hfma
healthcare financial management association

PROPOSED RULE: MEDICARE INPATIENT HOSPITAL OPERATING AND CAPITAL PAYMENT FOR FISCAL YEAR 2017

TABLE OF CONTENTS

The proposed rule was be published in the *Federal Register* on April 27, 2016. Written or electronic comments on the proposals must be submitted to CMS by close of business June 17, 2016. A final rule will be published around August 1, 2016, with the rates and policy changes generally taking effect on October 1, 2016.

Please note that the Roman numeral convention will not follow the proposed rule as we have removed some sections to shorten the summary.

I. PPS Rate Updates and Impact of the Rule; Outliers

CMS estimates that policies and rates in the proposed rule would increase combined operating and capital payments to the approximately 3,330 acute care hospitals paid under the IPPS by about $539 million in FY 2017 compared to FY 2016. The increase results from an increase of about $375 million in IPPS operating payments and an increase of about $164 million in IPPS capital payments.

A. Inpatient Hospital Operating Update for FY 2017

The proposed rule would increase IPPS operating payment *rates* by 0.85 percent for hospitals which successfully report quality measures and are meaningful users of electronic health records (EHR).

Factor	Percent Change
FY 2017 inflation (market basket) update	2.8
Multifactor productivity adjustment	-0.5
Additional -0.75 percentage point update adjustment required by the ACA	-0.75
Subtotal – "applicable percentage increase"	*1.55*
Documentation and coding recoupment required by ATRA	-1.5
Permanently remove "2 midnight" -0.2 adjustment and correct for FYs 2014-2016	+0.8
Net increase in national standardized amounts (before application of budget neutrality factors)	*0.85**
*CMS displays this amount as 0.9.	

Hospitals that fail to participate successfully in the Hospital Inpatient Quality Reporting (IQR) Program or are not meaningful users of EHR do not receive the full "applicable percentage increase."

- For FY 2017, hospitals that choose not to participate in the IQR Program are subject to a one-fourth reduction of the market basket update, which is a reduction of **0.7 percentage points**.
- Any hospital that is not a meaningful EHR user will be subject to a three-quarters reduction of the market basket update. In FY 2017 that is a reduction of **2.1 percentage points**.

B. Payment Impacts

While the proposed FY 2017 standardized amounts received an "applicable percentage increase" of 1.55 percent from the FY 2016 rates, the CMS payment impact analysis shows average per case operating payments increasing 0.7 percent. However, not all policy changes are reflected in this total (e.g. proposed changes related to DSH payments and readmissions reduction are not

included in the 0.7 total. The factors that are included in the impact table of the proposed rule follow:

Contributing Factor	**National Percent Change**
FY 2017 increase in proposed rule payment rates (from table above)	+0.85*
Frontier hospital wage index floor and out-migration wage adjustment	+0.1**
FY 2017 outlier payments at 5.1 percent compared to 5.3 percent estimate of actual FY 2016 outlier payments	-0.2
Total	*+0.7***

*CMS displays this amount as 0.9.
**The frontier hospital wage index floor increases payments about $56 million to 50 hospitals and the out-migration adjustment increases payments about $31 million to 249 providers.
***Total reflects interactions and rounding.

Table I Impact Analysis

Detailed impact estimates are displayed in Table I of the proposed rule (reproduced in the Appendix to this summary). The following table summarizes the impact by hospital category.

Hospital Type	**All Proposed Rule Changes**
All Hospitals	0.7%
Large Urban	0.6%
Other Urban	0.7%
Rural	0.8%
Major Teaching	0.8%

The effects of several significant policies are not included in the rule's impact analysis:

- Payments for Medicare DSH and uncompensated care will be $168 million lower than in FY 2016. See section IV.F below for details of the policy changes.
- The Hospital Readmissions Reduction Program (HRRP) would reduce FY 2017 payments to an estimated 2,603 hospitals by $523 million, an increase of $100 million over the estimated FY 2016 savings.
- The HAC Reduction Program will reduce total IPPS payments by 1 percentage point to an estimated 774 hospitals. The impact analysis does not include any dollar estimate of these penalties.
- No discussion is included in the impact analysis regarding the impact of the HAC payment provision that precludes higher payment for certain secondary diagnoses unless they were present at the time of admission.
- The hospital value-based purchasing (VBP) program is budget neutral but will redistribute about $1.7 billion based on hospitals' performance scores.

- Expiration of new technology add-on payments for four technologies is estimated to decrease payments in FY 2017 by $50 million.

Based on the above estimates, the net aggregate effect of these policies would reduce payments in FY 2017 by about $318 million compared to FY 2016.

C. IPPS Standardized Amounts for FY 2017

FY 2017 PROPOSED RULE TABLES 1A-1D

TABLE 1A. PROPOSED NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS; LABOR/NONLABOR (69.6 PERCENT LABOR SHARE/30.4 PERCENT NONLABOR SHARE IF WAGE INDEX IS GREATER THAN 1)—FY 2017							
Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 1.55 Percent)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = -0.55 Percent)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = 0.85 Percent)			Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = - 1.25 Percent)
Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor
$3,836.20	$1,675.59	$3,756.87	$1,640.94	$3,809.76	$1,664.04	$3,730.43	$1,629.39

TABLE 1B. PROPOSED NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE IF WAGE INDEX LESS THAN OR EQUAL TO 1)							
Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 1.55 Percent)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = -0.55 Percent)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = 0.85 Percent)		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = - 1.25 Percent)	
Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor
$3,417.31	$2,094.48	$3,346.64	$2,051.17	$3,393.76	$2,080.04	$3,323.09	$2,036.73

TABLE 1C. PROPOSED ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR PUERTO RICO, LABOR/NONLABOR (NATIONAL: 62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE BECAUSE WAGE INDEX IS LESS THAN OR EQUAL TO 1)—FY 2017				
	Rates if Wage Index Greater Than 1		Rates if Wage Index Less Than or Equal to 1	
	Labor	**Nonlabor**	**Labor**	**Nonlabor**
National[1]	Not Applicable	Not Applicable	$3,417.31	$2,094.48
[1]For FY 2017, there are no CBSAs in Puerto Rico with a proposed national wage index greater than 1.				

TABLE 1D. PROPOSED CAPITAL STANDARD FEDERAL PAYMENT RATE	
	Rate
National	$446.35

Note that the standardized amounts do not include the 2 percent Medicare sequester reduction that began in 2013 and will continue until 2024 absent new legislation. The sequester reduction is applied as the last step in determining the payment amount for submitted claims and it does not affect the underlying methodology used to calculate MS-DRG weights or standardized amounts.

As discussed in section IV.A below, effective January 1, 2016 separate standardized amounts for Puerto Rico no longer apply. The separate labor-related share of 62 percent continues.

D. Outlier Payments and Threshold

FY 2017 outlier threshold. CMS proposes an outlier fixed-loss cost threshold for FY 2017 equal to the prospective payment rate for the MS-DRG, plus any IME, empirically justified Medicare DSH payments, estimated uncompensated care payment, and any add-on payments for new technology, plus $23,681.

CMS projects that the final outlier threshold for FY 2017 will result in outlier payments equal to 5.1 percent of operating DRG payments and 6.26 percent of capital payments based on the respective federal rates, and it adjusts the respective operating and capital standardized amounts using the different percentages.

II. Changes to MS-DRG Classifications and Relative Weights

A. FY 2017 Documentation and Coding Adjustment

CMS proposes to continue in FY 2017 the process of documentation and coding adjustments that began in FY 2008 along with the transition to MS-DRGs, including the final stage of a four-year $11 billion recoupment.

FY 2017 Proposal

For FY 2017, CMS proposes to complete the $11 billion recoupment by making an estimated -1.5 percent adjustment to the FY 2017 standardized amounts and leaving in place the cumulative the -2.4 percent adjustments made for FY 2014 through FY 2016. Notably, the final adjustment will reflect the President's Budget Midsession Review, and could differ from the current -1.5 percent estimate. Its current estimate of the total recoupment that will be completed by the end of FY 2016 is $5.95 billion.

The OACT memorandum attributes the increased percentage reduction in this final installment to lower-than-expected IPPS spending, due to market basket increases that were lower than projected and fewer inpatient stays.

CMS reiterates that it had anticipated that once the full $11 billion recoupment was completed, it would increase the FY 2018 payment rates to restore the cumulative reduction level, which originally was estimated to be 3.2 percent. However, section 414 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, Pub. L. 114-10) replaces the one-time FY 2018 increase with rate increases equal to 0.5 percent for each of the six years beginning with FY 2018 and ending with FY 2023. Section 414 of MACRA also removes the Secretary's authority to make an additional prospective adjustment to IPPS rates to offset payment increases resulting from documentation and coding changes for discharges occurring during fiscal year 2010. (This amount has been estimated to be 0.55 percent.)

B. Proposed Add-On Payments for New Services and Technologies

1) Proposed FY 2017 Status of Technologies Approved for FY 2016 Add-On Payments

a. CardioMEMS™ HF (Heart Failure) System (Add-on Proposed to Continued)

The CardioMEMS™ HF System is an implantable hemodynamic monitoring system comprised of an implantable sensor/monitor placed in the distal pulmonary artery (PA); pulmonary artery hemodynamic monitoring is used in the management of HF. Because the 3-year anniversary date of the CardioMEMS™ HF System on the US market will occur in FY 2017 (May 28, 2017), CMS proposes to continue the new technology add-on payments. The maximum new technology add-on payment for a case involving the CardioMEMS™ HF System would remain at $8,8075 for FY 2017. CMS estimates the FY 2017 add-on payments for this technology at approximately $11.3 million.

b. Blinatumomab (BLINCYTO™) (Add-on Proposed to Continued)

BLINCYTO™ is a bi-specific T-cell engager (BiTE) used for the treatment of Philadelphia chromosome-negative (Ph-) relapsed or refractory (R/R) B-cell precursor acute-lymphoblastic leukemia (ALL), a rare aggressive cancer.

Because the 3-year anniversary date of the entry of BLINCYTO™ on the US market will occur after FY 2017 (December 17, 2017), CMS proposes to continue the new technology add-on payments. The maximum new technology add-on payment for a case involving BLINCYTO™ would remain at $8,8075 for FY 2017. CMS estimates the FY 2017 add-on payments for this technology at approximately $4.6 million.

c. LUTONIX® Drug Coated Balloon (DCB) Percutaneous Transluminal Angioplasty (PTA) Catheter and IN.PACT™ Admiral™ Paclitaxel Coated Percutaneous Transluminal Angioplasty (PTA) Balloon Catheter (Add-on Proposed to Continued)

Two manufacturers, CR Bard Inc. and Medtronic, submitted applications for . LUTONIX® Drug Coated Balloon (DCB) Percutaneous Transluminal Angioplasty (PTA) and IN.PACT™ Admiral™ Paclitaxel Coated Percutaneous Transluminal Angioplasty (PTA) Balloon Catheter, respectively. Both of these technologies are DCB PTA for patients with peripheral artery disease (PAD). The applicants note that the DCB catheter is a device-drug combination product comprised of a device component (an over-the-wire balloon catheter) and a drug component on the balloon. Because the 3-year anniversary date of the entry of LUTONIX® on the US market will occur after FY 2017, CMS proposes to continue the new technology add-on payments for both the LUTONIX® and IN.PACT™ Admiral™ technologies. The maximum new technology add-on payment for a case involving LUTONIX® and IN.PACT™ Admiral™ would remain at $1,035.72 for FY 2017. CMS estimates the FY 2017 add-on payments for this technology at approximately $36.1 million.

d. Kcentra™ (Add-on Discontinued)

Kcentra™ is a replacement therapy for fresh frozen plasma (FFP) for patients with an acquired coagulation factor deficiency due to warfarin. CMS proposes to discontinue the new technology add-on payment. CMS explains that, it extends add-on payments for an additional year only if the 3-year anniversary date of the product's entry on the market occurs in the latter half of the fiscal year. Kcentra's™ 3-year anniversary date (April 29, 2016) occurs prior to the beginning of FY 2017.

e. Argus® II Retinal Prosthesis System (Add-on Discontinued)

The Argus® II System is an active implantable medical device that is intended to provide electrical stimulation of the retina to induce visual perception in patients who are profoundly blind due to retinitis pigmentosa (RP). Because the 3-year anniversary date of the entry of the Argus® II System on the US market (December 20, 2016) will occur in the first half of FY 2017, CMS proposes to discontinue the new technology add-on payment for this technology.

f. MitraClip® System (Add-on Discontinued)

The MitraClip® System is a transcatheter mitral valve system that includes a MitraClip® device implant, a steerable guide catheter, and a clip delivery system. Because the 3-year anniversary

date of the entry of MitraClip® System on the US market will occur in the first half of FY 2017 (October 24, 2016), CMS proposes to discontinue the new technology add-on payments.

g. Responsive Neurostimulator (RNS®) System (Add-on Discontinued)

The RNS® is an implantable medical device developed by NeuroPace, Inc. for treating people with epilepsy whose partial onset seizures have not been adequately controlled with antiepileptic medications. Because the 3-year anniversary date of entry of the RNS® System on the US market will occur in the first half of FY 2017 (November 14, 2016), CMS proposes to discontinue the new technology add-on payments.

5. Proposed FY 2017 Applications for New Technology Add-On Payments

CMS received nine applications for new technology add-on payments for FY 2017. CMS notes that all applicants for new technology add-on payments must have FDA approval by July 1 of each year prior to the beginning of the FY that the application is being considered. The summary below provides a high level discussion of each new technology assessment; readers are advised to review the proposed rule for more detailed information. **CMS invites public comment on whether the nine technologies in question meet the newness, cost and substantial clinical improvement criteria.**

a. MAGEC® Spinal Bracing and Distraction System (MAGEC® Spine)

Ellipse Technologies, Inc. submitted an application for the MAGEC® Spine, a spinal growth rod that can be used in the treatment of patients diagnosed with early onset scoliosis. The device consists of a spinal growth rod that can be lengthened through the use of magnets controlled by an external remote controller.

b. MIRODERM Biologic Wound Matrix (MIRODERM)

Miromatrix Medical , Inc. submitted an application for the MIRODERM, a non-crosslinked acellular wound matrix derived from porcine liver and processed and stored in a phosphate buffered aqueous solution. The applicant noted that MIRODERM is the only acellular skin substitute derived from the liver. MIRODERM is used for the management of wounds including partial and full-thickness wounds, chronic vascular ulcers, trauma wounds and surgical wounds.

c. Idarucizumab

Boehringer Ingelheim Pharmaceuticals, Inc. submitted an application for Idarucizumab, a product developed as an antidote to Dabigatran, an oral direct thrombin inhibitor also manufactured by Boehringer Ingelheim Pharmaceuticals, Inc. As a direct thrombin inhibitor, Dabigatran is indicated to: (1) reduce the risk of stroke and systemic embolism in patients diagnosed with nonvalvular atrial fibrillation (NVAF); (2) treat deep venous thrombosis (DVT) and pulmonary embolism (PE) in patients who have been administered a parenteral anticoagulant for 5 to 10 days; and (3) reduce the risk of recurrence of DVT and PE in patients diagnosed with NVAF.

d. Titan Spine Endoskeleton® and nanoLOCK™ Interbody Device (Titan Spine nanoLOCK™)

Titan Spine submitted an application for Titan Spine nanoLOCK™, a nanotechnology-based interbody medical device with a dual acid-etched titanium interbody system used to treat patients with degenerative disc disease (DDD).

e. Adexanet Alfa

Portola Pharmaceuticals, Inc. submitted an application for Andexanet Alfa, an antidote to treat patients receiving treatment with an oral Factor Xa inhibitor who suffer a major bleeding episode and require urgent reversal of direct and indirect Factor Xa anticoagulation. Factor Xa inhibitors are oral anticoagulants used to prevent stroke and systemic embolism in patients with atrial fibrillation (AF).

f. Defibrotide (Defitelio®)

Jazz Pharmaceuticals submitted an application for Defitelio®, a treatment for patients diagnosed with hepatic veno-occlusive disease (VOD) with evidence of multi-organ dysfunction. VOD is a life-threatening complication resulting from hematopoietic stem cells transplantation. VOD is believed to result of endothelial cell damage and hepatocellular injury from high-dose conditioning regiments administered prior to transplant.

g. EDWARDS INTUITY Elite™ Valve System (INTUITY)

Edwards Lifesciences submitted an application for INTUITY, a device which uses a rapid deployment valve system and serves as a prosthetic aortic valve inserted during surgical aortic valve replacement (AVR).

h. GORE®EXCLUDER® Iliac Branch Endoprosthesis (IBE)

W.L. Gore and Associates, Inc. submitted an application for the GORE IBE device which is designed to be used in conjunction with the GORE®EXCLUDER® AAA Endoprosthesis for the treatment of patients requiring repair of common iliac or aortoiliac aneurysms. When deployed the device excludes the common iliac aneurysm from systemic blood flow, while preserving blood flow in the external and internal iliac arteries.

i. Vistogard™ (Uridine Triacetate)

BTG International Inc. submitted an application for Vistogard™ an antidote to fluorouracil toxicity. The chemotherapeutic agent 5-fluorouracil (5-FU) is used to treat a variety of solid tumors and there is a risk for toxicity in patients receiving 5-FU. The applicant stated that current treatment for fluorouracil toxicity is supportive care, including discontinuation of the drug, hydration, and filgrastim for neutropenia, as well as antibiotics, antiemetics, and other treatments for potential gastrointestinal and cardiovascular compromise.

III. Changes to the Hospital Wage Index for Acute Care Hospitals

A. Core-Based Statistical Areas for the Hospital Wage Index

CMS notes that OMB occasionally issues minor updates to statistical areas in years between the decennial censuses. On July 15, 2015, OMB issued an update (OMB Bulletin No. 15-01) to the current statistical areas that are based on the OMB delineations issued on February 28, 2013, in

OMB Bulletin No. 13-01. OMB Bulletin No. 15-01 supersedes OMB Bulletin No. 13-01; a copy of Bulletin No. 15-01 is available at http://www.whitehouse.gov/omb/bulletins_default.

In the proposed rule, CMS identifies 3 changes that are relevant to the IPPS wage index.

