Executive Summary: CMS 2017 IPPS Final Rule
Key Financial and Operational Impacts from the Final 2017 IPPS Rule:

The 2017 inpatient prospective payment system (IPPS) final rule was made available on August 2, 2016. A detailed summary of the rule will be available on the HFMA Regulatory Resources page shortly.

1) **Base Operating Rate**: The IPPS base operating rate increased by .95% for hospitals that successfully reported quality measures and are "meaningful users" of certified electronic health records (EHRs). The table below lists the final operating rates for hospitals under a variety of circumstances.

FY17 FINAL RULE TABLES 1A-1D

	Standardized Operating Amounts Wage Index > 1		**Standardized Operating Amounts Wage Index < 1**	
	Labor	Non-Labor	Labor	Non-Labor
Submitted Quality Data and Is a Meaningful User	$3,839.57	$1,677.06	$3,420.31	$2,096.32
Did Not Submit Quality Data and Is a Meaningful User	$3,814.07	$1,665.92	$3,397.59	$2,082.40
Submitted Quality Data and Is Not a Meaningful User	$3,763.08	$1,643.65	$3,352.17	$2,054.56
Did Not Submit Quality Data and Is a Not Meaningful User	$3,737.58	$1,632.51	$3,329.46	$2,040.63
Puerto Rico	N/A	N/A	$3,420.31	$2,096.32

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.

2) **National Capital Rate**: The final national capital rate for FY17 is $446.81.

3) **Outlier Threshold**: The final fixed loss outlier threshold increases to $23,570, which will decrease outlier payments.

4) **Documentation and Coding**: CMS finalizes its proposal to complete the $11 billion recoupment mandated by the American Taxpayer Relief Act of 2012 by making an estimated -1.5 percent adjustment to the FY17 standardized amounts and leaving in place the cumulative the -2.4 percent adjustments made for FY14 through FY16. For FY18 through FY23 the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) replaces the one-time FY18 increase to reverse

the cumulative effects of the documentation and coding adjustments on base rates with rate increases equal to 0.5 percent per year. Section 414 of MACRA also removes the HHS 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 FY10.

5) **Reversal of Two-Midnight Related Payment Reduction**: CMS finalizes its proposal to reverse the unsubstantiated .2% reduction in inpatient MS-DRG payments as a result of the implementation of the two-midnight rule that began in FY14. CMS implements these policies by including a permanent factor of 1/0.998 and a temporary one-time factor of 1.006 in calculating the FY17 standardized amount, the hospital-specific payment rates, and the national capital federal rate.

6) **Overall impact of Other Policy Changes**: The final rule impact analysis shows average per case operating payments increasing 0.9%. However, this only includes policy changes related to productivity adjustments as mandated by the Affordable Care Act (ACA), documentation and coding, the .2% two-midnight "give-back," wage index frontier adjustment, and the increase of the fixed loss outlier threshold. Please see Table I in the attached Appendix for specific impacts by type of hospital and region. The policy changes discussed below are not included in CMS's impact analysis. It is estimated that when incorporated into the analysis the net aggregate effect on payments in FY17 will reduce per unit payments by about -$306 million relative to FY16.

7) **Readmissions Penalty**: The penalty for excess readmissions for select conditions remains at 3% of operating payments for FY17. CMS analysis shows payments to an estimated 2,588 hospitals will be reduced by $528 million, an additional reduction of $108 million compared to FY16.

   The payment adjustment factors are available here.

   For FY17 CMS will add a readmissions measure for coronary artery bypass grafting (CABG).

8) **Value Based Purchasing Program**: The hospital VBP will reduce payments by 2% in FY17. The program is budget neutral, but will redistribute about $1.8 billion from low performing hospitals to high performing hospitals based on their historical performance scores. Table 16A provides updated proxy factors based on the March 2016 update to the FY15 MedPAR file.

   The final rule adds measures and makes technical changes to existing measures that providers need to be aware of.

   Included in the Appendix are tables that provide domain weighting, case minimums, domain scoring minimums for FY19, and measures for the years 2017 - 2022.

9) **HAC:** An estimated 771 hospitals will have their total IPPS payments reduced by 1% in FY17 for the hospital-acquired conditions (HAC) penalty. A table in the Appendix includes HAC measures for 2015 – 2019.

10) **Notice of Outpatient Observation Status to Medicare Beneficiaries**: The final rule includes regulations to implement the Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act[1] which would require hospitals and critical access hospitals (CAHs), as a 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[2] receiving observation services, and the implications of that status.

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 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 is revising the MOON in response to comments. Stakeholders have 30 days in which to comment on the revised notice (which is available here). CMS anticipates that final Paperwork Reduction Act approval of the MOON will occur around the time the implementing regulations are effective. Approval will be announced on the CMS Beneficiary Notices Initiative web site and in a Health Plan Management System memorandum to Medicare Advantage plans. Upon Office of Personnel Management approval, hospitals will have 90 days to fully implement use of the MOON.

