two issues related to the calculation of the wage index:
  1. What future rulemaking or cost reporting changes should be implemented in order to remove the overhead wage-related costs for areas excluded from the wage index calculation i.e. applying a single allocation methodology between Worksheet S-3 Part IV and Worksheet S-3 Part II, lines 17 through 25.
  2. What can be done about the inconsistent reporting of home office salaries and wage-related costs? CMS is considering an end to the reporting of home office costs on line 14 of Worksheet S-3, Part II, and is considering requiring that home office costs be reported as part of the lines representing overhead; possibly by adding lines, columns, or by subscripting lines 27 and 28.
- **Changes to the Three-Year Average Pension Policy** (*no FR page reference*): Prior to FFY 2017, CMS calculated the pension cost component of the wage index as the three-year average of pension contributions using cost report data for the base wage index year and the each year immediately before and after the base . As adopted in the FFY 2016 IPPS final rule, beginning in FFY 2017, CMS will calculate the three-year average pension contribution using the base cost report year and the two preceding years. Hence, for FFY 2017 (the first year of this change) the pension component of the wage index will use the same three years of data that have been used for FFY 2016. Hospitals should review their status on Table 2 of the IPPS proposed rule, and notify CMS if they believe that an acquired hospital’s reclassification was mistakenly terminated by CMS.
- **Wage Index Development Timetable for FFY 2018** (*Display Copy pages 517-519*): Applications for FFY 2018 wage index reclassifications are due to the MGCRB by September 1, 2016. CMS is proposing to revise the MBCRB submission policy such that, for FFYs 2018 and beyond, hospitals would be required to send a copy of the reclassification application to CMS electronically, not on paper. CMS is also clarifying that in cases of hospital mergers, if the acquired hospital had been receiving an MGCRB reclassification, it will continue to receive that reclassification until the end of the 3-year reclassification period.
- **Criteria for an Individual Hospital Seeking Redesignation to Another Area** (*April 21, 2016 Federal Register pages 23,433-23,435*): Based on the outcome of *Geisinger Community Medical Center v. Secretary, United States Department of Health and Human Services* on July 23, 2015, CMS is revising its regulations regarding hospitals redesignated as rural that are seeking MGCRB reclassification to a different CBSA.

Effective with reclassification applications for FFY 2018, a hospital may apply for MGCRB reclassification while retaining a rural redesignation. This allows these hospitals to use the distance and average hourly wage criteria applicable for rural hospitals for their reclassification application.

A hospital that has an active MGCRB reclassification that is also approved for a rural redesignation will be allowed to maintain both classifications simultaneously. Those hospitals would receive a reclassified urban wage index and would be considered rural for all other purposes.

Hospitals reclassified in under this policy will be included in the calculation of the state's rural wage index if including the hospital raises the state's rural floor. These hospitals would also be included in the wage index calculation of both their home CBSA, as well as that for the reclassification wage index of the MGCRB reclassified CBSA. However, CMS states that these hospitals will be excluded from the calculation of a state's reclassified rural wage index.

A complete list of the proposed wage indexes for payment in FFY 2017 is available on Table 2 on the CMS Web site at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2017-NPRM-Tables-2-and-3.zip>.

## Quality-Based Payment Adjustments

*Display Copy pages 620-733*

For FFY 2017, IPPS payments to hospitals will be adjusted for quality performance under the Value Based Purchasing (VBP) Program, Readmissions Reduction Program (RRP), and the Hospital-Acquired Conditions (HAC) Reduction Program. The following provides detail on the FFY 2017 programs and payment adjustment factors (future program year program changes are addressed at the end of this Brief):

- **VBP Adjustment** (*Display Copy pages 640-706*): The FFY 2017 program will include hospital quality data for 21 measures in 5 domains: safety of care; clinical care - process; clinical care - outcomes; patient experience of care; and efficiency. By law, the VBP Program must be budget neutral and the FFY 2017 program will be funded by a 2.0% reduction in IPPS payments for hospitals that meet the program eligibility criteria (estimated at \$1.7 billion) compared to a 1.75% in FFY 2016. Because the program is budget neutral, hospitals can earn back some, all, or more than their 2.0% reduction.