- Garfield County, OK (with principal city Enid, OK) now qualifies as an urban new CBSA (CBSA 21420 Enid, OK)
- Bedford City, VA is now part of Bedford County, VA, but the CBSA remains Lynchburg, VA (CBSA 31340)
- Macon, GA, CBSA 31420 is renamed Macon-Bibb County, GA (same CBSA number)

Effective October 1, 2016, CMS proposes to implement the revisions beginning with the FY 2017 wage indexes; it proposes to use the definitions to calculate area wage indexes in a generally consistent manner as the CBSA-based methods that were finalized in the FY 2005 and FY 2015 IPPS final rules.

B. Method for Computing the Proposed FY 2017 Unadjusted Wage Index

The proposed FY 2017 national average hourly wage, unadjusted for occupational mix, is **$41.1026.** CMS no longer proposes to compute a separate unadjusted wage index for Puerto Rico because section 601 of the Consolidated Appropriations Act, 2016 (Public Law 114-113) provided for 100 percent payment based on the national standardized amount for Puerto Rico hospitals.

C. Proposed Occupational Mix Adjustment to the FY 2017 Wage Index

The proposed FY 2017 occupational mix-adjusted national average hourly wage (including Puerto Rico) is **$41.0651**.

CMS proposes to calculate the occupational mix adjustment factor using the same methodology it used for FYs 2012 through 2016 and to apply the occupational mix adjustment to 100 percent of the FY 2017 wage index.

D. Transitional Wage Indexes

In the FY 2015 IPPS/LTCH PPS final rule, CMS established transition methodologies to mitigate any negative payment impacts experienced by hospitals due to its adoption of the new OMB labor market area delineations. These transition periods were designed to address payment impacts for hospitals in urban areas that became rural, hospitals that qualified as urban under section 1886(d)(8)(B) of the Act (“Lugar hospitals”) that became rural, and hospitals that experienced a decrease in wage index under the new OMB delineations; the transition periods are for FYs 2015, 2016 and 2017. CMS does not propose any changes to the transition policies and reminds readers that FY 2017 will be the third and final year of the transition periods.

1. Transition for Hospitals in Urban Areas That Became Rural

In the FY 2015 IPPS/LTCH PPS final rule, CMS adopted a policy for hospitals located in an urban county that became rural under the new OMB delineations (and had no form of wage index reclassification or redesignation in place for FY 2015) to assign them the urban wage

index value of the Core-Based Statistical Area (CBSA) in which they are physically located for FY 2014 for a period of 3 fiscal years (with the rural and imputed floors applied and with the rural floor budget neutrality adjustment applied to the area wage index).

CMS notes situations in which a hospital could not be assigned the wage index value of the CBSA in which it was geographically located in FY 2014. In these cases, CMS proposes to continue its approach to assign the wage index of the labor market area to which the hospital is closest. CMS states that any such assignment made in FY 2015 will continue for FY 2017. CMS proposes to continue its policy that if a hospital seeks and is granted reclassification or redesignation for FY 2017, the hospital will permanently lose its 3-year transitional assigned wage index status, and will not be eligible to reinstate it.

CMS notes that these hospitals maintain their status as rural hospitals for other payment considerations and are included in the statewide rural area in which they are geographically located. CMS states that after the 3-year transition period, these formerly urban hospitals will receive their statewide rural wage index beginning in FY 2018, absent any reclassification or redesignation.

2. Transition for Hospitals Deemed Urban under Section 1886(d)(8)(B) of the Act Where the Urban Area Became Rural

In the FY 2015 IPPS/LTCH PPS final rule, CMS finalized a policy to apply a 3-year transition to hospitals redesignated to urban areas under section 1886(d)(8)(B) of the Act for FY 2014 that are no longer deemed urban under the new OMB delineations and revert to being rural. Hospitals designated as urban under section 1886(d)(8)(B) of the Act are generally referred to as "Lugar" hospitals. For FY 2017, CMS is not proposing any changes to this policy and will continue with the third year of its implementation of this transition policy. If the hospital cannot be assigned the wage index value of the CBSA in which it was geographically located in FY 2014, CMS proposes to continue its approach to assign the wage index of the labor market area to which it is closest. CMS notes that the wage index assignment based on this transition policy will be forfeited if the hospital obtains any form of wage index reclassification or redesignation.

CMS also proposes to apply the 3-year transition adjustments in a budget neutral manner and would make an adjustment to the standardized amount to ensure budget neutrality of the transitional wage indexes.

E. Proposed Rural, Imputed, and Frontier Floors

CMS notes that the rural floor will increase the FY 2017 proposed wage index for 371 hospitals.

CMS projects that, in aggregate, rural hospitals will experience a 0.2 percent decrease in payments as a result of the rural floor budget neutrality requirement; hospitals located in other urban areas (populations of 1 million or fewer) would experience no change in payments; and urban hospitals in the New England region can expect a 0.8 percent increase in payments, primarily due to the application of the proposed rural floor in Massachusetts.

CMS again proposes to extend for one additional year (through September 30, 2017) its temporary imputed floor program whereby CMS imputes a "floor" for States with no rural

counties. Under the OMB's new labor market area delineations, Delaware, New Jersey and Rhode Island are all-urban States. CMS proposes to continue both the original imputed floor methodology (which benefits New Jersey and in theory Delaware) and the alternative, temporary methodology for the benefit of Rhode Island, which has only one CBSA in contrast to New Jersey's 7 and Delaware's 3. Under this alternative, the lowest post-reclassified wage index assigned to a hospital in a State with one CBSA (viz. Rhode Island) is increased by a factor equal to the average percentage difference between the post-reclassified, pre-floor area wage index and the post-reclassified, rural floor wage index (absent rural floor budget neutrality).

CMS does not propose any changes to the frontier floor wage index policies for FY 2017. Thus, fifty hospitals in Montana, Nevada, North Dakota, South Dakota, and Wyoming would receive the frontier floor value of 1.0000 for FY 2017.

F. Proposed Revisions to the Wage Index Based on Hospital Redesignations and Reclassifications

CMS notes that 299 hospitals were approved for wage index reclassifications starting in FY 2017 by the Medicare Geographic Classification Review Board (MGCRB), and because such reclassifications are effective for 3 years, a total of 867 hospitals are in a reclassification status for FY 2017 (including those initially approved by the MGCRB for FYs 2015 and 2016).

Applications for FY 2018 reclassifications are due to the MGCRB *by September 1, 2016* which is also the deadline for canceling a previous wage index reclassification withdrawal or termination. Changes to the wage index by reason of reclassification withdrawals, terminations, wage index corrections, appeals and the CMS review process would be incorporated in the final FY 2017 wage index values.

Provisions Relating to Lugar Hospitals

CMS treats a hospital located in a rural county adjacent to one or more urban areas as being located in the urban MSA to which the greatest number of workers in the county commute if certain adjacency and commuting criteria are met. CMS issued an interim, final rule with comment period (CMS-1664-IFC) to implement decisions in two recent cases[1]. Effective with reclassifications beginning with FY 2018, the interim, final rule with comment period allows hospitals nationwide to reclassify based on their acquired rural status under §412.103; a hospital with an existing MGCRB reclassification may seek rural reclassification for IPPS payment and other purposes and still retain its existing MGCRB reclassification—in other words, the hospital may have more than one reclassification simultaneously.

In this proposed rule, CMS clarifies that a hospital with Lugar status under section 1886(d)(8)(B)(i) of the Act may simultaneously receive an urban to rural reclassification under section 1886(d)(8)(E) of the Act and §412.103. CMS also clarifies that it will treat the wage data of hospitals with simultaneous Lugar status and §412.103 reclassification as Lugar hospitals for wage index calculation and wage index payment purposes. CMS also notes that, for payment

[1] Geisinger Community Medical Center v. Secretary, United States Department of Health and Human Services, 794 F.3d 383 (3d Cir. 2015) and Lawrence + Memorial Hospital v. Burwell, No. 15-164, 2016 WL 423702 (2d Cir. Feb. 4, 2015).

purposes other than the wage index, a hospital with simultaneous Lugar status and §412.103 reclassification receives payment as a rural hospital.

G. Out-Migration Adjustment Based on Commuting Patterns of Hospital Employees

Table 2 lists the proposed out-migration wage index adjustments for FY 2017. The "out-migration" adjustment is an adjustment to the hospital wage index based on commuting patterns of hospital employees.[2] CMS proposes to use the same policies, procedures and computation that were used for the FY 2012 out-migration adjustment, and estimates increased payments of approximately $31 million in FY 2017 for 249 hospitals receiving the out-migration adjustment. This provision is not budget neutral.

H. Notification Regarding Proposed CMS "Lock-In" Date for Urban to Rural Reclassifications under §412.103.

A qualifying hospital located in an urban area may apply to be reclassified as rural. The hospital must meet criteria under §412.103 as well as application requirements. Currently, a hospital may apply at any time for an urban to rural reclassification under §412.103, and the effective date, if approved, is the filing date of the application.

CMS proposes to establish what it calls a "lock-in" date for the list of hospitals with rural status under §412.103; the date would be the second Monday in June each year. This means that a hospital seeking to reclassify as rural under §412.103 for the next fiscal year must file its application no later than 70 days before the second Monday in June. The effective date of the reclassification would still be the filing date of the application.

I. Process for Requests for Wage Index Data Correction

CMS notes that it will release the final wage index data public use files in late April, 2016 at the following CMS Web site: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files-Items/FY2017-Wage-Index-Home-Page.html. CMS notes that these files are made available solely for the limited purpose of identifying any potential errors made by CMS or the MAC in the entry of the final wage index data. If a hospital believes a potential error exists because of these reasons, the hospital is required to send its request and supporting documentation to CMS and to the MAC no later than May 23, 2016. Verified corrections will be incorporated into the final wage index in the FY 2017 IPPS/LTCH PPS final rule.

If errors are identified by hospitals after the May 23, 2016 deadline, CMS retains the right (but not the obligation) to make midyear changes to the wage index under limited circumstances as follows: 1) the MAC or CMS erred in tabulating its data; and 2) the hospital could not have known about the error, or could not have had an opportunity to correct the error, by the May 23, 2016

[2] Hospitals located in counties that qualify for the payment adjustment are to receive an increase in the wage index that is equal to a weighted average of the difference between the wage index of the resident county, post-reclassification and the higher wage index work area(s), weighted by the overall percentage of workers who are employed in an area with a higher wage index.

deadline. If such a correction would change the wage index value for an area, the revised wage index would be effective prospectively from the correction date.

J. Labor-Related Share for the FY 2017 Wage Index

CMS proposes to apply the wage index to the labor-related share of 62 percent of the national standardized amount for hospitals with wage indices less than 1.0 for FY 2017 and 69.6 percent of the national standardized amount for hospitals with wage indices greater than 1.0. Tables 1A and 1B in section VI of the Addendum to the proposed rule reflect the proposed national labor-related share.

For Puerto Rico hospitals, CMS no longer proposes to compute separate labor-related share and nonlabor-related share percentages for the Puerto Rico-specific standardized amounts because section 601 of the Consolidated Appropriations Act, 2016 provided for 100 percent payment based on the national standardized amount for Puerto Rico hospitals.

K. Solicitation of Comments on Treatment of Overhead and Home Office Costs in the Wage Index Calculation

In step 4 of the calculation of the unadjusted wage index, CMS allocates overhead costs to hospital areas excluded from the wage index calculation. Because of changes to CMS Form 2552-10, Worksheet S-3, Part IV, which require hospitals to itemize wage-related costs, CMS believes "it is possible to conclude" that hospitals' own allocation methods are properly allocating wage-related costs both for direct cost centers and overhead areas for excluded areas. If this is true, it is not entirely clear why CMS should continue to estimate and remove the overhead wage-related costs for excluded areas from the unadjusted wage index calculation.

CMS solicits comments to better understand (1) the manner in which hospitals report wage-related costs on Worksheet S-3, Part IV, (2) the allocation methods hospitals use to allocate wage-related costs, and (3) the treatment of direct versus overhead employee wage-related costs. CMS also seeks suggestions for possible modifications to Worksheet S-3, Parts II and IV respectively, which would obviate the need for CMS to estimate and remove overhead wage-related costs associated with excluded areas of the hospital from the unadjusted wage index.

IV. Other Decisions and Changes to the IPPS for Operating Costs and Graduate Medical Education (GME) Costs

A. Changes to Operating Payments for Subsection (d) Puerto Rico Hospitals

Effective January 1, 2016 Puerto Rico hospitals are paid based fully on the national standardized amount, as required by section 601 of the Consolidated Appropriations Act, 2016 (Pub.L.114-113). Prior to that date, these hospitals were paid based on a blended rate that was 75 percent of the national standardized amount and 25 percent of a Puerto Rico-specific standardized amount. CMS implemented this requirement using Change Request 9523. In this rule it proposes to make conforming changes to 42 CFR 412.204 to reflect the new policy.

B. Changes in the Inpatient Hospital Update for FY 2017 (§§412.64(d))

The inpatient hospital update for FY 2017 is calculated by determining the rate of increase in the hospital market basket for IPPS hospitals in all areas, subject to the following possible reductions (in the order presented):

1. For hospitals that fail to submit quality information, the FY 2017 inpatient hospital update will be reduced by one quarter of the applicable percentage increase.[3]
2. For a hospital that is not a meaningful electronic health record (EHR) user (and to which no exemption applies), the FY 2017 inpatient hospital update will be reduced by three-quarters of the market basket update.[4]
3. For all hospitals, the FY 2017 inpatient hospital update is subject to a 0.5 percentage point reduction for changes in economy-wide productivity (i.e., the multifactor productivity (MFP) adjustment)[5] which may result in an applicable percentage increase of less than zero.
4. For all hospitals, the statute calls for a 0.75 percentage point reduction for FY 2017[6] which may result in an applicable percentage increase of less than zero.

One of four different applicable percentage increases may apply to a hospital, depending on whether it submits quality data and/or is a meaningful EHR user, as shown in the following table.

FY 2016	**Hospital Submitted Quality Data and is a Meaningful EHR User**	**Hospital Submitted Quality Data and is NOT a Meaningful EHR User**	**Hospital Did NOT Submit Quality Data and is a Meaningful EHR User**	**Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User**
Market Basket Rate-of-Increase	2.8	2.8	2.8	2.8
Adjustment for Failure to Submit Quality Data	0.0	0.0	-0.7	-0.7
Adjustment for Failure to be a Meaningful EHR User	0.0	-2.1	0.0	-2.1
MFP Adjustment	-0.5	-0.5	-0.5	-0.5
Statutory Adjustment (Section 1886(b)(3)(B)(xii)	-0.75	-0.75	-0.75	-0.75
Proposed Applicable Percentage Increase Applied to Standardized	**1.55**	**-0.55**	**0.85**	**-1.25**

[3] See section 1886(b)(3)(B)(viii) of the Act. This adjustment is calculated before the application of any payment adjustment under sections 1886(b)(3)(B)(ix) [failure to be a meaningful EHR user], 1886(b)(3)(B)(xi) [MFP adjustment], and 1886(b)(3)(B)(xii) [the statutory adjustment] of the Act.

[4] See section 1886(b)(3)(B)(ix) of the Act. This adjustment is calculated before the application of any payment adjustment under sections 1886(b)(3)(B)(viii) [failure to submit quality information], 1886(b)(3)(B)(xi) [MFP adjustment], and 1886(b)(3)(B)(xii) [the statutory adjustment] of the Act.

[5] See section 1886(b)(3)(B)(xi) of the Act.

[6] See section 1886(b)(3)(B)(xii)(IV) of the Act.

For SCHs and MDHs, CMS proposes the same four possible applicable percentage increases shown in the table above. (The MDH program was extended under MACRA through FY 2017.) CMS notes that because there is no longer a Puerto Rico-specific standardized amount there is no longer a need for a separate update. However, Puerto Rico hospitals are not subject to the quality data requirements, and the penalty for hospitals that are not meaningful EHR users will not apply in Puerto Rico until FY 2022.

C. Rural Referral Centers: Annual Updates to Case-Mix Index and Discharge Criteria (§412.96)

CMS proposes revised criteria for purposes of determining rural referral center (RRC) status, including updated minimum national and regional case mix index (CMI) values and updated minimum national and regional numbers of discharges. These factors are among those used to determine whether a hospital qualifies for RRC status.

To qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2016, CMS proposes that a rural hospital with fewer than 275 beds available for use must, among other things:

- Have a CMI value for FY 2015 that is at least—
    - 1.6125, or
    - The median CMI value (not transfer adjusted) for urban hospitals (excluding hospitals with approved teaching programs) calculated by CMS for the census region in which the hospital is located.
- Have as the number of discharges for its cost reporting period that began during FY 2014 at least—
    - 5,000 (3,000 for an osteopathic hospital) or
    - The median number of discharges for urban hospitals in the census region in which the hospital is located.

D. Proposed Payment Adjustment for Low-Volume Hospitals (§412.101)

For discharges occurring during FY 2017, a hospital will qualify as a low volume hospital if (1) it is more than 15 miles from the nearest subsection (d) hospital, and (2) it has no more than 1,600 Medicare Part A discharges. The payment adjustment for qualifying low-volume hospitals is determined using a continuous linear sliding scale equation that results in a low-volume hospital payment adjustment ranging from an additional 25 percent for hospitals with 200 or fewer Medicare discharges to a zero percent additional payment adjustment for hospitals with 1,600 or more Medicare discharges.

CMS proposes to update the discharge data source used to identify qualifying hospitals and to calculate the percentage increase in the payment adjustment from the most recently available MedPAR data from the December 2015 update of the FY 2015 MedPAR file. Table 14 in the Addendum to the proposed rule lists the subsection (d) hospitals with fewer than 1,600 Medicare Part A discharges based on that data; the table does not indicate whether a hospital meets the mileage criterion. CMS proposes to use more recent data if available for the final rule.

A hospital seeking this adjustment must provide written notice and sufficient documentation to its MAC that it meets the discharge and distance requirements by not later than September 1, 2016, for the adjustment to apply to discharges made during FY 2017. A hospital that qualified as a low-volume hospital for FY 2016 may continue to receive the adjustment in FY 2017 without reapplying if it continues to meet the criteria; the hospital must send written verification to its MAC by September 1, 2016 that it continues to meet the mileage criterion.