While the data applicable to the FFY 2017 VBP program is still being aggregated, CMS has calculated and published proxy factors based on the current year's (FFY 2016) program. Hospitals should use caution in reviewing these factors as they do not reflect performance on the new measures for FFY 2017, changes to domain weights, updated performance periods/standards, nor changes to hospital eligibility.

The proxy factors published with the proposed rule are available in Table 16 on the CMS website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2017-NPRM-Table-16.zip>.

Effective with the FFY 2017 VBP program, CMS is proposing to increase, from two to three, the minimum number of surveys in a fiscal year on which a hospital is cited for "immediate jeopardy" in order to be excluded from the Hospital VBP program,.

CMS anticipates making actual FFY 2017 VBP adjustment factors available in October 2016. Details and information on the program currently in place for FFY 2016 and FFY 2017 program are available on CMS' QualityNet website at <https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772039937>.

- **Readmissions Reduction Program (RRP) (Display Copy pages 620-639):** The FFY 2017 RRP will evaluate hospitals on 6 conditions/procedures: acute myocardial infarction (AMI), heart failure (HF), pneumonia (PN) (expanded to include diagnoses of sepsis with a secondary diagnosis of pneumonia, and aspiration pneumonia), chronic obstructive pulmonary disease (COPD), elective total hip arthroplasty (THA) and total knee arthroplasty (TKA), and coronary artery bypass graft (CABG). The RRP is not budget neutral; hospitals can either maintain full payment levels or be subject to a penalty of up to 3.0%.

The proposed proxy FFY 2017 RRP factors are published with the proposed rule in Table 15 and on the CMS website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2017-NPRM-Table-15.zip>.

Details and information on the RRP currently are available on CMS' QualityNet website at <https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772412458>.

- **HAC Reduction Program (Display Copy pages 707-733):** The FFY 2017 HAC program will evaluate hospital performance on 6 measures: the AHRQ Patient Safety Indicator (PSI)-90—a composite of 8 individual HAC measures, Central Line-Associated Bloodstream Infection (CLABSI) rates, Catheter-Associated Urinary Tract Infection (CAUTI) rates, the Surgical Site Infection (SSI) Pooled Standardized Infection Ratio, Methicillin-resistant Staphylococcus Aurea (MRSA) rates (New in FFY 2017), and Clostridium difficile (C.diff.) rates (New in FFY 2017). The HAC Reduction Program is not budget neutral; hospitals with a total HAC Score that falls within the worst performing quartile for all eligible hospitals will be subject to a 1.0% reduction in IPPS payments. CMS states that it expects to release the list of hospitals subject to the HAC penalty for FFY 2017 in October 2016.

CMS also provides clarification in the proposed rule on two topics regarding the HAC reduction program: First is that, in order for a hospital to be considered having “complete data” for PSI-90, the hospital must have 3 or more discharges in at least 1 of the 8 indicators comprising the PSI-90 measure. The hospital must also have 12 or more months of data for PSI-90 in order to receive a Domain 1 score under the HAC program.

The other clarification pertains to newly opened hospitals. CMS states that *“if a hospital files a notice of participation (NOP) with the Hospital IQR Program within 6 months of opening, the hospital would be required to begin submitting data for the CDC NHSN HAI measures no larger than the first day of the quarter following the NOP.”* Furthermore, *“if a hospital does not file a NOP with the Hospital IQR Program within 6 months of opening, the hospital would be required to begin submitting data for the CDC NHSN HAI measures on the first day of the quarter following the end of the 6-month period to file the NOP.”*

## Quality-Based Payment Policies—FFYs 2018 and Beyond

For FFYs 2018 and beyond, CMS is proposing new policies and measures for its quality-based payment programs as follows:

- **VBP Program—FFYs 2018 through 2022 (Display Copy pages 640-706):** CMS has already adopted VBP program rules through FFY 2018 and some program policies and rules beyond FFY 2018. CMS is proposing further program updates/changes for FFYs 2018-2022. These changes include:
  - Measure additions/deletions for FFYs 2021 and 2022 (the proposed measure changes would continue the shift of the program’s focus from process measures to patient outcomes/efficiency measures);
  - New data collection time periods (baseline/performance periods) for the FFY 2018-2021 program years;
  - National performance standards for a subset of the FFY 2019, 2021 and 2022 program measures (performance standards for other program measures for future program years will be put forward in future rulemaking);

- Effective for FFY 2021, an update to the patient cohort comprising the Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization measure to include patients with a principal discharge diagnosis of aspiration pneumonia, and those with a principal discharge diagnosis of sepsis (excluding severe sepsis), with a secondary diagnosis of pneumonia coded as present on admission.
- Effective for the FFY 2019 program year, the “Patient- and Caregiver-Centered Experience of Care/Care Coordination” domain will be renamed the “Person and Community Engagement” domain.

CMS also addresses a potential change to the CAUTI and CLABSI measures. Similar to the change made for the FFY 2018 HAC Reduction Program, CMS is proposing to expand the data sets used to create the CAUTI and CLABSI measures to cover medical and surgical wards in addition to the Intensive Care Units (ICUs) they currently cover. This change would affect VBP-eligible hospitals beginning with the FFY 2019 program.

Finally, CMS is considering the future adoption of a scoring methodology to produce a composite “value” score that would assess overall quality and efficiency measure performance. CMS is seeking comments on two general approaches:

- Specific value measures developed and then incorporated into the IQR and VBP programs through the measure development process; or
- Using the VBP Program scoring methodology to either compare scores on specific quality and cost measures; or by comparing quality and efficiency domain scores.

Details and tables on the proposed measures, collection time periods, performance standards, and measure weighting are available on the pages listed above. Other details and information on the program currently in place for FFY 2016 and FFY 2017 program are available on CMS’ QualityNet website at <https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772039937>.

- **Readmissions Reduction Program** (*Display Copy pages 620-639*): CMS did not issue any proposed changes for future years of the Readmissions Reduction Program in this proposed rule.

Details and information on the program currently in place is available on CMS’ QualityNet website at <https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772412458>.

- **HAC Reduction Program—FFYs 2017-2019** (*Display Copy pages 707-733*): For FFY 2018, CMS is proposing to adopt a modified version of the PSI-90 composite measure titled “Patient Safety and Adverse Events Composite” comprised of 10 component indicators (up from 8). The changes between this and the current PSI-90 composite measure include:

- The addition of—
  - PSI 09: Perioperative Hemorrhage or Hematoma Rate;
  - PSI 10: Physiologic and Metabolic Derangement Rate; and
  - PSI 11: Postoperative Respiratory Failure Rate.
- The removal of—
  - PSI 07: Central Venous Catheter-Related Blood Stream Infection Rate
- Changes to—
  - PSI 12: Perioperative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT) Rate; and
  - PSI 15: Accidental Puncture or Laceration Rate.
- Weighting of component indicators based on harms associated with the events, in addition to volume.

CMS is proposing, starting with FFY 2017, to allow some flexibility in the use of a period other than 24 months in the calculation of the Total HAC score. This proposal is because CMS’ system requires an ICD-10 risk adjusted version of the AHRQ QI PSI software by December 2016. CMS is also proposing to utilize a 15-month performance period (July 1, 2014 – Sept. 30, 2015) for the PSI-90 measure used in the FFY 2018 HAC Reduction Program, as well as a 21-month performance period (Oct. 1, 2015 – Sept. 30, 2017) for the FFY 2019 HAC Reduction Program, based on the nationwide conversion to ICD-10-CM.

CMS is also proposing to change the scoring methodology for the HAC measures, beginning FFY 2018. Currently, a hospital's individual HAC scores can range from 1 to 10, based upon which national performance decile of they fall into, (lower deciles translating to better scores). CMS' proposal would employ a continuous scoring methodology utilizing Winsorized z-scores.

$$Z\text{-Score} = \frac{(\text{Hospital's Measure Performance} - \text{Mean Performance for All Hospitals})}{\text{Standard Deviation for All Hospitals}}$$

The Z-score would represent each hospital's performance in terms of standard deviation units from the national average (mean); poor performing hospitals would receive a positive z-score (above the national mean) and high performers would receive a negative score (below the national mean). Scoring for domains, Total HAC Scores, and penalty determinations would remain unchanged.

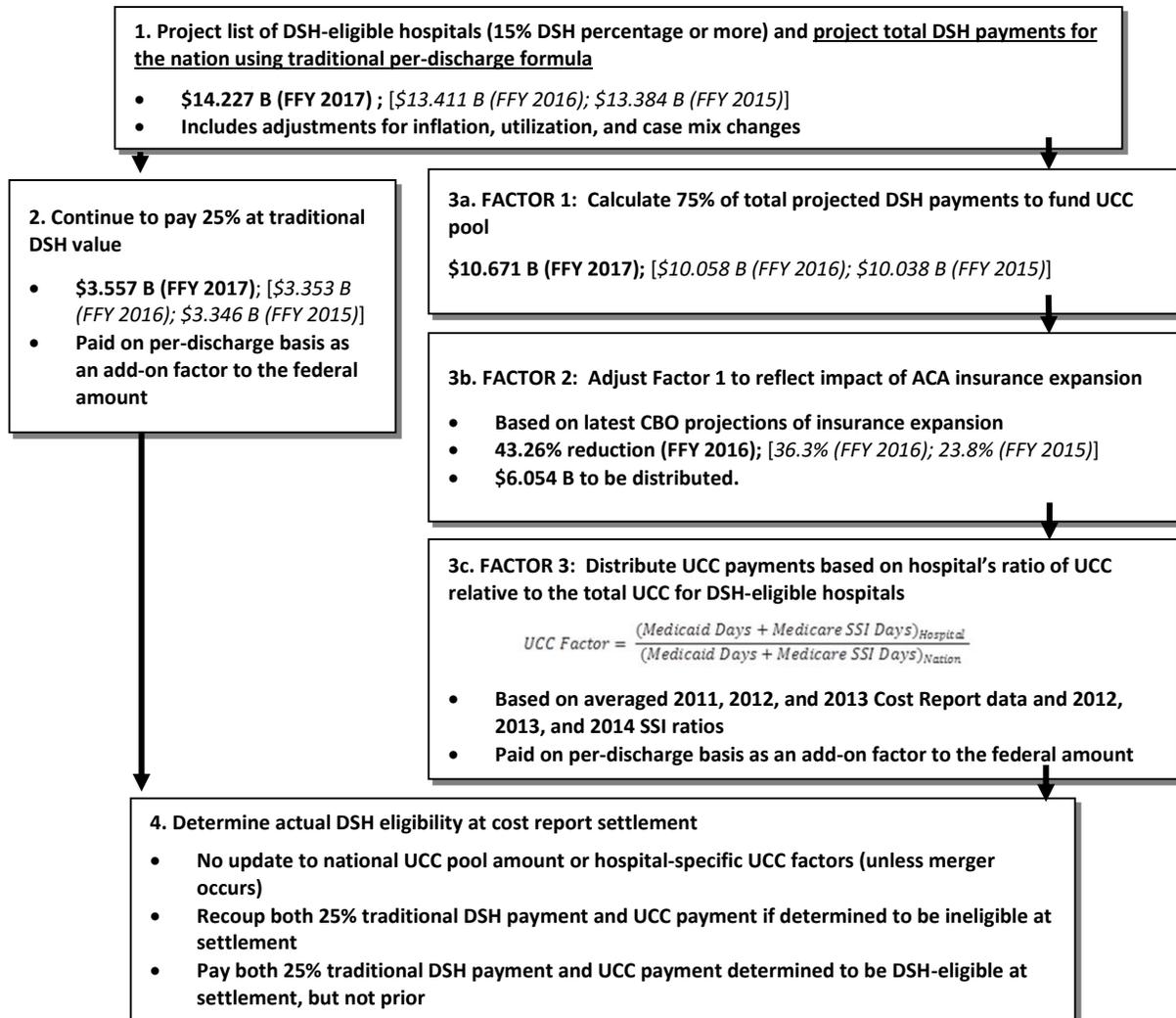
## DSH Payments

Display Copy pages 566-619

The ACA mandates the implementation of new Medicare DSH calculations and payments in order to address the reductions to uncompensated care as coverage expansion takes effect. By law, 25% of estimated DSH funds, using the traditional formula, must continue to be paid to DSH-eligible hospitals. The remaining 75% of the funds (referred to as the Uncompensated Care (UCC) pool, are subject to reduction to reflect the impact of insurance expansion under the ACA. This UCC pool is to be distributed to hospitals based on each hospital's proportion of UCC relative to the total UCC for all DSH-eligible hospitals.

- **DSH Payment Methodology for FFY 2017** (Display Copy pages 566-619):

The following schematic describes the DSH payment methodology mandated by the ACA along with how the program is proposed to change from FFY 2015 to FFY 2017:



The DSH dollars available to hospitals under the ACA's payment formula are proposed to decline in FFY 2017 and will continue to be reduced in the coming years as insurance coverage rates are expected to increase.