For requests submitted after September 1, 2016 that are approved, the adjustment will apply prospectively to discharges within 30 days after the MAC approval date.

E. Indirect Medicare Education (IME) Payment Adjustment Factor for FY 2016 (§412.105)

Pursuant to statute,[7] for discharges occurring in FY 2017 the proposed rule would continue to apply the IME adjustment factor of 5.5 percent for every approximately 10-percent increase in a hospital's resident-to-bed ratio.

F. Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs)

1. Payment Adjustment Methodology for Medicare Disproportionate Share Hospitals (DSHs) under Section 3133 of the Affordable Care Act (§412.106)

Section 3133 of the ACA added a new section 1886(r) to the Act changing the methodology for computing the Medicare DSH payment adjustment. Beginning with FY 2014 discharges, hospitals that qualify for Medicare DSH payments receive two separately calculated payments. The first payment equals 25 percent of the amount they would have received under the statutory formula for Medicare DSH payments prior to the ACA amendments. CMS refers to this payment as the "empirically justified Medicare DSH payment." The remaining amount, equal to the Secretary's estimate of 75 percent of what otherwise would have been paid as Medicare DSH payments, reduced to reflect changes in the percentage of individuals under age 65 who are uninsured, is used make additional payments to each hospital that qualifies for "empirically justified Medicare DSH payments" and also provides uncompensated care. CMS refers to these additional payments as the "uncompensated care payments."

For FY 2017, CMS proposes to continue these policies unchanged from the FY 2016 final rule:

- The ACA DSH provisions would apply to:
    - hospitals in Puerto Rico; and
    - sole community hospitals if they are paid based on the federal rate and not the hospital-specific rate.
- The ACA DSH provisions would not apply to:
    - sole community hospitals paid based on the hospital-specific rate (because add-on payments, such as outliers, DSH, and IME, do not apply to these hospitals);
    - the 14 hospitals participating in the Rural Community Hospital Demonstration (because these hospitals also do not receive DSH payments); or

[7] See section 1886(d)(5)(B) of the Act which provides for an IME formula multiplier of 1.35 for discharges occurring on or after October 1, 2007.

  - hospitals in Maryland, which are not paid under Section 1886(d) of the Act because the state entered into an agreement with CMS that Maryland hospitals will be paid under the Maryland All-Payer Model.
- MDHs paid under the IPPS federal rate are eligible to receive Medicare DSH payments if their disproportionate patient percentage is at least 15 percent. CMS applies the same process to determine eligibility for Medicare DSH and the uncompensated care payment as it does for all other IPPS hospitals. The MDH program was extended by MACRA through September 30, 2017. MDHs are paid based on the IPPS Federal rate or, if higher, the IPPS Federal rate plus 75 percent of the amount by which the Federal rate is exceeded by the updated hospital-specific rate.

CMS makes interim DSH payments equal to 25 percent of what the DSH payment would have been absent the ACA changes. Final eligibility for Medicare DSH payments and the final amount of the payments for eligible hospitals is determined at cost report settlement, as occurred prior to the ACA changes.

2. Uncompensated Care Payments

Regarding the uncompensated care portion of the DSH payment, for FY 2017 CMS proposes to generally continue the same policies unchanged from the FY 2016 final rule, with one exception. CMS proposes to use an average of data derived from three cost reporting periods instead of one cost reporting period (discussed in more detail under Factor 3). The following policies would remain unchanged from the FY 2016 final rule under this proposal:

- As required by statute, only hospitals that receive empirically justified Medicare DSH payments in FY 2017 will be eligible to receive an additional Medicare uncompensated care payment for that year.
- Uncompensated care payments would be made on a per discharge basis through the IPPS PRICER program, as discussed below.[8]
- The statutory 12-percent cap on the Medicare DSH payment adjustment percentage for certain rural hospitals applies to the amount of the empirically justified DSH payment and to the determination of Factor 1 in the uncompensated care formula (discussed below), but would not limit the amount of DSH uncompensated care payments that a hospital can receive.

The statute provides that the uncompensated care portion of the DSH payment amount for each DSH hospital is the product of three factors:

- Factor 1 equals 75 percent of the aggregate DSH payments that would be made under section 1886(d)(5)(F) without application of the DSH changes made by the ACA;

[8] For SCHs, the fiscal intermediary/MAC determines whether the federal or hospital-specific rate is projected to yield the highest aggregate payment prior to the beginning of the federal fiscal year and automatically makes interim payments at the higher rate using the best data available. DSH uncompensated care payments are considered in determining whether the federal or the hospital-specific rate is higher. If the federal rate is higher, SCHs that receive interim empirically justified DSH payments also would receive interim uncompensated care payments. The fiscal intermediary/MAC will make a final adjustment of all payments, including eligibility for DSH payments and the amount of uncompensated care payments, at cost report settlement.

- Factor 2 reduces the amount based on the ratio of the percent of the population who are insured in the most recent period following implementation of the ACA to the percent of the population who were insured in a base year prior to ACA implementation; and
- Factor 3 is determined by a hospital's uncompensated care amount for a given time period relative to the uncompensated care amount for that same time period for all hospitals that receive Medicare DSH payments in that fiscal year, expressed as a percentage.

Proposed FY 2017 Factor 1

Factor 1 is the difference between CMS' estimates of: (1) the amount that would have been paid in Medicare DSH payments for FY 2017 in the absence of the ACA payment provision and (2) the amount of empirically justified Medicare DSH payments that are estimated to be made for FY 2017 taking into account the requirement to reduce Medicare DSH payments by 75 percent.

The March 2016 OACT estimate for Medicare DSH payments for FY 2017, before application of the ACA reduction, is $14.227 billion. Based on this, the estimate for empirically justified Medicare DSH payments for FY 2016 after the ACA reduction is proposed to be $3.556 billion (25 percent of the total amount estimated). Thus, **CMS proposes that FY 2016 Factor 1, which is the difference between these two estimates, would be $10.671 billion ($14.227 billion minus $3.556 billion).**

Proposed FY 2016 Factor 2

Factor 2 is based on the percent change, essentially since implementation of the ACA, in the percent of individuals under the age of 65 who are uninsured.

For FY 2017, CMS proposes to continue the following policies unchanged from the FY 2016 final rule:

- CMS uses CBO's estimate that includes all residents, including unauthorized immigrants, to establish the 2013 baseline regarding the percent who are uninsured.
- For FYs 2014-2017, CMS' estimate of the uninsurance percentage for baseline year 2013 is 18 percent (calculated from the CBO March 20, 2010 letter reporting an estimate of the "Insured Share of the Nonelderly Population Including All Residents" as 82 percent).[9]
- CMS uses the same data source, CBO estimates, to determine the percent of individuals without insurance for the post-implementation years beginning with 2014.
- CMS uses the most recently available CBO estimates of insurance rates at the time of determination for each payment year, and does not adjust Factor 2 retroactively to account for more recent estimates that become available after publication of the final rule.
- CMS normalizes the CBO estimates, which are for calendar years, to correspond with the appropriate fiscal years. CMS normalizes the estimate of uninsurance for FY 2017 by

[9] The CBO estimate excludes Puerto Rico, which is encompassed by the ACA provision on DSH. CMS concludes that the impact of excluding Puerto Rico from the insurance estimate is negligible.

calculating a weighted average of the CBO estimates for CY 2016 and CY 2017, respectively.[10]

For the FY 2017 proposed rule, CMS used CBO's March 2015 estimates of the effects of the ACA on health insurance coverage (available at https://www.cbo.gov/sites/default/files/51298-2015-03-ACA.pdf). CBO's March 2015 estimate of individuals under the age of 65 with insurance in CY 2016 is 89 percent. Therefore, CBO's most recent estimate of the rate of uninsurance in CY 2016 is 11 percent (i.e., 100 percent minus 89 percent). Similarly, CBO's March 2015 estimate of individuals under the age of 65 with insurance in CY 2017 is 90 percent, and thus the estimated rate of uninsurance in CY 2017 is 10 percent.

Using these CBO estimates, CMS calculates the proposed Factor 2 for FY 2017 as follows:

- CY 2016 rate of insurance coverage (March 2015 CBO estimate): 89 percent
- CY 2017 rate of insurance coverage (March 2015 CBO estimate): 90 percent
- FY 2016 rate of insurance coverage: (89 percent * .25) + (90 percent * .75) = 89.75 percent
- Percent of individuals without insurance for 2013 (March 2010 CBO estimate): 18 percent
- Percent of individuals without insurance for FY 2017 (weighted average): 10.25 percent
- 1-|((0.1025-0.18)/0.18)|= 1- 0.4306=0.5694 (56.94 percent)
- 0.5694 (56.94 percent) - .002 (0.2 percentage points for FY 2017 under section 1886(r)(2)(B)(i) of the Act) = 0.5674 or 56.74 percent
- 0.5674 = Factor 2

Thus, **CMS calculated Factor 2 for the FY 2016 proposed rule to be 0.5674, or 56.74 percent, and the proposed uncompensated care amount for FY 2017 to be $10.671 billion "times" 0.5674 = $6.054 billion**, which is about $352 million less than the FY 2016 uncompensated care payment total of about $6.406 billion; the percentage reduction is 5.5 percent.[11]

Proposed FY 2016 Factor 3

Factor 3 equals the proportion of hospitals' aggregate uncompensated care attributable to each IPPS hospital (including Puerto Rico PPS hospitals). The product of Factors 1 and 2 determines the total pool available for uncompensated care payments. This result multiplied by Factor 3 determines the amount of the uncompensated care payment that each eligible hospital will receive.

As in FY 2014-2016, CMS proposes for FY 2017 to determine Factor 3 based on the utilization of insured low-income patients defined as inpatient days of Medicaid patients plus inpatient days of Medicare SSI patients. CMS believes it remains premature in FY 2017 to propose the use of S-10 data for purposes of determining Factor 3 because of concerns regarding variations in the data reported on the Worksheet S-10 and the completeness of these data.

[10] The estimate for baseline year 2013 is the same whether it is normalized to FY 2013 or not because the CBO estimates indicate a rate of uninsurance of 18 percent for both CY 2012 and CY 2013, the calendar years involved in normalizing the estimate for FY 2013.

[11] For FY 2016, CMS determined Factor 2 to be 0.6369 and the amount available for uncompensated care payments for FY 2016 is approximately $6.406 billion.

For FY 2017, CMS also proposes to make a change to the data that will be used to calculate Factor 3 for Puerto Rico hospitals. Because residents of Puerto Rico are not eligible for SSI benefits, CMS proposes to create a proxy for SSI days for Puerto Rico hospitals for use in the Factor 3 calculation. CMS proposes, for purpose of calculating Factor 3, to use a proxy for Medicare SSI days for each Puerto Rico hospital equal to 14 percent (or 0.14) of its Medicaid days. This value would replace whatever value would have otherwise been computed for this hospital.

In FY 2016, CMS changed the time period used to determine low-income patient days by holding constant the cost report years used to calculate Medicaid days. In 2016, CMS calculated Factor 3 using SSI days from the FY 2013 SSI ratios, Medicaid days from 2012 cost report data submitted to CMS by Indian Health Service hospitals and the more recent of hospital-specific full year 2012 cost reports (unless that cost report was unavailable or reflected less than a full 12-month year, in which case CMS used the cost report from 2012 or 2011 that was closest to being a full 12-month cost report). CMS used the March 2015 update of the hospital cost report data in the HCRIS database. In the prior year (FY 2015) CMS used the most recently available full year of Medicare cost report data for determining Medicaid days and the most recently available SSI ratios for the Medicare SSI days.

Since publication of that rule, CMS has learned that some members of the hospital community have been disadvantaged by using only one cost reporting period to determine a hospital's share of uncompensated care. Hospitals have reported unpredictable swings in their low-income insured days between cost reporting periods. To mitigate this issue, CMS believes it would be appropriate to expand the time period for the data used to calculate Factor 3 from one cost reporting period to three cost reporting periods.

To address these issues, for FY 2017 CMS proposes to use an average of data derived from three cost reporting periods instead of one cost reporting period to compute Factor 3. Consistent with its policies adopted in the FY 2016 rule, CMS would advance the most recent cost report years used to obtain Medicaid days and Medicare SSI days in FY 2017 by one year and continue to extract Medicaid days data from the most recent update of HCRIS, which for FY 2017 would be the March 2015 update. If the hospital does not have data for one or more of the three cost reporting period, CMS would divide the sum of the individual Factor 3s by the number of cost reporting periods for which there are data.

Hospital mergers

For FY 2017, CMS proposes to continue its policies that were finalized in the FY 2015 IPPS/LTCH PPS final rule to address specific issues regarding the process and data to be employed in determining Factor 3 in the case of hospital mergers. Specifically CMS:

- identifies the hospitals that merged after the period from which data are being used to calculate Factor 3 but before the publication of the final rule;
- defines a merger to be an acquisition where the Medicare provider agreement of one hospital is subsumed into the provider agreement of the surviving provider;
- does not consider an acquisition to be a merger in situations where the new owner voluntarily terminates the Medicare provider agreement of the hospital it purchased by rejecting assignment of the previous owner's provider agreement;

- identifies mergers by querying the Medicare contractors since a copy of each final sales agreement/transaction indicating the effective date of the acquisition is generally submitted to the Medicare contractors once an acquisition is finalized; and
- treats hospitals that merge after the development of the final rule as new hospitals are treated. That is, the newly merged hospital's interim uncompensated care payments would be based only on the data of the surviving hospital's CCN available when the final rule for the applicable fiscal year is prepared. At cost report settlement, however, CMS would determine the newly merged hospital's final uncompensated care payments based on the Medicaid days and SSI days reported on the cost report used for the applicable fiscal year. Thus, it revises the numerator of Factor 3 for the newly merged hospital to reflect the Medicaid and SSI days reported on the cost report for the applicable fiscal year.

CMS publishes a table on the CMS Web site, in conjunction with the issuance of each fiscal year's proposed and final IPPS rules, containing a list of the mergers known to CMS and the computed uncompensated care payment for each merged hospital. Hospitals have 60 days from the date of public display of each year's proposed rule to review the tables and notify CMS in writing of any inaccuracies; for the FY 2017 proposed rule, the deadline is June 17, 2016. After the publication of the IPPS/LTCH PPS final rule, hospitals will have until August 31 of that year (for FY 2016, the deadline is August 31, 2016) to review and submit comments on the accuracy of these tables for the applicable fiscal year.

4. Calculation of Factor 3 for FY 2018 and Subsequent Years

Proposed Data Source and Time Period for FY 2018 and Subsequent Years, Including Methodology for Incorporating Worksheet S-10 Data

CMS proposes to begin incorporating the use of Worksheet S-10 data to calculate uncompensated care payments in FY 2018. Under its proposed policy to use an average of data derived from three cost reporting periods, CMS would continue to use low-income insured patient days as a proxy for uncompensated care for FYs 2018 and FYs 2019 in combination with the Worksheet S-10 data and move exclusively to Worksheet S-10 data by FY 2020. CMS will use 1-year of Worksheet S-10 data in FY 2018, 2 years in FY 2019, and by 2020 and subsequent years will use 3 years of Worksheet S-10 data to calculate Factor 3.

This approach is consistent with CMS' proposal to determine Factor 3 using data over a period of three cost reporting periods. CMS would use the following data sources for FYs 2018, 2019, and 2020:

- For FY 2018, CMS would calculate Factor 3 based on an average of Factor 3 calculated using low-income insured days (proxy data) determined using Medicaid days from FY 2012 and FY 2013 cost reports and FY 2014 and FY 2015 SSI ratios, and Factor 3 calculated using uncompensated care data based on FY 2014 Worksheet S-10.
- For FY 2019, CMS would calculate Factor 3 based on an average of Factor 3 calculated using low-income insured days (proxy data) determined using Medicaid days from the FY 2013 cost report and the FY 2015 SSI ratios, and Factor 3 calculated using uncompensated care data based Worksheet S-10 from the FYs 2014 and 2015 cost reports.

- For FY 2020, CMS would calculate Factor 3 using uncompensated care data based on Worksheet S-10 data from FYs 2014, 2015 and 2016 cost reports.
- After 2020, CMS would advance the 3-year time period by 1 year to determine the cost reports used.

For FY 2018, the computation of the average for each hospital would work in the following way:

- Step 1: Calculate Factor 3 using the low-income insured days proxy based on FY 2012 cost report data and the FY 2014 SSI ratio;
- Step 2: Calculate Factor 3 using the insured low-income days proxy based on FY 2013 cost report data and the FY 2015 SSI ratio;
- Step 3: Calculate Factor 3 based on the FY 2014 Worksheet S-10 data; and
- Step 4: Average the Factor 3 values that are computed in Steps 1, 2, and 3; that is, adding the Factor 3 values from FY 2012, FY 2013, and FY 2014 for each hospital, and dividing that amount by the number of cost reporting periods with data to compute an average Factor 3.

Proposed Definition of Uncompensated Care for FY 2018 and Subsequent Fiscal Years

CMS proposes for purposes of calculating Factor 3 and uncompensated care costs beginning in FY 2018, "uncompensated care" would be defined as the amount on line 30 of Worksheet S-10, which is the cost of charity care and the cost of non-Medicare bad debt. CMS notes that a common theme of almost all the definitions that it explored is that they include both "charity care" and "bad debt". Worksheet S-10 employs the following definition of charity care plus non-Medicare bad debt.

CMS also proposes to exclude Medicaid shortfalls reported on Worksheet S-10 from the definition of uncompensated care for purposes of calculating Factor 3.

Other Methodological Considerations for FY 2018 and Subsequent Fiscal Years

CMS intends to revise the current Worksheet S-10 cost report instructions for Line 20 concerning the timing of reporting charity care, such that charity care will be reported based on date of write-off, and not based on date of service. This is consistent with charity write-offs that hospitals report in accordance with GAAP and this change had been requested by some commenters for reporting consistency.