- **Eligibility for FFY 2017 DSH Payments** (*Display Copy pages 572-576*): CMS is projecting that 2,427 hospitals will be eligible for DSH payments in FFY 2017. Only hospitals identified in the final rule as DSH-eligible will be paid as such during FFY 2017. CMS has made a file available that includes DSH eligibility status, UCC factors, payment amounts, and other data elements critical to the DSH payment methodology. The file (Table 18) is available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcutelnpatientPPS/Downloads/FY2017-NPRM-Table-18.zip>.

According to the tables provided in this proposed rule, 29 hospitals that were not eligible for DSH in FFY 2016 are projected to receive DSH payments in FFY 2017; while 92 are projected to lose eligibility due to changes in their Medicare and Medicaid days.

- **Adjustment to Factor 3 Determination** (*Display Copy pages 587-601*): CMS has been using the ratio of Medicaid and Medicare SSI days for Factor 3, based on data for the most recent available year. In this proposed rule, CMS notes that the use of only 1 year's data has caused large fluctuations from year to year. CMS is proposing, beginning in FFY 2017, to calculate the Factor 3 UCC DSH distribution factor based on up to 3 years of data: the most current year and the two prior years. A Factor 3 value would be calculated for each year individually and the final UCC factor would be the average of those three values. If cost report data is missing for any year, that hospital's final Factor 3 value would be based on the average of the useable cost report data. This change should result in improved stability of individual hospital DSH UCC payments going forward.

For the FFY 2017 UCC pool distribution, CMS is proposing to utilize Medicaid data from the 2011, 2012, and 2013 Medicare cost reports and data from the 2012, 2013, and 2014 Medicare SSI files. Because the 2014 SSI data is not yet available, CMS is using 2013 for both years 2 and 3 in the proposed rule. Because residents of Puerto Rico are not eligible for SSI benefits, CMS is proposing to apply a proxy value of 14% of Medicaid days as the Medicare SSI days for hospitals in Puerto Rico. This ratio is based on the average ratio of Medicaid days to Medicare SSI days nationally (excluding Puerto Rico).