Trims to Apply to CCRs on Line 1 of Worksheet S-10

CMS also discusses the concern by some commenters that uncompensated care costs reported on Worksheet S-10 should be audited due to extremely high values consistently reported by some hospitals. CMS believes that it would be appropriate to apply statistical trims to the CCRs that are considered anomalies on Worksheet S-10, just as CMS applies trims to hospitals' CCRs used to calculate high-cost outlier payments. In this case, the Medicare contractor may use a statewide CCR for hospitals whose operating or capital CCR is in excess of 3 standard deviations above the corresponding national geometric mean (or the CCR ceiling). CMS is considering proposals which would trim hospitals' CCRs to ensure reasonable CCRs are used to convert charges to costs for purposes of determining uncompensated care costs.

G. Hospital Readmissions Reduction Program (HRRP)

The Hospital Readmissions Reduction Program reduces payments to Medicare PPS hospitals having readmissions exceeding an expected level. The list of conditions to which the HRRP applies in FY 2016 is: acute myocardial infarction (AMI), heart failure (HF), pneumonia (PN), total hip arthroplasty (THA)/total knee arthroplasty (TKA) and chronic obstructive pulmonary disease (COPD). In the FY 2015 IPPS/LTCH PPS final rule the list of conditions for FY 2017 was finalized to include these and coronary artery bypass surgery (CABG).

1. Addition of CABG Readmissions Measure

For FY 2017, CMS proposes a methodology for the previously-finalized addition of the measure of 30-day, all cause, and unplanned readmissions following CABG. Under the proposal, CABG admissions would be identified using the exclusions previously finalized in the FY 2015 IPPS/LTCH PPS final rule. Excluded admissions would be those for patients who are discharged against medical advice; patients who die during the initial hospitalization; patients with a repeat CABG procedure during the measurement period (only the first CABG admission is selected); and admissions for patients without at least 30-days post-discharge enrollment in Medicare FFS. Exclusions applied to the other conditions for FY 2016 would continue unchanged, and the established policy for excluding all admissions for patients enrolled in Medicare Advantage would continue.

2. Other HRRP Policies

The proposed rule designates the applicable period for FY 2017 to be the 3-year period from July 1, 2012 through June 30, 2015. That is, the excess readmissions ratios and the payment adjustment (including aggregate payments for excess readmissions and aggregate payments for all discharges) proposed for FY 2017 are based on data from the 3-year time period of July 1, 2012 through June 30, 2015.

H. Hospital Value-Based Purchasing (VBP) Program

1. VBP Payment in FY 2017

Based on the December 2015 update of the FY 2015 MedPAR file, CMS estimates that the total amount available for VBP Program payments in FY 2017 is approximately $1.7 billion. This reflects the requirement that for FY 2017 VBP Program payments equal 2.0 percent of base operating DRG payments.

CMS has posted on the FY 2017 IPPS proposed rule web page a Table 16 which includes proxy hospital-specific value-based incentive payment adjustment factors for FY 2017 based on hospitals' TPSs from the FY 2016 Hospital VBP Program; these proxies therefore reflect the performance periods, measures, and domain weights in effect for that year. In the final rule CMS will publish a Table 16A which reflects changes based on the March 2016 update to the FY 2015 MedPAR file.

2. Changes to the PSI 90 Measure

CMS proposes to change the performance period for the PSI 90 composite patient safety measure that was previously adopted for FY 2018. The previously finalized period would measure performance for the 24-month period July 1, 2014 through June 30, 2016. The proposed period would be 15 months: July 1, 2014 through September 30, 2015. The base year period, which was used to calculate the previously announced performance standards, would not change – July 1, 2010 through June 30, 2012.

Two reasons are offered for this proposed change. First, because the implementation of ICD-10-CM began on October 1, 2015, the previously adopted performance period would result in combining both ICD-9 and ICD-10 claims data.

Finally, CMS indicates its intention to propose to use a modified version of the PSI 90 measure for the VBP Program in future rulemaking. Specifically, the measure was changed (discussed below in the HAC section) during the 2014 National Quality Forum (NQF) maintenance review.

3. Domain Name Change

CMS proposes to shorten the name of the Care Coordination and Patient-and Caregiver-Centered Experience of care domain to Person and Community Engagement, beginning with FY 2019.

4. Change to NHSN Measure Locations

The current VBP measures of Central Line Blood Stream Infection (CLABSI) and Catheter-Associated Urinary Tract Infection (CAUTI) use data from adult, pediatric and neonatal intensive care units (ICUs) to assess hospital performance. Effective January 1, 2015 under the IQR Program, these measures were expanded to include data from adult and pediatric medical, surgical and medical/surgical wards as well as ICUs.

CMS proposes to include the expanded CLABSI and CAUTI measures beginning with FY 2019 payment, with a proposed baseline period of calendar year 2015 and a performance period of calendar year 2017.

5. New and Modified Measures for FY 2021

Beginning with FY 2021 payment, CMS proposes two new measures and a modification of the existing pneumonia mortality measure.

New Measures. Two new risk-standardized payment measures are proposed for addition to the VBP program beginning with FY 2021 payment: Risk-Standardized Payment Associated with a 30-Day Episode of Care for AMI and Risk Standardized Payment Associated with a 30-Day Episode of Care for Heart Failure. Both measures are NQF-endorsed, and have previously been adopted for the IQR Program. Initial measure data were posted on the Hospital Compare website in December 2014 (AMI) and July 2015 (HF). The measures would be added to the VBP Program efficiency domain. Measure specifications are available at

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html.

Modified Pneumonia Mortality Measure. CMS proposes to adopt a modified version of the pneumonia mortality measure into the VBP Program beginning with FY 2021 payment. The 30-day, all-cause risk-standardized mortality rate following pneumonia hospitalization measure was modified for purposes of the hospital IQR Program in the FY 2016 IPPS/LTCH PPS final rule, with initial modified data to be posted on the Hospital Compare website in July 2016. The modification expanded the measure cohort to include 1) patients with a principal discharge diagnosis of aspiration pneumonia and 2) patients with a principal discharge diagnosis of sepsis (excluding severe sepsis) and a secondary diagnosis of pneumonia present on admission as well as the original cohort of patients with a principal diagnosis of pneumonia. CMS cites evidence regarding an increase in the use of sepsis as a principal diagnosis for patients admitted with pneumonia and other studies which it says support the expansions as making the measure more complete and accurate and more comparable across hospitals.

6. Scoring of Efficiency Measures

For purposes of the VBP Program, CMS proposes that the AMI and HF payment measures be scored in the same way as the existing MSPB measure, but it **invites comments on alternatives**.

Under the MSPB scoring approach, for achievement points, a ratio would be calculated for a hospital that is the hospital's spending (for AMI or HF) divided by the median spending (for AMI or HF) across all hospitals for the performance period. For these measures the achievement thresholds would be set at the median spending ratio across all hospitals for the performance period, and the benchmark would be the mean of the lowest decile of spending ratios during the performance period. A hospital would receive the maximum 10 points if it had a ratio at or below the benchmark; it would receive 0 points if it had a ratio above the achievement threshold. Ratios that fell above the benchmark but at or below the achievement threshold would receive 1 to 9 points using the following formula:

[9*((achievement threshold – hospital's performance period ratio)/(achievement threshold-benchmark))]+0.5

Improvement points would be awarded by comparing a hospital's performance during the performance period to its own performance during the baseline period.

7. New Measure for FY 2022

CMS proposes to add one measure beginning with FY 2022 payment: Hospital 30-Day, All Cause, Risk-Standardized Mortality Rate following CABG (NQF #2558). This measure was added to the IQR Program measure set in the FY 2015 IPPS/LTCH PPS final rule and initial data were posted on the Hospital Compare website in July 2015. This measure would be added to the Clinical Care domain. CMS cites the high volume and high cost of CABG procedures and variation in mortality rates as the rationale for inclusion of this measure in the VBP Program.

8. Performance and Baseline Periods

In past years CMS has annually proposed baseline and performance periods for VBP Program measures. This year, it proposes to adopt program time periods by length, which would apply for all future program years unless changed in future rulemaking. The proposed baseline and performance period lengths and the periods proposed for FY 2019 and for selected other measures and years are shown in the table below. As noted, for some outcome measures, the periods were previously finalized. The rule also includes tables showing the proposed periods for all measures for payment in FYs 2020, 2021 and 2022; these tables are not reproduced in this summary.

Proposed Baseline and Performance Periods for FY 2019 and Selected Years			
Domain/Measure	**Proposed Period Length**	**FY 2019 Baseline Period**	**FY 2019 Performance Period**
Person and Community Engagement (HCAHPS and 3-item care transition)	12 month period; baseline CY 4 years prior to program year; performance CY 2 years prior	1/1/15–12/31/15	1/1/17–12/31/17
Clinical Care	36 month period		
Mortality*		7/1/09–6/30/12	7/1/14–6/30/17
THA/TKA*		7/1/10–6/30/13	1/1/15–6/30/17
Safety	12 month period (except for PSI-90); baseline CY 4 years prior to program year; performance CY 2 years prior		
PSI-90**		7/1/11–6/30/13	7/1/15–6/30/17
PC-01 and NHSN (CAUTI, CLABSI, SSI, CDI, MRSA)		1/1/15–12/31/15	1/1/17–12/31/17
Efficiency and Cost Reduction (MSPB)	12 month period; baseline CY 4 years prior to program year; performance CY 2 years prior	1/1/15–12/31/15	1/1/17–12/31/17
* Previously finalized ** The proposed 12-month period for safety domain measures does not apply to PSI 90; CMS proposes to shorten the FY 2018 performance period for this measure to avoid mixing ICD-9 and ICD-10 data, and says that it will consider its options and address the FY 2019 performance period in next year's rulemaking.			

10. Performance Standards

Although not reproduced in this summary, the proposed rule includes tables showing the proposed numerical performance standards (achievement thresholds and benchmarks) for each measure in the FY 2019 measure set and previously adopted and newly finalized standards for certain safety and clinical care domain measures for FYs 2020, 2021 and 2022.

11. FY 2019 Scoring Methodology, including Domain Weighting

CMS proposes to continue for FY 2019 the previously adopted Hospital VBP Program scoring methodology and the domain weights established for FY 2018 (each domain weighted at 25 percent).

Proposed Domain Weights for FY 2019	
Domain	**Weight**
Safety	25%
Clinical Care	25%
Efficiency and Cost Reduction	25%
Person and Community Engagement (Patient and Caregiver Centered Experience of Care/Care Coordination)	25%

No changes are proposed for the case and measure minimums needed to receive a VBP Program score for FY 2019. These are shown in the following table. Hospitals must have scores on at least three domains in order to receive a Total Performance Score; proportional reweighting is used when scores are not available for all domains.

Case Minimums for FY 2019	
Type of Measure	**Cases**
NHSN measures	1 predicted infection
AHRQ PSI 90 composite measure	3 cases for any underlying Indicator**
PC-01 measure	10 cases
Mortality	25 cases
Medicare Spending per Beneficiary*	25 cases
HCAHPS	100 surveys
*The 25 case minimum would also apply to the AMI and HF payment measures proposed for FY 2021 and later years **CMS proposes in this rule that beginning with FY 2017 payment, hospitals must also have 12 months or more of PSI-90 data to receive a Domain 1 score	

Measure Minimums for Domain Score FY 2019	
Domain	**Minimum Measures**
Safety (includes NSHN, AHRQ PSI 90, PC-01)	3
Clinical Care (mortality)	2
Efficiency and Cost Reduction	MSPB score
Person and Community Engagement Patient and Caregiver Centered Experience of Care/Care Coordination	HCAHPS score

13. Impact Analysis

Appendix A of the proposed rule includes a table and discussion of the estimated impact of the VBP Program for FY 2016 by type of hospital. However, these calculations rely on the FY 2016 hospital performance scores (based on the measures, performance periods and performance standards in effect for that year) to estimate the effects of the 2017 VBP Program.

Summary Table VBP-1: Measures and Domains for selected payment years					
Measure	**2017**	**2018**	**2019/ 2020**	**2021**	**2022**
Clinical Care–Process (*removed beginning 2018)*					
AMI-7a Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	X	Removed			
IMM-2 Influenza Immunization	X	Removed			
Perinatal Care: elective delivery < 39 completed weeks gestation	X	Moved to Safety domain			
Clinical Care–Outcomes *(labeled as 'Clinical Care' beginning 2018)*					
Acute Myocardial Infarction (AMI) 30-day mortality rate	X	X	X	X	X
Heart Failure (HF) 30-day mortality rate	X	X	X	X	X
Pneumonia (PN) 30- day mortality rate	X	X	X	X	X
Complication rate for elective primary total hip arthroplasty/total knee arthroplasty			X	X	X
Chronic Obstructive Pulmonary Disease (COPD) 30-day mortality rate				X	X
CABG 30-day mortality rate					*Proposed*
Safety					
AHRQ PSI–90 patient safety composite	X	X	X	X	X
Central Line Associated Blood Stream Infection (CLABSI)	X	X	X	X	X
Catheter Associated Urinary Tract Infection (CAUTI)	X	X	X	X	X
Surgical Site Infection: Colon Abdominal hysterectomy	X	X	X	X	X
Methicillin-Resistant Staphylococcus Aureus (MRSA) Bacteremia	X	X	X	X	X
Clostridium Difficile infection (CDI)	X	X	X	X	X
Perinatal Care: elective delivery < 39 completed weeks gestation (oved from Clinical Care – Process)	In Clinical Care – Process domain	X	X	X	X

Patient and Caregiver Centered Experience of Care/Care Coordination *(Person and Community Engagement)*					
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)					
8 dimensions: Communication with Nurses Communication with Doctors Responsiveness of Hospital Staff Pain Management Communication About Medicines Cleanliness and Quietness of Hospital Environment Discharge Information Overall Rating of Hospital	X	X	X	X	X
9th dimension: 3-Item Care Transition measure		X	X	X	X
Efficiency and Cost Reduction					
Medicare Spending per Beneficiary	X	X	X	X	X
AMI payment per 30-day episode				*Proposed*	
HF payment per 30-day episode				*Proposed*	

SUMMARY TABLE VBP-2. **Final Hospital VBP Program Domains and Measures for FYs 2013-2016**					
Measure ID	**Measure Description**	**2013**	**2014**	**2015**	**2016**
Process of Care Domain					
AMI-7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	X	X	X	X
AMI-8a	Primary PCI Received Within 90 Minutes of Hospital Arrival	X	X	X	
IMM-2	Influenza Immunization				X
HF-1	Discharge Instructions	X	X	X	
PN-3b	Blood Cultures Performed in the ED Prior to Initial Antibiotic Received in Hospital	X	X	X	
PN-6	Initial Antibiotic Selection for CAP in Immunocompetent Patient	X	X	X	X
SCIP-Inf-1	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision	X	X	X	
SCIP-Inf-2	Prophylactic Antibiotic Selection for Surgical Patients	X	X	X	X
SCIP-Inf-3	Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time	X	X	X	X
SCIP-Inf-4	Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose	X	X	X	
SCIP-Inf-9	Urinary Catheter Removal on Post-Operative Day 1 or 2		X	X	X
SCIP–Card-2	Surgery Patients on a Beta Blocker Prior to Arrival That Received a Beta Blocker During the Perioperative Period	X	X	X	X
SCIP-VTE-1	Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered	X	X		
SCIP-VTE-2	Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery	X	X	X	X
Patient Experience of Care Domain					

SUMMARY TABLE VBP-2. Final Hospital VBP Program Domains and Measures for FYs 2013-2016					
Measure ID	**Measure Description**	**2013**	**2014**	**2015**	**2016**
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) (8 dimensions)		X	X	X	X
Outcome Domain					
MORT-30-AMI	Acute Myocardial Infarction (AMI) 30-Day Mortality Rate		X	X	X
MORT-30-HF	Heart Failure (HF) 30-Day Mortality Rate		X	X	X
MORT-30-PN	Pneumonia (PN) 30-Day Mortality Rate		X	X	X
AHRQ PSI 90	Complication/patient safety for selected indicators (composite)			X	X
CLABSI	Central Line-Associated Blood Stream Infection			X	X
CAUTI	Catheter-Associated Urinary Tract Infection				X
SSI	Surgical Site Infection Colon Abdominal Hysterectomy				X
Efficiency Domain					
MSPB-1	Medicare spending per beneficiary			X	X

I. Hospital-Acquired Condition (HAC) Reduction Program

CMS proposes changes to FY 2017 HAC Reduction Program policies that it characterizes as clarifications and proposes for FY 2018 the adoption of a modified version of the PSI-90 measure and a completely new scoring system for the program.

2. Proposals for FY 2017

Two proposals for incorporation into the HAC Reduction Program for FY 2017 are offered as clarifications, but CMS invites public comments on adoption of these policies.

First, CMS proposes to require that hospitals have 12 months or more of data in order to have "complete data" to receive a score on the PSI-90 measure. This would be in addition to the current requirement that defines "complete data" to be three or more discharges for at least one PSI-90 component indicator. That is, hospitals would be required to have three or more discharges for at least one PSI-90 component indicator and 12 months or more of data to receive a Domain 1 score. CMS is concerned that hospitals with less than 12 months data are receiving scores on the measure; analysis by Mathematica Policy Research has determined that the measure is unreliable with a performance period of less than 12 months. No changes are proposed to the requirement that hospitals have a score on at least one of the two domains in order to receive a HAC Reduction Program score.

Second, with respect to newly opened hospitals, CMS clarifies that hospitals must submit CDC NHSN HAI data for the HAC Reduction Program even when the hospital may not be required to report under the IQR Program. The IQR program is voluntary; the HAC Reduction Program applies to almost all IPPS hospitals. CMS proposes the following requirements for newly opened hospitals:

- A hospital that files a notice of participation (NOP) with the Hospital IQR Program within 6 months of opening would be required to begin submitting data for the CDC NHSN HAI measures no later than the first day of the quarter following the NOP.
- 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.

CMS emphasizes that the clarification does not change the calculation of the Domain 2 score.