- **Future Use of Data from Cost Report Worksheet S-10 for Determining Factor 3** (*Display Copy pages 601-619*): CMS has been using Medicaid and Medicare SSI days as a proxy for uncompensated care in Factor 3 since FFY 2014 and proposes to do so again for FFY 2017, due to concerns regarding data variability and lack of reporting experience with S-10 Worksheet. However, CMS states that it is seeing an improving correlation between Factor 3 values calculated using data on uncompensated care from Worksheet S-10 and those calculated using data from the IRS Form 990. CMS is proposing to phase-in the use of data reported on Line 30 of Worksheet S-10 (Charity Care and Non-Medicare Bad Debt Expense) of the Medicare cost report in order to determine the UCC payment factor (Factor 3), starting with FFY 2014 cost reports for DSH payments in FFY 2018.

The Worksheet S-10 data would be phased-in as part of the three year averaging process for Factor 3; i.e. an average of 2 years of proxy data (2012 and 2013) and 1 year of S-10 data (2014) for FFY 2018 DSH payments, 1 year of proxy data (2013) and 2 years of S-10 data (2014, 2015) for FFY 2019 DSH payments, and 3 years of S-10 data for FFY 2020 DSH payments and thereafter.

CMS is also proposing to revise the instructions for Line 20 of Worksheet S-10 (Total Initial Obligation of Patients Approved for Charity Care) such that charity care will be reported based on the write-off date, not the date of service. In order to account for hospitals that consistently report very high uncompensated care values on Worksheet S-10, CMS is also proposing to implement a "double trim" methodology targeting the cost to charge ratio. The proposed methodology may be found on pages 617-619 of the proposed rule Display Copy.

## **GME Payments**

*Display Copy pages 565-566 and 734-745*

Beginning FFY 2017, CMS is proposing to allow an urban hospital's rural training track FTE limitation to be equal to the actual number of resident FTEs training in that rural track, for the first five years of the track's existence. The rural track FTE limitation would come into effect beginning with the cost reporting period coinciding with or following the start of the sixth program year. This change is to address concerns that such a program needs sufficient time to become established before a limitation is applied. FTEs assigned to the rural training track would still be included in a hospital's 3-year rolling average resident count, and are subject to the IME intern-resident-to-bed ratio cap for hospitals with established FTE caps. This change in policy would be effective rural training tracks started on or after October 1, 2012, and will align the rural training track timeframe with CMS' new teaching hospital cap adjustment policy; which was extended to five years, as part of the FFY 2013 final rule, to provide additional growth time for new teaching hospitals programs.

The Indirect Medical Education (IME) adjustment factor will remain at 1.35 for FFY 2017.

## **Updates to the MS-DRGs**

*Display Copy pages 100-484 and 1,329-1,330*

Each year CMS updates the MS-DRG classifications and relative weights to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. Changes proposed to the MS-DRGs for FFY 2017 will decrease the number of payable DRGs from 758 to 757. The majority of the DRG weights (83%) will change by less than +/- 5%.

The full list of FFY 2017 DRGs, DRG weights, and flags for those subject to the post-acute care transfer policy are available in Table 5 on the CMS website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2017-NPRM-Table-5.zip>.

For comparison purposes, the FFY 2016 DRGs are available in Table 5 on the CMS website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2016-CMS-1632-FR-Table-5.zip>.

## **Outlier Payments**

*Display Copy pages 1,343-1,358*

To maintain outlier payments at 5.1% of total IPPS payments, CMS proposes an outlier threshold of \$23,681 for FFY 2017. The proposed threshold is 5.04% higher than the current (FFY 2016) outlier threshold of \$22,544. CMS cites an increase in hospital charges as the reason for the threshold increase.

## **Updates to the IQR Program and Electronic Reporting Under the Program**

*Display Copy pages 944-1,065*

CMS is proposing to add four new measures (three clinical episode-based payment measures, one claims-based outcome measure) and remove 15 measures (two of which are topped-out and 13 that have been suspended) to the Hospital IQR program beginning in FFY 2019. CMS is also proposing to refine two previously adopted measures for FFY 2018.

CMS also proposes two changes to the electronic clinical quality measures (eCQMs). For the calendar year (CY) 2017 reporting period/FFY 2019 payment determination and subsequent years, CMS is proposing to require reporting on all proposed eCQMs in order to achieve CMS' goals of alignment with the EHR Incentive Program.