3. Change to FY 2018 Measures

CMS proposes to adopt refinements to the AHRQ PSI-90 composite safety measure (NQF #0531) for the HAC Reduction Program beginning with FY 2018 payment. NQF undertook maintenance review of this measure and re-endorsed it with changes in December 2015. In addition to changing the measure name to "Patient Safety and Adverse Events Composite" the re-endorsed measure which CMS refers to as "modified PSI-90," includes the following modifications:

- PSI 07, central venous catheter-related blood stream infection rate is removed because of overlap with the NHSN CLABSI measure
- PSI 09 postoperative hemorrhage or hematoma rate; PSI 10 physiologic and metabolic derangement rate, and PSI 11 Postoperative respiratory failure rate are added
- PSI 12 perioperative pulmonary embolism or deep vein thrombosis rate and PSI 15 accidental puncture or laceration rate are re-specificed
- The weighting of component indicators is changed to account for harms associated with adverse events as well as the number of adverse events.

CMS refers readers to the AHRQ Quality Indicator Empirical Methods available at www.qualityindicators.ahrq.gov. Information is also available from NQF at file:///C:/Users/pttz/Downloads/patient_safety_voting_memo%20(1).pdf.

4. Change to HAC Reduction Program Scoring

CMS proposes to replace the decile-based scoring system in place for the HAC Reduction Program (described in item 1 above) with a new system that uses a "Winsorized Z-Score Method." This method was one identified by a Technical Expert Panel that identified several problems with the current approach. Those are: ties at the penalty threshold, hospitals with limited data identified as poor performers; and hospitals with zero adverse events under PSI-90 (Domain 1) and no Domain 2 score that nonetheless were identified as eligible for the penalty. A summary of the panel discussion is available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/TechnicalExpertPanels.html.

Unlike the current decile-based scoring system, however, CMS says the proposed method would result in continuous scores and avoid the ties that have resulted in CMS not being able to penalize exactly 25 percent of hospitals. For example, CMS says that under the current system hospitals with meaningfully different measure results may end up in the same decile while others with similar performance may fall into different deciles. For both the FY 2015 and 2016 fewer

than 25 percent of hospitals had total scores above the penalty threshold (21.9 percent and 23.7 percent, respectively).

CMS believes this method also creates a more level playing for hospitals that only have Domain 1 scores. CMS notes that under the current scoring system for FY 2016, a small number of hospitals that had zero adverse events in Domain 1 and no Domain 2 scores were identified in the worse performing quartile. Despite having PSI 90 scores close to the mean, these hospitals received a Domain 1 score of 7.0, which was greater than the 6.75 cutoff for the penalty determination. CMS states that Domain 2 scores tend to be lower than Domain 1 scores, which meant these hospitals were at a disadvantage having only a Domain 1 score.[12] CMS reports that it "waived the penalty" for these zero adverse event hospitals so that they would not be treated as poor performers.

5. Applicable Time Periods for FY 2018 and FY 2019

CMS proposes to modify its previously adopted policy (42 CFR 412.170) to use a 2-year performance period for the HAC Reduction Program. Specifically, CMS proposes to modify the regulations to permit it flexibility to use a period other than 2 years. The implementation of ICD-10 with claims beginning October 1, 2015 can result in a performance period for the HAC Reduction Program claims-based AHRQ-PSI 90 measure that includes both ICD-9 and ICD-10 data. In order to avoid this result, CMS proposes that for FY 2018 a 15-month performance period be used for PSI-90 (July 1, 2014 through September 30, 2015). This period includes only ICD-9-based claims. For 2019, a 21 month period would be used (October 1, 2015 through September 30, 2017) that includes only ICD-10 claims. The previously adopted performance period for the NHSN Domain 2 measures would be unchanged (CYs 2015 and 2016 for FY 2018 payment and CYs 2016 and 2017 for FY 2019 payment).

[12] CMS' explanation of why Domain 2 scores are lower is: "This is because hospitals are assigned the minimum of one point for any measure for which they have a measure result of zero. For example, for the CAUTI measure, if 13 percent of hospitals have an SIR of zero, one point is assigned to each of these hospitals, even though the decile approach is intended to assign 10 percent of hospitals to each decile. Two points would be assigned to the remaining seven percent of hospitals that would fall in the second decile. This phenomenon does not affect Domain 1 scores, since the reliability-adjusted PSI 90 measure result is not equal to zero in any hospital."

Summary Table HAC-1 HAC Reduction Program Measures, Performance Periods, and Domain Weights *(Proposals in Italics)*					
	FY 2015	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**
Domain 1: AHRQ Patient Safety Indicators					
PSI-90 (PSI-90 is a composite of eight PSI measures: PSI-3 (pressure ulcer rate), PSI-6 (iatrogenic pneumothorax), PSI-7 (Central venous catheter related blood stream infections rate), PSI-8 (Postoperative hip fracture rate), PSI-12 (postoperative VE or DVT rate, PSI-13 (Postoperative sepsis rate), PSI-14 (Wound dehiscence rate), and PSI-15 (accidental puncture or Laceration).	X	X	X	*	*
Applicable Time Period/(Performance Period)	7/1/11-6/30/13	7/1/12-6/30/14	7/1/13-6/30/15	*7/1/14-9/30 /15*	*10/1/15-9/30/17*
Domain 1 weight	35%	25%	15%	*	*
Domain 2: CDC HAI Measures					
Central Line-associated Blood Stream Infection (CLABSI)	X	X	X	*	*
Catheter-associated Urinary Tract Infection (CAUTI)	X	X	X	*	*
Surgical Site Infection (SSI): ◦ SSI Following Colon Surgery ◦ SSI Following Abdominal Hysterectomy		X	X	*	*
Methicillin-resistant staphylococcus aureus (MRSA)			X	*	*
Clostridium difficile			X	*	*
Applicable Time Period/(Performance Period)	1/1/12-12/31/13	1/1/13-12/31/14	1/1/14-12/31/15	*1/1/15-12/31/16*	*1/1/16-12/31/17*
Domain 2 weight	65%	75%	85%	*	*
*CMS does not propose weightings for FYs 2018 or 2019. Measures are not proposed either, but continuation of current measures is implied in the discussion of the proposed applicable time periods.					

7. Impact Analysis

The rule includes a table showing the percent of hospitals, by type, estimated to be subject to the 1 percent payment reduction. **It shows that hospitals with 300 or more beds, teaching hospitals, hospitals with a DSH percent of 50 percent or more, and hospitals with fewer than 25 beds are disproportionately penalized.**

J. Payment for Graduate Medical Education (GME) and Indirect Medical Education (IME) Costs (§§412.105, 413.75 through 413.83)

Background

CMS initially established rules for new programs such that a teaching hospital's unweighted FTE resident cap for a new program would be adjusted based on the sum of the product of the highest number of FTE residents in any program year during the third year of the first new program, for each new residency training program established during that 3-year period, and the minimum accredited length for each type of program. The 3-year window started when a new program begins, and the teaching hospital first trains residents for the first time in the new program (usually July 1), and ended when the third program year of the first new program ends.

The 3-year window was increased to 5 years in the FY 2013 IPPS/LTCH PPS final rule because commenters believed that the 3-year window was not sufficient for a hospital to grow its new residency programs and to establish FTE caps that truly reflect the number of residents the hospital would actually train once fully grown. Under the rules, an urban hospital that begins to train residents in a new program for the first time on or after October 1, 2012 will not receive an adjustment to its cap for new programs established more than 5 years after residents begin training in the first new program; by contrast, a rural hospital's cap may be adjusted for participating in training residents in a new program *at any time.* In other words, a rural hospital's cap is adjusted for each new program based on a 5-year growth window.

In the FY 2015 IPPS/LTCH PPS final rule, CMS changed its FTE resident cap implementation rules so that the caps would be effective beginning with the hospital's cost reporting period that coincides with or follows the start of the sixth program year of the first new program, or in the case of a rural hospital, beginning with the hospital's cost reporting period that coincides with or follows the start of the sixth program year of *each individual* new program. In that final rule, CMS also made the effective date of the 3-year rolling average and the IME intern/resident-to-bed (IRB) ratio consistent with the effective dates of the new program FTE resident caps, which means those residents participating in new programs are included in the hospital's 3-year rolling average and IRB ratio cap.

Proposed Policy Changes Relating to Rural Training Tracks at Urban Hospitals

When CMS implemented the changes described above in the 2013 and 2015 IPPS/LTCH PPS final rules, it neglected to make parallel changes for purposes of rural training tracks which means that the limitations for rural training tracks remains at 3 program years and effective after 3 program years. CMS proposes the following conforming changes for rural training tracks:

- To permit that, in the first 5 program years of the rural track's existence, the rural track FTE limitation for each urban hospital will be the actual number of FTE residents training in the rural training track at the urban hospital, and
- Beginning with the urban hospital's cost reporting period that coincides with or follows the start of the sixth program year of the rural training track's existence, the rural track FTE limitation would take effect.

However, while CMS proposes that an urban hospital's rural track FTE limit would first be effective beginning with the cost reporting period that coincides or follows the sixth program year of the rural training track program, the rural training track program's FTEs would be included in the 3-year rolling average and are subject to the IME IRB ratio cap for hospitals with established caps. This would be the case even within the first 5 program years before the beginning of the urban hospital's cost reporting period that coincides with or follows the sixth program year. CMS believes the statute and its regulations require this policy outcome. This would not apply to a new rural training track program by an urban hospital that is establishing an FTE cap for the first time.

Under the proposed policy, CMS clarifies that the urban hospital must still rotate residents in the rural track training program for more than one-half the duration of the program[13] and must comply with other provisions of §413.79(k), including (k)(5) (relating to counting residents, documentation requirements, and requirements to train in the rural area), (k)(6) (reopening of cost reports if CMS discovers residents did not complete training in the rural area) and §(k)(7) (consequences of a change in the OMB designation of an area from rural to urban). With respect to 413.79(k)(7), CMS proposes to make a conforming change for rural track programs started on or after October 1, 2012 to permit a 5-year growth period in lieu of the 3-year period for programs started before that date under those regulations as currently in effect.

K. Rural Community Hospital Demonstration Program

Proposed FY 2017 Budget Neutrality Offset Amount

For hospitals participating in the budget neutral, rural community hospital demonstration program, CMS has for the past few fiscal years used its 3-step methodology (adopted in the FY 2013 IPPS/LTCH PPS final rule) to calculate the budget neutrality offset amount that is applied across aggregate IPPS payments.

However, for FY 2017, CMS does not propose to make any adjustment to the standardized amounts for the rural community hospital demonstration program. Because the demonstration will have substantially phased out by October 1, 2016 CMS proposes to reconcile the budget neutrality offset amounts for FYs 2011 through 2016 with the actual costs of the demonstration for those years at one time when all of the finalized cost reports for cost reporting periods beginning in those fiscal years become available. CMS expects to do the reconciliation in FY 2020.

L. Proposed Hospital and CAH Notification Procedures for Outpatients Receiving Observation Services.

CMS proposes regulations to implement the NOTICE Act[14] which would require hospitals and CAHs, as a Medicare condition of participation, to provide to individuals receiving outpatient observation services for more than 24 hours both a written notice and an oral explanation that the individual is an outpatient[15] receiving observation services and the implications of that status. The proposed notice process would be effective August 6, 2016.

[13] Duration of the program refers to the minimum accredited length of a particular specialty of the rural track training program.

[14] The Notice of Observation Treatment and Implication for Care Eligibility Act, Public Law 114-42.

[15] CMS defines outpatient to mean a person who has not been admitted as an inpatient but is registered on hospital/CAH records as an outpatient who receives services (versus only supplies) directly from the hospital/CAH.

CMS proposes that hospitals and CAHs use a standardized written notice called the Medicare Outpatient Observation Notice (MOON) which would include all the requisite elements specified in the NOTICE Act. Specifically, the MOON would

- Explain that the individual was an outpatient—not an inpatient
- Explain the reason for outpatient status (i.e., that the physician believes the individual doesn't currently need inpatient services but requires observation to decide whether the patient should be admitted or discharged)
- Explain the implications of receiving observation services as an outpatient, such as Medicare cost-sharing requirements and eligibility for skilled nursing facility (SNF) care
- Provide the explanations in standardized language (using plain language written for beneficiary comprehension)
- Include a blank section that a hospital/CAH may use for additional information
- Include a dedicated signature area to acknowledge receipt and understanding of the notice

CMS will provide guidance for the oral notification in forthcoming Medicare manual provisions.

CMS proposes that the term individuals in this context refers to Medicare beneficiaries regardless of whether the services furnished are payable under the Medicare program; thus a beneficiary entitled to Part A but not enrolled in Part B would still receive the notice. Medicare Advantage (or other Medicare health plan) enrollees would also receive the notice. CMS emphasizes that the requirement applies only to those Medicare beneficiaries receiving treatment as outpatients and receiving observations services for more than 24 hours.

CMS proposes that notice must be given to these individuals no later than 36 hours after observation services begin. However, the notice must be provided sooner if the individual is to be transferred, discharged or **admitted as an inpatient before the end of the 36 hour period**; the MOON must be provided before transfer, discharge or inpatient admission. In the case of a Condition Code 44 situation[16], **CMS proposes that the MOON be provided within the timeframes described above, and the period for outpatient observation services begins upon the physician order.**

The notice must be signed to acknowledge receipt and understanding. CMS proposes that the individual, or a person acting on the individual's behalf, must sign the notice. Where the individual (or person acting on behalf of the individual) refuses to sign, the MOON must be signed by the hospital staff member who presents the notice, and would include the staff member's name and title, the certification statement that the notice was presented, and the date and time the notice was presented.

In cases where a CMS reviewer denies a claim for inpatient services as not medically reasonable and necessary, CMS clarifies that there would be no requirement to issue a MOON; the same

[16] CMS describes a Condition Code 44 as a circumstance where a physician initially orders inpatient services but the hospital, after internal utilization review while the patient is hospitalized, determines the services do not meet inpatient criteria, and the hospital (with concurrence of the physician) discontinues inpatient services and orders outpatient observation services.

policy applies where a hospital under its own utilization review (after a beneficiary is discharged) determines the inpatient admission is not medically reasonable and necessary and bills for the services under Part B. In both cases, the patient's status remains inpatient.

M. Clarification Regarding the Medicare Utilization Requirement for Medicare-Dependent, Small Rural Hospitals (MDHs) (§ 412.108)

The Medicare-Dependent, Small Rural Hospital Program (MDH) was extended through the end of FY 2017 by MACRA section 205. To qualify as an MDH hospital, a hospital (i) must be located in a rural area; (ii) must not have more than 100 beds; (iii) must not be a sole community hospital; and (iv) must have a "high percentage of Medicare discharges." A high percentage of Medicare discharges means that at least 60 percent of the hospital's inpatient days or discharges must be attributable to inpatients who are entitled to Part A; this is determined using either (i) the cost reporting period beginning in FY 1987 or (ii) two of the three most recently audited cost reporting periods for which settled cost reports are available. CMS counts days and discharges for Medicare Advantage (MA) enrollees toward the 60 percent utilization requirement.

Hospitals eligible for payments for costs associated with IME, DGME, DSH, etc., for their inpatients who are MA enrollees must submit timely claims to be paid for those costs, and CMS will only include MA days and discharges as reported (and verified) on the cost report.

For hospitals not eligible for IME, DGME, DSH, etc., payments, CMS clarifies that it will include MA days and discharges in the Medicare utilization calculation regardless of whether the hospital submitted claims if the hospital submits proper documentation (e.g., provider logs) for the MAC to verify the days and discharges reported on the cost report. CMS notes that timely submission of these claims leads to more expeditious determinations that a hospital will qualify as an MDH.

N**. Adjustment to IPPS Rates Resulting from 2-Midnight Policy**

CMS adopted the 2-midnight policy in the FY 2014 IPPS/LTCH PPS final rule effective for discharges beginning October 1, 2013. At the time, CMS actuaries estimated a $220 million increase in expenditures attributable to the 2-midnight rule, and CMS reduced by 0.2 percent the standardized amount, the Puerto Rico standardized amount, the hospital-specific payment rates, as well as the national capital Federal rate and the Puerto Rico-specific capital rate for that fiscal year (and subsequently fiscal years 2015 and 2016).

CMS notes that in the original estimate for the reduction relatively small changes on utilization of inpatient and outpatient settings would have a disproportionate effect on estimated net costs. The actuaries' most recent estimate of the 2-midnight policy varies between a savings and a cost over the FY 2014 to FY 2015 period. While maintaining its position that the original reductions established in 2013 were reasonable, CMS proposes to

- Beginning in FY 2017, prospectively and permanently remove the 0.2 percent reductions; and
- Only for FY 2017, temporarily increase the rates to address the effect of the 0.2 percent reductions for FY 2014 through 2016.

CMS proposes to implement these policies by including a permanent factor of 1/0.998 and a temporary one-time factor of 1.006 in calculating the FY 2017 standardized amount, the hospital-specific payment rates, and the national capital Federal rate.

V. Changes to the IPPS for Capital-Related Costs

National Capital Federal Rate for FY 2017. For FY 2016, CMS established a national capital federal rate of $438.75. Under the proposed rule, CMS would establish increase the national capital federal rate for FY 2017 by 1.7 percent based adjusted for factors as detailed in the tables below. As a result of this update and the proposed budget neutrality factors discussed below, CMS proposes a national capital federal rate of $446.35 for FY 2017.

PROPOSED CMS FY 2017 UPDATE FACTOR TO THE CAPITAL FEDERAL RATE	
Capital Input Price Index* (FY 2010-based CPI)	1.2
Intensity	0.0
Case-Mix Adjustment Factors:	
Real Across DRG Change	-0.5
Projected Case-Mix Change	0.5
Subtotal	1.2
Effect of FY 2014 Reclassification and Recalibration	0.0
Forecast Error Correction	-0.3
Total Update	0.9

Comparison of Factors and Adjustments:
FY 2016 Capital Federal Rate and Proposed FY 2017 Capital Federal Rate

	FY 2016	**Proposed FY 2017**	**Change**	**Percent Change**
Update Factor[1]	1.0130	1.009	1.009	0.9
GAF/DRG Adjustment Factor[1]	0.9976	0.9993	0.9993	-0.07
Outlier Adjustment Factor[2]	0.9365	0.9374	1.0010	0.10
Permanent 2-midnight policy adjustment factor	N/A	1.002	1.002	0.2
One-time 2-midnight policy adjustment factor	N/A	1.006	1.006	0.6
Capital Federal Rate	$438.75	$446.35	1.0173	1.73

[1] The proposed update factor and the proposed GAF/DRG budget neutrality adjustment factors are built permanently into the capital Federal rates. Thus, for example, the incremental change from FY 2016 to FY 2017 resulting from the application of the proposed 0.9993 GAF/DRG budget neutrality adjustment factor for FY 2017 is a net change of 0.9993 (or -0.07 percent).

[2] The proposed outlier reduction factor is not built permanently into the capital Federal rate; that is, the factor is not applied cumulatively in determining the capital Federal rate. Thus, for example, the net change resulting from the application of the proposed FY 2017 outlier adjustment factor is 0.9374/0.9365, or 1.0010 (or 0.10 percent).

VI. Changes to the Long-Term Care Hospital Prospective Payment System (LTCH PPS) for FY 2017

A. Background

For FY 2017, CMS again applies the term "LTCH PPS standard Federal payment rate case" when the criteria for site neutral payment rate exclusion are met and applies the term "site neutral payment rate case" to any LTCH PPS case when the criteria are not met. The criteria for exclusion from the site neutral payment remain the same for FY 2017:

- Case cannot have a principal diagnosis (DRG) relating to a psychiatric diagnosis or rehabilitation (the DRG criterion)
- Case must be immediately preceded by discharge from an acute care hospital that included at least 3 days in an intensive care unit (the ICU criterion)
- Case must be immediately preceded by discharge from an acute care hospital and the LTCH discharge must be assigned to an MS-LTC-DRG based on the beneficiary's receipt of at least 96 hours of ventilator services in the LTCH (the ventilator criterion).

To qualify for exclusion from the site neutral payment rate, the case must meet the DRG criterion and either the ICU or ventilator criterion

CMS proposes updates for LTCHs using a process that is generally consistent with prior regulatory policy and that cross-links to relevant IPPS provisions.

Summary of Proposed Changes to LTCH PPS for FY 2017*	
Standard Federal Rate, FY 2016	$41,762.85
Proposed update factors	
Market basket change	+2.7%
Multi-factor productivity adjustment	-0.5%
Additional adjustment required by statute	-0.75%
Penalty for hospitals not reporting quality data	-2.0%
Net update, LTCHs reporting quality data	+1.45% (1.0145)
Net update LTCHs not reporting quality data	-0.55% (0.9945)
Proposed Adjustments	
Average wage index budget neutrality adjustment	0.998723
Proposed Standard Federal Rate, **FY 2017**	
LTCHs reporting quality data ($41,762.85∗1.0145∗0.998723)	$42,314.31
LTCHs not reporting quality data ($41,762.85∗0.9945∗0.998723)	$41,480.12
Proposed Fixed-loss Amount for High-Cost Outlier (HCO) Cases	
LTCH PPS standard Federal payment rate cases	$22,728
Site neutral payment rate case (same as the proposed IPPS fixed-loss amount)	$23,681
Impact of Proposed Policy Changes on LTCH Payments	
Total estimated impact	-6.9% (-$355 million)
LTCH standard Federal payment rate cases (55% of LTCH cases)	+0.2% (+12 million)
Site neutral payment rate cases (45 % of LTCH cases)**	-7.2% (-$367 million)

Summary of Proposed Changes to LTCH PPS for FY 2017*
*More detail is available in Table IV, "Impact of Proposed Payment Rate and Policy Changes to LTCH PPS Payments for Standard Payment Rate Cases for FY 2017" (see page 1547 in display copy). Table IV does not include the impact of site neutral payment rate cases. ** LTCH site neutral payment rate cases are paid a rate that is based on the lower of the IPPS comparable per diem amount or 100 percent of the estimated cost of the case.

B. Proposed Modification to the Application of the Site Neutral Payment Rate

As in FY2016, site neutral payment rate cases are again paid in FY 2017 at a rate that is based on the lower of the IPPS comparable per diem amount rate or 100 percent of the estimated cost of the cases. For FY 2017, CMS proposes a single technical correction. To implement the exclusion criteria from the site neutral payment rate required defining a "subsection (d) hospital" and this was done under § 412.503 for FY 2016. However, a related cross-reference was incorrectly made to § 412.526 rather than to § 412.522. For FY 2017 CMS proposes to revise § 412.503 to correct the error.

C. Proposed Modifications to the "25-Percent Threshold Policy" Payment

CMS applies a per discharge adjustment to payments to an LTCH when admissions to that LTCH from a single referring hospital exceed a threshold during a single cost reporting period (usually 25%, but up to 50% under rural or MSA-dominant exceptions). This adjustment was first implemented in the FY2005 IPPS final rule and is known as the "25-percent threshold policy". The policy seeks to limit incentives for acute care hospitals and LTCHs to join up in pairs to split a single episode of care into separate acute hospital and LTCH stays. Some LTCHs are statutorily exempt from the threshold adjustment, and full implementation of regulatory changes to expand the threshold to most LTCHs has been statutorily delayed. The most recent delay is set to expire at the end of FY 2016 reporting periods. Anticipating that expiration, CMS now proposes to create a new, unified "25-percent threshold policy" through a combination of actions that incorporate many of the existing policy provisions:

- Create the new policy effective October 1, 2016 sunsetting the existing policy
- Like the existing policy, the new policy would apply to both LTCH PPS standard Federal rate cases and site-neutral payment cases and would not apply to "subclause (II) LTCHs or "grandfathered hospitals-within-hospitals"
- To facilitate transparency, the new policy will utilize the CMS Certification Numbers (CNN) from referring hospital discharge claims and from LTCH discharge claims to calculate the numerator and denominator (respectively) for each LTCH's threshold calculation
- As under the current policy, payment for discharges causing an LTCH to meet or exceed its applicable threshold will be the lesser of the LTCH PPS payment amount (at the Federal standard or site neutral rate as applicable) or an IPPS equivalent amount;
    - Only discharges causing an LTCH to meet or exceed its applicable threshold will be subject to payment adjustments; other discharges would not be affected

    - LTCH discharges that had been high-cost outliers at their referring hospitals or those that are Medicare Advantage discharges would not be subject to the threshold
- The new policy would continue the current threshold applicable to rural LTCHs at 50 percent
- The new policy would continue the current threshold range for special treatment of LTCHs located in an MSA with an MSA-dominant referring hospital
    - The threshold range would continue to be 25-50 percent and the same threshold will continue to apply to all of that LTCH's referring hospitals
- CMS newly proposes that for LTCHs with multiple location who are paid under the LTCH PPS, all locations of the LTCH must be rural or be located in an MSA-dominant area to qualify for the respective special treatments.

D. Proposed Refinement to the Payment Adjustment for "Subclause II" LTCHs: Limitations on Beneficiary Charges

Payment for both operating and capital costs under the LTCH PPS to "subclause (II) LTCHs" is based upon reasonable cost-based payment rules termed "TEFRA-like". In the FY 2016 final rule, CMS clarified that a site neutral payment or an LTCH PPS standard Federal rate payment should be considered the full LTCH PPS payment, setting limits to allowable charges to Medicare beneficiaries to applicable deductibles and copay amounts until the high-cost outlier threshold is met, plus noncovered services as if the case were paid under the Federal rate. For FY 2017 CMS proposes to similarly limit allowable charges to Medicare beneficiaries discharged from "subclause (II) LTCHs". The adjusted "TEFRA-like" payment is to be considered the full LTCH PPS payment until the high-cost outlier threshold is met, and applies only to LTCH costs incurred for days for which the beneficiary has an available benefit day. CMS further proposes that beneficiary charges by "subclause (II) LTCHs" be limited to deductible and coinsurance amounts and § 489.20(a) items and services; a beneficiary may not be charged for services that were not the basis for the adjusted LTCH PPS payment amount under § 412.526.

E. Impact of Proposed Payment Rate and Policy Changes to LTCH PPS Payments for FY 2017

1. CMS Impact Analysis for LTCHs

CMS projects that the overall impact of the proposed payment rate and policy changes, for all LTCHs from FY 2016 to FY 2017, would result in a decrease of 6.9 percent or $355 million in aggregate payments (from $5.112 billion to $4.757 billion).

Summary of Impact of Proposed Changes to LTCH PPS for Standard Federal Payment Rate Cases for FY 2017 *		
LTCH Classification	**Number of LTCHs**	**Estimated percent change in payments per discharge**
All LTCH providers	420	+0.3%
By Location:		
Rural	21	+0.2%
Urban	399	+0.3%
By Ownership Type:		
Voluntary	78	+0.2%
Proprietary	325	+0.3%
Government	17	+0.3%
By Region		
New England	13	+0.3%
Middle Atlantic	26	+0.3%
South Atlantic	63	+0.3%
East North Central	69	+0.2%
East South Central	34	+0.2%
West North Central	29	+0.2%
West South Central	128	+0.2%
Mountain	33	+0.2%
Pacific	25	+0.4%
*More detail is available in Table IV, "Impact of Proposed Payment Rate and Policy Changes to LTCH PPS Payments for Standard Federal Payment Rate Cases, For FY 2017", (see page 1547 of display copy). The temporary exclusion from the site neutral payment rate provided by Section 231 of Pub.L. 114-113 is not reflected in these estimated FY 2017 LTCH payments.		

VIII. Quality Data Reporting Requirements for Specific Providers and Suppliers

A. Hospital Inpatient Quality Reporting (IQR) Program

CMS proposes a number of changes to the Hospital IQR Program, including elimination of some measures, addition of 3 condition-specific payment measures and a measure of excess days following hospitalization for pneumonia. The resulting measure set proposed for FY 2019 includes a total of 61 mandatory measures.

Table VIII at the end of this section shows the proposed measure set for FY 2019, and for reference the previously adopted IQR Program measure sets for the FY 2017 and FY 2018 payment determinations are also included.

1. Removal of Measures for the FY 2019 Payment Determination and Subsequent Years

CMS proposes to remove 15 measures from the IQR Program beginning with the FY 2019 payment determination, shown in the table below.

Measures Proposed for Removal for FY 2019 Payment and Beyond
Electronic Clinical Quality Measures
AMI-2: Aspirin Prescribed at Discharge for AMI (NQF #0142)
AMI-7a: Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival
AMI-10: Statin Prescribed at Discharge
HTN: Healthy Term Newborn (NQF #0716)
PN-6: Initial Antibiotic Selection for Community-Acquired Pneumonia (CAP) in Immunocompetent Patients (NQF #0147)
SCIP-Inf-1a: Prophylactic Antibiotic Received within 1 Hour Prior to Surgical Incision (NQF #0527)
SCIP-Inf-2a: Prophylactic Antibiotic Selection for Surgical Patients (NQF #0528)
SCIP-Inf-9: Urinary Catheter Removed on Postoperative Day 1 (POD1) or Postoperative Day 2 (POD2) with Day of Surgery Being Day Zero
STK-4: Thrombolytic Therapy (NQF #0437)
VTE-3: Venous Thromboembolism Patients with Anticoagulation Overlap Therapy (NQF #0373)
VTE-4: Venous Thromboembolism Patients Receiving Unfractionated Heparin (UFH) with Dosages/Platelet Count Monitoring by Protocol (or Nomogram)
VTE-5: Venous Thromboembolism Discharge Instructions
VTE-6: Incidence of Potentially Preventable VTE*
Structural Measures
Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care
Participation in a Systematic Clinical Database Registry for General Surgery
Chart-abstracted Measures
STK-4: Thrombolytic Therapy (NQF #0437)
VTE-5: VTE Discharge Instructions
*Chart-abstracted version is retained.

2. Refinements to Existing Measures

CMS proposes to modify specifications for two previously adopted claims-based measures beginning with the FY 2018 payment determination.

Pneumonia Payment per 30-Day Episode. The patient cohort for the pneumonia payment measure would be modified to align with the cohort previously finalized for the pneumonia mortality and pneumonia readmissions measures. The proposal would expands the patient cohort for the pneumonia payment measure to include patients with a principal discharge diagnosis of aspiration pneumonia and patients with a principal discharge diagnosis of sepsis (excluding severe sepsis) with a secondary diagnosis of pneumonia that was present on admission as well as patients with a principal discharge diagnosis of viral or bacterial pneumonia.

CMS estimates that with the proposed change, 9.3 percent of hospitals would change from “average” to “greater than average” payment, 1.4 percent from “greater than average” to “average”, 8.5 percent from “average” to “less than average,” and 1.8 percent from “less than average” to “average.”

Modified PSI 90. CMS proposes to adopt the modified PSI 90 measure, renamed the AHRQ Patient Safety and Adverse Events Composite (NQF #0531). A discussion of the modifications to PSI 90 is included earlier in this summary in the HAC Reduction Program.

The reporting period for the modified PSI 90 measure would be changed from 24 months to shorter periods in both FY 2018 and 2019 in order to accommodate the adoption of ICD-10 on October 1, 2015.

3. Proposed New Measures for the FY 2019 Payment Determination and Subsequent Years

CMS proposes to adopt the following four measures beginning with the FY 2019 payment determination.

- Aortic Aneurysm Procedure Clinical Episode-Based Payment (AA Payment) Measure;
- Cholecystectomy and Common Duct Exploration Clinical Episode-Based Payment (Chole and CDE Payment) Measure;
- Spinal Fusion Clinical Episode-Based Payment (SFusion Payment) Measure; and
- Excess Days in Acute Care after Hospitalization for Pneumonia.

The three proposed clinical episode payment measures would be constructed in the same way as previously adopted episode payment measures for kidney/UTI, cellulitis, and gastrointestinal hemorrhage as well as the MSPB measure.

The proposed rule does not include any links to specifications for the measure of excess days after hospitalization for pneumonia.

4. Reporting of Electronic Clinical Quality Measures for FY 2019

CMS proposes that beginning with the FY 2017 reporting period /FY 2019 payment determination, hospitals must submit a full year of data on all the proposed IQR Program eCQMs (a total of 15) by February 28, 2017. In making this proposal CMS says it considered requiring reporting of 8 measures for FY 2019 and the full set beginning in 2020, but decided that FY 2019 is the appropriate time because hospitals have had several years to report data electronically, 95 percent of hospitals attest to successful eCQM reporting under the EHR Incentive Program, and the proposed rule would reduce the number of eCQMs from 28 to 15 which would reduce the certification burden on hospitals and allow them to focus on a small set of eCQMs.

A clarification is made for the FY 2019 payment determination and subsequent years with respect to the chart-abstracted versions of ED-1, ED-2, PC-01 and VTE-6. CMS clarifies that hospitals must submit the required data for both the chart-abstracted version and a full year of data on the eCQM versions of these measures.

5. Possible Changes to Measures, Topics, and Public Reporting for Future Years

CMS describes several measure changes it is considering for future addition to the IQR Program and invites comments. They are:

- Changes to the Stroke Mortality Measure. CMS says it is refining the stroke mortality measure to include stroke severity in the risk adjustment and may propose this refinement as early as the FY 2022 payment determination (July 2017- June 2020 reporting period).
- NHSN Antimicrobial Use Measure (NQF # 2720). This measures assesses antibiotic use in hospitals based on medication administration data that hospitals collect and report to NHSN compared with predicted use based on national data.
- Behavioral Health. CMS cites a gap in understanding the quality of care given to inpatient psychiatric patients in acute hospital beds, and invites public comment on behavioral health measures appropriate for inclusion in the IQR Program in future years, including measures adopted for the Inpatient Psychiatric Facility Quality Reporting Program
- Changes to Public Reporting. CMS seeks comment on the possibility of including on the Hospital Compare website IQR Program measure data that is stratified by race, ethnicity, sex and disability.

6. Form, Manner, and Timing of Quality Data Submission

CMS does not propose any changes to the procedural requirements for the IQR Program previously adopted or to the previously adopted data submission requirements for chart-abstracted measures, HCAHPS, structural measures or measures reported through the CDC NHSN.

With respect to electronically-specified measures, CMS makes several proposals:

- The eCQM data certification process previously adopted for the CY 2016 reporting period /FY 2018 payment determination would be continued for FY 2019. This would require hospitals to report using either the 2014 or 2015 edition of CEHRT for the CY 2017 reporting period/FY 2019 payment determination.
- For the CY 2018 reporting period/FY 2020 payment determination, CMS proposes that the 2015 edition of CEHRT be required.
- The data submission deadline beginning with the CY 2017 reporting period/FY 2019 payment determination would be the end of 2 months following the close of the reporting period calendar year. For example, for the FY 2019 payment determination the deadline would be February 28, 2018. This would align the IQR Program reporting deadline with that of the Medicare EHR Incentive Program. CMS notes that under the Medicaid EHR Incentive Program deadlines differ by state.

In general, CMS says that it proposes to align the IQR Program with the Medicare and Medicaid EHR Incentive Programs by removing 13 eCQMs, requiring submission of all available eCQMs, requiring annual submission of four quarters of eCQM data, continued use of 2014 or 2015 CEHRT for the 2017 reporting period/FY2019 payment determination, requiring use of 2015 CEHRT for the 2018 reporting period/FY 2020 payment determination and setting an eCQM data submission deadline that is 2 months after the end of the reporting period (aligns with Medicare EHR Incentive Program only).

9. Impact Analysis

In the regulatory impact analysis section of the proposed rule, CMS reports that at the time of the analysis 90 hospitals were estimated to not receive the full update for FY 2016 because they did not participate in the IQR Program or failed the program requirements, but met the meaningful use requirements under the EHR Incentive Program; 147 hospitals met the IQR Program requirements but not the meaningful use requirements; and 30 hospitals did not meet the requirements of either program and therefore received the largest update factor reduction.