CMS is proposing to require that one year of data be submitted for each of the required eQMs for the CY 2017 reporting period and thereafter.

A table on pages 1,016-1,020 of the final rule outlines the Hospital IQR Program measure set for the FFY 2019 payment determination and subsequent years and includes both previously adopted and new measures.

## **New Technology**

*Display Copy pages 362-484*

CMS states its views on numerous new medical services or technologies that are potentially eligible for add-on payments outside the PPS. CMS is proposing to: discontinue add-on payments for four medical services/technologies, continue new technology add-on payments for three, and is seeking public comment on ten.

## **Expiration of the More Inclusive Low-Volume Adjustment Criteria**

*Display Copy pages 560-565*

Legislative action by Congress over the past several years had mandated changes to the low-volume hospital adjustment criteria, allowing more hospitals to qualify for the adjustment and modifying the amount of the adjustments. MACRA extended the relaxed low volume adjustment criteria (15-mile/1,600 discharge) for an additional 30 months, through the end of FFY 2017. Hospitals newly seeking the adjustment for FFY 2017 are required to make a request in writing to their MAC by September 1, 2016 in order to achieve the adjustment beginning October 1. Hospitals that request the status after September 1 and qualify will be eligible for the adjustment, prospectively, within 30 days of the MAC's determination.

## **Medicare Dependent Hospitals (MDH)**

*Display Copy pages 784-788*

The Medicare-Dependent Hospital (MDH) program has been extended several times by Congressional legislative action. Most recently, MACRA extended this program by an additional 30 months, through the end of FFY 2017.

CMS clarifies, in this proposed rule, that the 60% Medicare utilization requirement to retain MDH status is inclusive of days or discharges provided by the hospital to Medicare Advantage beneficiaries, not just fee-for-service. It is important that MDH hospitals submit claims for these individuals in a timely manner.

## **RRC Status**

*Display Copy pages 555-560*

Hospitals that meet certain criteria can be classified as Rural Referral Centers (RRCs). This special status provides an exemption from the 12% rural cap on traditional DSH payments and special treatment with respect to geographic reclassification. Each year, CMS updates the minimum case-mix index and discharge criteria related to achieving RRC status (for hospitals that cannot meet the minimum 275 bed criteria). The proposed FFY 2017 minimum case-mix and discharge values by region are available on pages 557-559 of the Display Copy of the proposed rule.

## **Medicare Outpatient Observation Notice**

*Display Copy pages 764-778*

On August 6, 2015, Congress enacted the Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act) requiring hospitals and Critical Access Hospitals (CAHs) to provide written notification to individuals who are receiving observation services for more than 24 hours, effective August 6, 2016.

CMS is proposing to implement the NOTICE Act and to require use of a new CMS-developed standardized notice, the Medicare Outpatient Observation Notice (MOON). CMS believes that by requiring the use of a standardized notice, providers would be assured that they are providing all of the statutorily required elements in a manner that the individuals receiving it will understand.

This notice must be provided, in conjunction with an oral explanation, to any individual entitled to benefits under Medicare that have received outpatient observation services for more than 24 hours, beginning at the clock time documented in the patient's medical record. Provision of the MOON must be no later than 36 hours after the start of observation services; and must be furnished sooner if the patient is transferred, discharged, or admitted to inpatient within that timeframe. Upon receipt of the notice, the Act requires that it be signed by the patient, or by a person acting on their behalf in order to acknowledge that it was provided. If the patient or individual acting on their behalf refuse to provide a signature, the notification must be signed by the staff member of the hospital or CAH who presented the written notification and include the name and title of the staff member, a certification statement that the notification was presented, as well as the date and time it was presented.

The MOON must be presented to a Medicare beneficiary regardless of whether the services provided are payable under Medicare (such as those enrolled in Part A, but not Part B).

The MOON is required to go through the Paperwork Reduction Act process, thus providing an opportunity to comment on the proposed notice.

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