Table VIII. IQR Program Measures for Payment Determination in FYs 2016 – 2019 **X= Mandatory measure *Proposals in Italics***				
	2016	**2017**	**2018**	**2019**
Chart-Abstracted Measures				
AMI-2 Aspirin prescribed at discharge for AMI	Removed			
AMI-7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival	X	X	Removed	
AMI-8a Timing of Receipt of Primary Percutaneous Coronary Intervention (PCI)	X	Removed		
AMI-10 Statin at discharge	Removed			
HF-2 Evaluation of left ventricular systolic function	X	Removed		
PN-6 Appropriate initial antibiotic selection	X	Removed		
STK-1 VTE prophylaxis	X	X	Removed	
STK-2 Antithrombotic therapy for ischemic stroke	X	Removed		
STK-3 Anticoagulation therapy for Afib/flutter	X	Removed		
STK-4 Thrombolytic therapy for acute ischemic stroke	X	X	X	*Remove*
STK-5 Antithrombotic therapy by end of hospital day 2	X	Removed		
STK-6 Discharged on statin	X	X	Removed	
STK-8 Stroke education	X	X	Removed	
STK-10 Assessed for rehabilitation services	X	Removed		
VTE-1 VTE prophylaxis*	X	X	Removed	
VTE-2 ICU VTE prophylaxis	X	X	Removed	
VTE-3 VTE patients with anticoagulation overlap therapy	X	X	Removed	
VTE-4 VTE patients receiving un-fractionated Heparin with doses/labs monitored by protocol	X	Removed		
VTE-5 VTE discharge instructions	X	X	X	*Remove*
VTE-6 Incidence of potentially preventable VTE	X	X	X	X
Severe sepsis and septic shock: management bundle (NQF #500)		X	X	X
SCIP INF-1 Prophylactic antibiotic received within 1 hour prior to surgical incision	X	Removed		
SCIP-INF-2 Prophylactic antibiotic selection for surgical patients	X	Removed		
SCIP-INF-3 Prophylactic antibiotics discontinued within 24 hours after surgery end time (48 hrs for cardiac surgery)	X	Removed		
SCIP-INF-4 Cardiac surgery patients with controlled 6AM postoperative serum glucose	Suspended July 2014		Removed	
SCIP–INF-9 Postoperative urinary catheter removal on postoperative day 1 or 2 with day of surgery being day zero	X	Removed		
SCIP-Cardiovascular-2 Surgery patients on a beta blocker prior to arrival who received a beta blocker during the perioperative period	X	Removed		
SCIP-VTE-2 Surgery patients who received appropriate VTE prophylaxis within 24 hours pre/post surgery	X	Removed		
ED-1 Median time from ED arrival to departure from the emergency room for patients admitted to the hospital (NQF #0495)	X	X	X	X
ED-2 Median time from admit decision to time of departure from the ED for patients admitted to the inpatient status (NQF #0497)	X	X	X	X
IMM-1 Immunization for pneumonia	Suspended		Removed	

Table VIII. IQR Program Measures for Payment Determination in FYs 2016 – 2019 **X= Mandatory measure *Proposals in Italics***				
	2016	**2017**	**2018**	**2019**
IMM-2 Immunization for influenza (NQF #1659)	X	X	X	X
PC-01 Elective delivery < 39 completed weeks gestation (NQF #0469)	X	X	X	X
Electronic Clinical Quality Measures				
AMI-2 Aspirin prescribed at discharge for AMI	voluntary reporting of eCQMs for (16 of 28 measures across three NQS domains)		Must report at least 4 eCQMs	*Remove*
AMI-7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival				*Remove*
AMI-8a Timing of Receipt of Primary Percutaneous Coronary Intervention (PCI) (NQF #0163)				*X*
AMI-10 Statin at discharge				*Remove*
PN-6 Appropriate initial antibiotic selection				*Remove*
STK-2 Antithrombotic therapy for ischemic stroke (NQF #0435)				*X*
STK-3 Anticoagulation therapy for Afib/flutter (NQF #0436)				*X*
STK-4 Thrombolytic therapy for acute ischemic stroke				*Remove*
STK-5 Antithrombotic therapy by end of hospital day 2 (NQF #0438)				*X*
ST K-6 Discharged on statin (NQF #0439)				*X*
STK-8 Stroke education				*X*
STK-10 Assessed for rehabilitation services (NQF #0441)				*X*
VTE-1 VTE prophylaxis (NQF #0371)				*X*
VTE-2 ICU VTE prophylaxis (NQF #0372)				*X*
VTE-3 VTE patients with anticoagulation overlap therapy				*Remove*
VTE-4 VTE patients receiving un-fractionated Heparin with doses/labs monitored by protocol				*Remove*
VTE-5 VTE discharge instructions				*Remove*
VTE-6 Incidence of potentially preventable VTE				*Remove*
SCIP INF-1 Prophylactic antibiotic received within 1 hour prior to surgical incision				*Remove*
SCIP-INF-2 Prophylactic antibiotic selection for surgical patients				*Remove*
SCIP–INF-9 Postoperative urinary catheter removal on postoperative day 1 or 2 with day of surgery being day zero				*Remove*
ED-1 Median time from ED arrival to departure from the emergency room for patients admitted to the hospital (NQF #0495)				*X*
ED-2 Median time from admit decision to time of departure from the ED for patients admitted to the inpatient status (NQF #0497)				*X*
PC-01 Elective delivery < 39 completed weeks gestation (NQF #0469)				*X*
PC-05 Exclusive breast milk feeding (NQF #0480)				*X*
Healthy term newborn				*Remove*
Hearing screening prior to hospital discharge				*X*
Children's asthma care – 3 home management plan of care document given to patient/caregiver				*X*
NHSN Measures				
Central Line Associated Bloodstream Infection (CLABSI)	X	X	X	X
Surgical Site Infection: Colon Surgery; Abdominal Hysterectomy	X	X	X	X
Catheter-Associated Urinary Tract Infection (CAUTI)	X	X	X	X
MRSA Bacteremia	X	X	X	X
Clostridium Difficile (C.Diff)	X	X	X	X
Healthcare Personnel Influenza Vaccination	X	X	X	X
Claims-Based Measures				
Mortality				
AMI 30-day mortality rate	X	X	X	X

Table VIII. IQR Program Measures for Payment Determination in FYs 2016 – 2019 X= Mandatory measure *Proposals in Italics*				
	2016	**2017**	**2018**	**2019**
Heart Failure (HF) 30-day mortality rate	X	X	X	X
Pneumonia 30-day mortality rate	X	X	X	X
Stroke 30-day mortality rate	X	X	X	X
COPD 30-day mortality rate	X	X	X	X
CABG 30-day mortality rate		X	X	X
Readmission				
AMI 30-day risk standardized readmission	X	X	X	X
Heart Failure 30-day risk standardized readmission	X	X	X	X
Pneumonia 30-day risk standardized readmission	X	X	X	X
Total Hip/Total Knee Arthroplasty (TKA/THA) 30-day risk standardized readmission	X	X	X	X
Hospital-wide all-cause unplanned readmission	X	X	X	X
Stroke 30-day risk standardized readmission	X	X	X	X
COPD 30-day risk standardized readmission	X	X	X	X
CABG 30-day risk standardized readmission		X	X	X
Patient Safety				
PSI-90 Patient safety composite (NQF #0531)	X	X	X	X
PSI-04 Death among surgical inpatients with serious, treatable complications (NQF #0351)	X	X	X	X
Surgical Complications				
THA/TKA complications	X	X	X	X
Efficiency/Condition-specific payment				
Medicare Spending per Beneficiary	X	X	X	X
AMI payment per 30-day episode of care	X	X	X	X
Heart Failure payment per 30-day episode of care		X	X	X
Pneumonia payment per 30-day episode of care		X	X	X
THA/TKA payment per 30-day episode of care			X	X
Excess days in acute care after hospitalization for AMI			X	X
Excess days in acute care after hospitalization for HF			X	X
Excess days in acute care after hospitalization for PN				*Proposed*
Kidney/UTI clinical episode-based payment				X
Cellulitis clinical episode-based payment				X
Gastrointestinal hemorrhage clinical episode-based payment				X
Aortic Aneurysm Procedure clinical episode-based payment				*Proposed*
Cholecystectomy/Common Duct Exploration episode-based payment				*Proposed*
Spinal Fusion clinical episode-based payment				*Proposed*
Patient Survey				
HCAHPS survey + 3-item Care Transition Measure	X	X	X	X
Structural Measures				
Participation in a Systematic Database for Cardiac Surgery	X	Removed		
Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care	X	X	X	*Remove*
Participation in a Systematic Clinical Database Registry for General Surgery	X	X	X	*Remove*
Safe Surgery Checklist Use	X	X	X	X
Hospital Survey on Patient Safety Culture			X	X

B. PPS Exempt Cancer Hospital Quality Reporting (PCHQR) Program

In the FY 2013 IPPS/LTCH final rule, CMS established a quality reporting program beginning in FY 2014 for PPS-exempt cancer hospitals (PCHs), as required under section 1866(k) of the Act, as added by section 3005 of the ACA. The PPS-exempt Cancer Hospital Quality Reporting (PCHQR) Program follows many of the policies established for the Hospital IQR Program, including the principles for selecting measures and the procedures for hospital participation in the program.

CMS proposes to modify the measure set for FY 2019. First, the existing measure Radiation Dose Limits to Normal Tissues (NQF #0382) would be updated to reflect updated specifications endorsed by the NQF subsequent to adoption of the measure.

CMS proposes addition of one new claims-based measure beginning with FY 2019: Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy. It assesses inpatient admissions and ED visits within 30 days of each outpatient chemotherapy encounter for certain qualifying diagnoses: anemia, dehydration, diarrhea, emesis, fever, nausea neutropenia, pain, pneumonia, or sepsis.

With respect to public reporting, CMS proposes several changes. First, public display of CLABSI and CAUTI data, scheduled for 2017, would be deferred due to the low volume of data. CMS will work with CDC to identify an appropriate timeframe for public reporting. Second, CMS proposes to begin public reporting of the measure External Beam Radiotherapy for Bone Metastases in 2017. Third, with respect to the measure Radiation Dose Limits to Normal Tissues scheduled for public reporting in 2016, if the proposed updates to the measure are adopted CMS proposes to begin display as soon as feasible after the 2017 data collection period ends.

The table below shows previously adopted PCHQR measures and public display timelines.

PCHQR Program Measures Proposed for 2019	
Measure	**Public Display**
Safety and Healthcare Associated Infection	
NHSN CLABSI (NQF #0139)	2017 *defer*
NHSN CAUTI (NQF #0138)	2017 *defer*
NHSN SSI (NQF #0753)	
NHSN CDI (NQF #1717)	
NSHN MRSA bacteremia (NQF #1716)	
NHSN Influenza vaccination coverage among health care personnel (NQF #0431)	
Clinical Process/Cancer-Specific Treatments	
Adjuvant chemotherapy is considered or administered within 4 months of surgery for certain colon cancer patients (NQF #0223)	2014
Combination chemotherapy is considered or administered within 4 mos. of diagnosis to certain breast cancer patients (NQF #0559)	2014
Adjuvant hormonal therapy for certain breast cancer patients (NQF #0220)	2015
Clinical Process/Oncology Care	
Oncology-Radiation Dose Limits to Normal Tissues (NQF #0382)	2016 *
Oncology: Plan of Care for Pain (NQF #0383)	2016
Oncology: Pain Intensity Quantified (NQF #0384)	2016

PCHQR Program Measures Proposed for 2019	
Prostate Cancer-Avoidance of Overuse Measure-Bone Scan for Staging Low-Risk Patients (NQF #0389)	2016
Prostate Cancer-Adjuvant Hormonal Therapy for High-Risk Patients (NQF #0390)	2016
Patient Experience of Care	
HCAHPS	2016
Clinical Effectiveness	
External Beam Radiotherapy for Bone Metastases (NQF#1822)	*2017 proposed*
Claims-Based Outcomes	
Admissions and ED Visits for Patients Receiving Outpatient Chemotherapy	
*If the proposed updates to this measure are adopted, CMS proposes to display the updated version as soon as feasible after the CY 2017 data collection.	

C. Long-Term Care Hospital Quality Reporting (LTCHQR) Program

In the FY 2012 IPPS/LTCH final rule, CMS established a quality reporting program beginning in FY 2014 for LTCHs, as required under section 1886(m) of the Act as added by section 3004 of the ACA. An LTCH that does not meet the requirements of participation in the LTCHQR Program for a rate year is subject to a 2.0 percentage point reduction in the update factor for that year.

The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 requires the Secretary to implement quality measures for five specified quality measure domains using standardized data elements to be nested within the assessment instruments currently required for submission by LTCHs and other post-acute care providers (IRFs, SNFs, and HHAs). Other measures are to address resource use, hospitalization, and discharge to the community. The intent of the Act is to enable interoperability and access to longitudinal information among post-acute providers to facilitate coordinated care, improve outcomes, and provide for quality comparisons across providers. For LTCHs, the Secretary must specify quality measures by October 1, 2018. For IRFs and SNFs the deadline is October 1, 2016, and for HHAs is January 1, 2019. In total, the IMPACT Act measure domains are:

- Skin integrity and changes in skin integrity;
- Functional status, cognitive function, and changes in function and cognitive function;
- Medication reconciliation;
- Incidence of major falls;
- Transfer of health information and care preferences when an individual transitions;
- Resource use measures, including total estimated Medicare spending per beneficiary;
- Discharge to community; and
- All-condition risk-adjusted potentially preventable hospital readmissions rates.

1. LTCHQR Program Measures for FY 2018

In addition to the 12 measures previously adopted for the LTCHQR Program measure set for the FY 2018 payment determination, CMS proposes the addition of four new measures, which were developed to meet requirements of the IMPACT Act. Three of the measures are proposed to begin with the FY 2018 payment determination and the fourth with the FY 2020 payment determination. Previously adopted and proposed measures are shown in a table at the end of this

section. With respect to each measure CMS says that it plans to provide initial confidential feedback to LTCHs prior to public reporting, which would begin with discharges for 2016 and 2017.

None of the four proposed measures is NQF-endorsed, and in each case the MAP recommended continued development. CMS says that is has subsequently continued to work on these measures

Medicare Spending per Beneficiary. CMS proposes to add a measure of Medicare spending per beneficiary for post-acute care that is specific to the LTCH setting, which it labels "MSPB-PAC LTCH." Similar measures have been developed for other PAC settings. These MSPB- PAC measures generally follow the construction of the MSPB measure currently used in the acute hospital IQR and VBP programs (NQF #2158), but there are differences. The MSPB measure evaluates all Medicare Parts A and B spending across all providers for an episode of care triggered by a hospital stay relative to national median spending for episodes across all hospitals. CMS says that the MSPB-PAC measures differ in that they exclude a limited set of unrelated services while the MSPB measure itself does not exclude any services.

The MSPB-PAC episodes are defined to begin within 30 days of discharge from an acute inpatient stay. That is, an LTCH stay that begins within 30 days of discharge from an acute hospital will be counted in both the MSPB and MSPB-PAC LTCH measures. CMS believes this overlap will create continuous accountability and align provider incentives.

One unique aspect of the proposed MSPB-PAC LTCH is that it separately treats episodes paid under the two LTCH payment policies. That is, standard and site neutral episodes would not be compared to each other.

Discharge to Community. This proposed claims-based risk-adjusted measure assesses "successful" discharge to the community from an LTCH, defined as those including no unplanned hospitalizations in an acute hospital or LTCH and no death in the 31 days following discharge. Community is defined using patient discharged status codes (01,06,81, and 86) as home or self-care, with or without home health services.

Preventable Readmissions. The third measure proposed to begin with FY 2018 payment would assess the risk-standardized readmission rate of potentially preventable readmissions for Medicare beneficiaries within 30 days of discharge from an LTCH. Readmissions include those to a short-stay hospital or an LTCH that are unplanned and potentially preventable. Potentially preventable readmissions are defined as those for which the probability of occurrence could be minimized with adequately planned, explained, and implemented post-discharge instructions, including the establishment of appropriate follow-up ambulatory care. Claims data for a two-year period would be used to calculate the measure. For the FY 2018 payment determination, the performance period would be CYs 2016 and 2017.

2. New LTCH QRP Measure for FY 2020

CMS proposes one new measure to begin with the FY 2020 payment determination: Drug Regiment Review Conducted with Follow-up for Identified Issues PAC. This measure would address the IMPACT Act domain of medication reconciliation. Using three standardized items

from the LTCH CARE data set, the measure would report the percentage of patient stays in which a drug regiment review was conducted at the time of admission and timely follow-up with a physician occurred each time potentially clinically significant medication issues were identified during the stay. The measure is not risk adjusted. For FY 2020, CARE data for three quarters from April 1, 2018 through December 31, 2018 would be used to calculate measure performance. For later years, data for a full calendar year would be used.

LTCHQR Program Measures				
Measure Title	**FYs 2014and 2015**	**FY 2016**	**FY 2017**	**FY 2018**
NHSN Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138)	X	X	X	X
NHSN Central line-associated Blood Stream Infection (CLABSI) Outcome Measure (NQF #0139)	X	X	X	X
Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short-Stay) (NQF #0678)		X	X	X
Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay) (NQF #0680)		X	X	X
Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431)		X	X	X
NHSN Facility-Wide Inpatient Hospital-onset Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure (NQF #1716)			X	X
NHSN Facility-Wide Inpatient Hospital-onset *Clostridium Difficile* Infection (CDI) Outcome Measure (NQF #1717)			X	X
All-Cause Unplanned Readmissions for 30 Days Post Discharge from LTCHs (NQF #2512)			X	X
Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (Application of NQF #0674)				X
Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631)				X
Change in Mobility among Long-Term Care Hospital Patients Requiring Ventilator Support (NQF #2632)				X
NHSN Ventilator Associated Event Outcome Measure				X
Medicare spending per beneficiary MSPB-PAC LTCH				*Proposed*
Discharge to Community PAC LTCH				*Proposed*
Preventable Readmissions 30 Days Post LTCH Discharge				*Proposed*
Drug Regimen Review Conducted with Follow-up				*Proposed 2020*

D. Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program

In this rule, CMS proposes to make the following changes to the IPFQR Program measures beginning in FY 2019:

- The existing measure “Screening for Metabolic Disorders” would be modified to exclude patients with a length of stay equal to or greater than 365 days or less than or equal to 3

days. The current exclusion differs in that the lower end is less than 3 days. This would align with other IPFQR Program measures that have short stay exclusions.

- Addition of the measure Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge (SUB-3) and the Subset Measure Alcohol & Other Drug Use Disorder Treatment at Discharge (SUB-3a) (NQF #1664). These measures assess patients identified with an alcohol or drug use disorder who receive or refuse at discharge a prescription for FDA-approved medications OR who receive or refuse a referral for addiction treatment.
- Addition of the measure 30-Day All Cause Readmission Following Psychiatric Hospitalization in an IPF. This measure would assess the rate of admissions to IPFs or acute care hospitals that occurs between days 3 and 30 post-discharge, except those considered planned under the CMS Planned Readmission algorithm. Claims data for a 24-month period would be used to calculate the rates. The measure would be risk adjusted, but not for SDS factors.

IPFQR Program Measures for FY 2019 ***(Proposals in Italics)***	
Measure ID	**Measure Description**
HBIPS-2	Hours of Physical Restraint Use (NQF #0640)
HBIPS-3	Hours of Seclusion Use (NQF #0641)
HBIPS-5	Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification (NQF #0560)
FUH	Follow-Up After Hospitalization for Mental Illness (NQF #0576)
SUB-1	Alcohol Use Screening (NQF #1661)
SUB-2 and SUB-2a	Alcohol Use Brief Intervention Provided or Offered and the subset, Alcohol Use Brief Intervention (NQF #1663)
TOB-1	Tobacco Use Screening (NQF #0651)
TOB-2 and TOB-2a	Tobacco Use Treatment Provided or Offered and the subset, Tobacco Use Treatment (during the hospital stay) (NQF #1654)
TOB-3 and TOB-3a	Tobacco Use Treatment Provided or Offered at Discharge and the subset, Tobacco Use Treatment at Discharge (NQF #1656)
IMM-2	Influenza Immunization (NQF #1659)
N/A	Transition Record with Specified Elements Received and Discharged Patients (NQF #0647)
N/A	Timely Transmission of Transition Record (NQF #0648)
N/A	Screening for Metabolic Disorders
N/A	Influenza Vaccination Coverage Among Healthcare Personnel
N/A	Assessment of Patient Experience of Care
N/A	Use of an Electronic Health Record (EHR)
Sub-3 and Sub3a	*Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and the subset measure Alcohol & Other Drug Use Disorder Treatment at Discharge (NQF #1664)*
Under review	*Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an IPF*

E. Clinical Quality Measurement for Eligible Hospitals and Critical Access Hospitals Participating in EHR Incentive Programs in 2017

A hospital that is not identified as a meaningful EHR user under the Medicare EHR Incentive Program is subject to a reduction of 2.1 percentage points in the update factor for FY 2017. In the impact analysis section of the final rule, CMS estimates that 147 hospitals will be subject to this update reduction.

CMS previously adopted for FY 2017 a CQM reporting period of one year (four quarters), except that hospitals and CAHs participating for the first year may report for any continuous 90-day period within CY 2017. In this rule, CMS proposes the following specific reporting period for hospitals and CAHs participating in the Medicare EHR Incentive Programs in 2017:

- For eligible hospitals and CAHs reporting CQMs by attestation, reporting for CY 2017 (for the four calendar year quarters) would be required by February 28, 2018. For those demonstrating meaningful use for the first time in 2017, attestation by that same date could alternatively be made for any continuous 90-day reporting period.
- For eligible hospitals and CAHs reporting CQMs electronically, the submission period for CY 2017 (for the four calendar year quarters) ends February 28, 2018.
- These reporting periods would apply for Medicaid, but states determine data submission methods and deadlines.

In order to align measures with the IQR Program, CMS proposes to remove 13 CQMs from the set of those available for reporting by eligible hospitals and CAHs under the Medicare and Medicaid EHR Incentive Programs. The list of measures proposed for removal appears in section VIII.A.1 above. CMS notes that all of the 16 remaining measures on Table 10 of the Stage 2 final rule (77 FR 54083-87) remain available for reporting, including one measure that relates to outpatient care and is not part of the IQR Program (ED 3, NQF #0496). The following CQM requirements apply:

- Eligible hospitals and CAHs reporting CQMs by attestation report on all 16 CQMs.
- For electronic reporting report on 15 of the 16 CQMs (the outpatient measure is not required). This is the proposed requirement for eligible hospitals and CAHs reporting for the EHR Incentive Program alone or for it and the IQR Program. Electronic reporting occurs through the QualityNet portal.

CMS proposes to continue its policy that electronic submission of CQMs must involve use of the most recent version of the CQM electronic specification for each CQM to which the EHR is certified. For electronic reporting in 2017, this means eligible hospitals and CAHs would be required to use the Spring 2017 version of the CQM electronic specifications available on the eCQI Resource Center Web page (https://ecqi.healthit.gov/).

The FY 2016 IPPS/LTCH PPS final rule (80 FR 49759), provided that an EHR certified for CQMs under the 2014 Edition certification criteria does not need to be recertified each time it is updated to a more recent version of the CQMs. Therefore, CMS proposes to accept the use of CEHRT certified to ONC's 2014 or 2015 Edition for CQM reporting in 2017. Certification to the 2015 Edition is expected to be available in 2016. Readers are referred to the EHR Incentive Program website for guides and tip sheets (http://www.cms.gov/ehrincentiveprograms).

Appendix: IPPS Regulatory Impact Analysis Table

Appendix: IPPS Regulatory Impact Analysis Table

TABLE I.—IMPACT ANALYSIS OF PROPOSED CHANGES TO THE IPPS FOR OPERATING COSTS FOR FY 2017

	Number of Hospitals[1]	Proposed Hospital Rate Update and Documentation and Coding Adjustment (1)[2]	Proposed FY 2017 Weights and DRG Changes with Application of Recalibration Budget Neutrality (2)[3]	Proposed FY 2016 Wage Data under New CBSA Designations with Application of Wage Budget Neutrality (3)[4]	FY 2017 MGCRB Reclassifications (4)[5]	Proposed Rural and Imputed Floor with Application of National Rural and Imputed Floor Budget Neutrality (5)[6]	Application of the Proposed Frontier Wage Index and Proposed Out-Migration Adjustment (6)[7]	All Proposed FY 2017 Changes (7)[8]
All Hospitals	3,330	0.9	0	0	0	0	0.1	0.7
By Geographic Location:								
Urban hospitals	2,512	0.8	0	0	-0.1	0	0.1	0.6
Large urban areas	1,378	0.8	0.1	0	-0.3	-0.1	0	0.6
Other urban areas	1,134	0.9	0	0	0.1	0.2	0.2	0.7
Rural hospitals	818	1.5	-0.4	0.1	1.4	-0.2	0.1	0.8
Bed Size (Urban):								
0-99 beds	656	0.8	-0.2	0.2	-0.5	0.1	0.2	0.7
100-199 beds	765	0.9	-0.2	0	0	0.3	0.2	0.5
200-299 beds	449	0.9	-0.1	-0.1	0.1	0	0.1	0.5
300-499 beds	429	0.9	0.1	0.1	-0.2	0	0.2	0.7
500 or more beds	213	0.8	0.2	-0.1	-0.2	-0.1	0	0.8
Bed Size (Rural):								
0-49 beds	320	1.3	-0.5	0.1	0.3	-0.2	0.3	0.6
50-99 beds	292	1.7	-0.6	0.1	0.8	-0.1	0.1	0.8
100-149 beds	119	1.5	-0.4	0	1.5	-0.2	0.2	0.6
150-199 beds	46	1.5	-0.2	0.1	1.7	-0.2	0	1.0
200 or more beds	41	1.5	-0.1	0.2	2.5	-0.2	0	1.2
Urban by Region:								
New England	116	0.7	0	-0.4	1.3	0.8	0	-0.6
Middle Atlantic	315	0.8	0.1	-0.3	0.5	-0.2	0.1	0.2
South Atlantic	406	0.9	0	-0.1	-0.4	-0.2	0.1	0.8
East North Central	390	0.8	0	0.1	-0.2	-0.3	0	1.1
East South Central	147	0.9	0	-0.2	-0.4	-0.3	0	1.0
West North Central	163	1.0	0.1	0	-0.7	-0.3	0.7	0.9
West South Central	384	0.8	0	0.3	-0.4	-0.3	0	1.2
Mountain	163	1.0	0	0.2	-0.4	0	0.2	0.7

	Number of Hospitals[1]	Proposed Hospital Rate Update and Documentation and Coding Adjustment (1)[2]	Proposed FY 2016 Weights and DRG Changes with Application of Recalibration Budget Neutrality (2)[3]	Proposed FY 2016 Wage Data under New CBSA Designations with Application of Wage Budget Neutrality (3)[4]	FY 2016 MGCR B Reclassifications (4)[5]	Proposed Rural and Imputed Floor with Application of National Rural and Imputed Floor Budget Neutrality (5)[6]	Application of the Proposed Frontier Wage Index and Proposed Out-Migration Adjustment (6)[7]	All Proposed FY 2016 Changes (7)[8]
Pacific	377	0.8	0	0.4	-0.4	1.1	0.1	0.4
Puerto Rico	51	0.8	0.1	-0.4	-0.9	0.2	0.1	0.3
Rural by Region:								
New England	21	1.2	-0.2	0.4	1.5	-0.2	0	1.2
Middle Atlantic	55	1.7	-0.4	0.1	0.6	-0.1	0.1	0.9
South Atlantic	127	1.4	-0.4	-0.1	2.5	-0.2	0.1	0.8
East North Central	115	1.6	-0.4	0	1.0	-0.1	0	0.9
East South Central	156	1.0	-0.3	0.4	2.1	-0.3	0.1	0.7
West North Central	99	2.1	-0.4	0	0.3	-0.1	0.3	1.0
West South Central	161	1.6	-0.5	0.2	1.6	-0.2	0.1	0.9
Mountain	60	1.6	-0.4	0.1	0.2	-0.1	0.1	0.7
Pacific	24	1.7	-0.5	-0.2	1.3	-0.1	0	0.8
By Payment Classification:								
Urban hospitals	2,455	0.8	0	0	-0.1	0	0.1	0.6
Large urban areas	1,372	0.8	0.1	0	-0.3	-0.1	0	0.6
Other urban areas	1,083	0.9	0	0	0.2	0.2	0.2	0.7
Rural areas	875	1.6	-0.4	0.1	1.1	-0.1	0.3	0.9
Teaching Status:								
Nonteaching	2,275	1.0	-0.2	0	0.2	0.1	0.1	0.6
Fewer than 100 residents	804	0.9	0	0	-0.1	0	0.2	0.7
100 or more residents	251	0.8	0.2	-0.1	-0.1	-0.2	0	0.8
Urban DSH:								
Non-DSH	597	0.9	0	-0.1	0.1	-0.1	0.1	0.5
100 or more beds	1,608	0.8	0.1	0	-0.1	0	0.1	0.7
Less than 100 beds	330	0.8	-0.3	0.1	-0.6	0.1	0.1	0.5
Rural DSH:								
SCH	266	2	-0.5	-0.1	0.1	-0.1	0.1	0.5
RRC	347	1.5	-0.3	0.1	1.5	-0.2	0.3	0.9
100 or more beds	33	0.8	-0.4	-0.1	2.9	-0.3	0.1	0.5
Less than 100 beds	149	0.7	-0.4	0.1	1.4	-0.3	0.5	0.2
Urban teaching and DSH:								

	Number of Hospitals[1]	Proposed Hospital Rate Update and Documentation and Coding Adjustment (1)[2]	Proposed FY 2016 Weights and DRG Changes with Application of Recalibration Budget Neutrality (2)[3]	Proposed FY 2016 Wage Data under New CBSA Designations with Application of Wage Budget Neutrality (3)[4]	FY 2016 MGCR B Reclassifications (4)[5]	Proposed Rural and Imputed Floor with Application of National Rural and Imputed Floor Budget Neutrality	Application of the Proposed Frontier Wage Index and Proposed Out-Migration Adjustment (6)[7]	All Proposed FY 2016 Changes (7)[8]
Both teaching and DSH	880	0.8	0.1	0	-0.2	-0.1	0.1	0.7
Teaching and no DSH	107	0.8	0	0	0.7	-0.1	0	0.2
No teaching and DSH	1,058	0.8	-0.1	0.1	0	0.2	0.1	0.5
No teaching and no DSH	410	0.8	0	-0.1	-0.3	0	0.1	0.7
Special Hospital Types:								
RRC	193	0.8	-0.1	0.2	2	-0.1	0.4	1.1
SCH	326	2	-0.3	-0.1	0	0	0	1.0
MDH	146	1.6	-0.6	0	0.5	-0.1	0.2	0.8
SCH and RRC	126	2	-0.3	0.1	0.4	-0.1	0	1.2
MDH and RRC	15	1.8	-0.5	-0.1	0.8	-0.1	0	1.3
Type of Ownership:								
Voluntary	1,914	0.9	0	0	0	0	0.1	0.7
Proprietary	858	0.9	0	0.1	0.1	0	0.1	0.8
Government	516	0.9	0	-0.2	-0.2	0.1	0.1	0.5
Medicare Utilization as a Percent of Inpatient Days:								
0-25	517	0.7	0.1	0	-0.4	0.1	0	0.7
25-50	2,128	0.9	0	0	0	0	0.1	0.7
50-65	546	1.1	-0.2	-0.1	0.6	0.1	0.1	0.5
Over 65	94	1.1	-0.3	0.3	-0.5	0.3	0.2	0.9
FY 2017 Reclassifications by the Medicare Geographic Classification Review Board:								
All Reclassified Hospitals	853	0.9	0	0	2.1	-0.1	0	0.6
Non-Reclassified Hospitals	2,477	0.9	0	0	-0.9	0	0.1	0.7
Urban Hospitals Reclassified	576	0.8	0	0	2	-0.1	0	0.5

	Number of Hospitals[1]	Proposed Hospital Rate Update and Documentation and Coding Adjustment (1)[2]	Proposed FY 2016 Weights and DRG Changes with Application of Recalibration Budget Neutrality (2)[3]	Proposed FY 2016 Wage Data under New CBSA Designations with Application of Wage Budget Neutrality (3)[4]	FY 2016 MGCR B Reclassifications (4)[5]	Proposed Rural and Imputed Floor with Application of National Rural and Imputed Floor Budget Neutrality	Application of the Proposed Frontier Wage Index and Proposed Out-Migration Adjustment (6)[7]	All Proposed FY 2016 Changes (7)[8]
Urban Nonreclassified Hospitals	1,879	0.8	0.1	0	-0.9	0.1	0.1	0.7
Rural Hospitals Reclassified Full Year	277	1.6	-0.3	0.1	2.3	-0.2	0	1.0
Rural Nonreclassified Hospitals Full Year	484	1.5	-0.5	0.2	-0.2	-0.1	0.3	0.7
All Section 401 Reclassified Hospitals:	57	1.7	-0.2	0.2	-0.4	0	1.2	1.0
Other Reclassified Hospitals (Section 1886(d)(8)(B))	57	1.2	-0.4	0.1	3	-0.3	0	0.6

[1] Because data necessary to classify some hospitals by category were missing, the total number of hospitals in each category may not equal the national total. Discharge data are from FY 2015, and hospital cost report data are from reporting periods beginning in FY 2012 and FY 2013.

[2] This column displays the payment impact of the proposed hospital rate update and other proposed adjustments including the proposed 1.55 percent adjustment to the national standardized amount and hospital-specific rate (the estimated 2.8 percent market basket update reduced by the 0.5 percentage point for the proposed multifactor productivity adjustment and the 0.75 percentage point reduction under the Affordable Care Act), the -1.5 percent proposed documentation and coding adjustment to the national standardized amount and the proposed adjustment of (1/0.998) to permanently remove the -0.2 percent reduction, and the proposed 1.006 temporary adjustment to address the effects of the 0.2 percent reduction in effect for FYs 2014 through 2016 related to the 2-midnight policy.

[3] This column displays the payment impact of the proposed changes to the Version 34 GROUPER, the proposed changes to the relative weights and the recalibration of the MS-DRG weights based on FY 2015 MedPAR data in accordance with section 1886(d)(4)(C)(iii) of the Act. This column displays the application of the proposed recalibration budget neutrality factor of 0.999006 in accordance with section 1886(d)(4)(C)(iii) of the Act.

[4] This column displays the payment impact of the proposed update to wage index data using FY 2013 cost report data and the OMB labor market area delineations based on 2010 Decennial Census data. This column displays the payment impact of the application of the proposed wage budget neutrality factor, which is calculated separately from the proposed recalibration budget neutrality factor, and is calculated in accordance with section 1886(d)(3)(E)(i) of the Act. The proposed wage budget neutrality factor is 0.999785.

[5] Shown here are the effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB) along with the effects of the continued implementation of the new OMB labor market area delineations on these reclassifications. The effects demonstrate the FY 2017 payment impact of going from no reclassifications to the reclassifications scheduled to be in effect for FY 2017. Reclassification for prior years has no bearing on the payment impacts shown here. This column reflects the proposed geographic budget neutrality factor of 0.988816.

[6] This column displays the effects of the proposed rural and imputed floor based on the continued implementation of the new OMB labor market area delineations. The Affordable Care Act requires the rural floor budget neutrality adjustment to be 100 percent national level adjustment. The proposed rural

floor budget neutrality factor (which includes the proposed imputed floor) applied to the wage index is 0.993806. This column also shows the effect of the 3-year transition for hospitals that were located in urban counties that became rural under the new OMB delineations or hospitals deemed urban where the urban area became rural under the new OMB delineations, with a proposed budget neutrality factor of 0.999999.

[7] This column shows the combined impact of the policy required under section 10324 of the Affordable Care Act that hospitals located in frontier States have a wage index no less than 1.0 and of section 1886(d)(13) of the Act, as added by section 505 of Pub. L. 108-173, which provides for an increase in a hospital's wage index if a threshold percentage of residents of the county where the hospital is located commute to work at hospitals in counties with higher wage indexes. These are non-budget neutral policies.

[8] This column shows the proposed changes in payments from FY 2016 to FY 2017. It reflects the impact of the proposed FY 2017 hospital update and the proposed adjustment for documentation and coding. It also reflects proposed changes in hospitals' reclassification status in FY 2017 compared to FY 2016. It incorporates all of the proposed changes displayed in Columns 1 through 6. The sum of these impacts may be different from the proposed percentage changes shown here due to rounding and interactive effects.

.