[1] The Notice of Observation Treatment and Implication for Care Eligibility Act, Public Law 114-42.
[2] 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.

Appendix: *Value-based Purchasing Tables*

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%

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

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					X
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

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				X	X
HF payment per 30-day episode				X	X
*CMS intends to propose removal of the current PSI-90 composite measure beginning with FY 2019 payment, and will propose the modified PSI-90 measure for addition to the VBP Program as soon as possible taking into account statutory constraints on addition of measures to the program. **In the Outpatient PPS proposed rule for 2017, CMS proposes to exclude the HCAHPS pain management dimension from the VBP Program scoring beginning with FY 2018 payment.					

Appendix: Hospital-Acquired Conditions Table

Summary Table: HAC Reduction Program Measures, Performance Periods, and Domain Weights					
	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	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	10/1/15-6/30/17
Domain 1 weight	35%	25%	15%	X	X
Domain 2: CDC HAI Measures					
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 (SSI): ◦ SSI Following Colon Surgery ◦ SSI Following Abdominal Hysterectomy		X	X	X	X
Methicillin-resistant staphylococcus aureus (MRSA)			X	X	X
Clostridium difficile			X	X	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 did not propose weightings for FYs 2018 or 2019. Continuation of current measures in these years is implied in the discussion of the proposed applicable time periods.					

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Appendix: Impact Analysis Table

TABLE I.—IMPACT ANALYSIS OF CHANGES TO THE IPPS FOR OPERATING COSTS FOR FY 2017								
	Number of Hospitals[1]	Hospital Rate Update and Documentation and Coding Adjustment (1)[2]	FY 2017 Weights and DRG Changes with Application of Recalibration Budget Neutrality (2)[3]	FY 2017 Wage Data under New CBSA Designations with Application of Wage Budget Neutrality (3)[4]	FY 2017 MGCRB Reclassifications (4)[5]	Rural and Imputed Floor with Application of National Rural and Imputed Floor Budget Neutrality (5)[6]	Application of the Frontier Wage Index and Out-Migration Adjustment (6)[7]	All FY 2017 Changes (7)[8]
All Hospitals	3,330	1.0	0.0	0.0	0.0	0.0	0.1	0.9
By Geographic Location:								
Urban hospitals	2,515	0.9	0.0	0.0	-0.1	0.0	0.1	0.9
Large urban areas	1,380	0.9	0.1	0.0	-0.3	-0.1	0.0	0.8
Other urban areas	1,135	1.0	0.0	0.0	0.1	0.2	0.2	1.0
Rural hospitals	815	1.6	-0.4	0.1	1.4	-0.2	0.1	1.2
Bed Size (Urban):								
0-99 beds	659	0.9	-0.2	0.2	-0.5	0.1	0.2	0.9
100-199 beds	767	1.0	-0.1	0.0	0.0	0.3	0.2	0.7
200-299 beds	446	1.0	-0.1	-0.1	0.1	0.0	0.1	0.7
300-499 beds	431	1.0	0.1	0.0	-0.2	0.0	0.2	0.9
500 or more beds	212	0.9	0.2	0.0	-0.2	-0.1	0.0	1.1
Bed Size (Rural):								
0-49 beds	317	1.5	-0.5	0.1	0.2	-0.2	0.3	1.0
50-99 beds	292	1.8	-0.6	0.1	0.8	-0.1	0.1	1.3
100-149 beds	120	1.6	-0.4	0.0	1.5	-0.2	0.2	1.0
150-199 beds	46	1.7	-0.2	0.2	1.7	-0.2	0.0	1.4
200 or more beds	40	1.6	-0.1	0.2	2.5	-0.2	0.0	1.5
Urban by Region:								
New England	116	0.8	0.0	-0.5	1.1	1.0	0.1	-0.4
Middle Atlantic	315	0.9	0.1	-0.1	0.8	-0.1	0.1	1.0
South Atlantic	407	1.0	0.0	-0.2	-0.5	-0.2	0.0	1.0
East North Central	390	0.9	0.0	-0.1	-0.2	-0.4	0.0	1.1
East South Central	147	1.0	0.0	-0.1	-0.4	-0.3	0.0	1.2
West North Central	163	1.1	0.1	-0.1	-0.8	-0.3	0.7	1.0
West South Central	385	0.9	0.0	0.2	-0.5	-0.3	0.0	1.3
Mountain	163	1.1	0.0	0.1	-0.4	0.0	0.2	0.9
Pacific	378	0.9	0.0	0.4	-0.4	1.0	0.1	0.6
Puerto Rico	51	0.9	0.1	-0.5	-1.0	0.1	0.1	0.3

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Rural by Region:								
New England	21	1.3	-0.2	0.3	1.4	-0.3	0.2	1.7
Middle Atlantic	54	1.7	-0.4	0.1	0.8	-0.2	0.1	1.5
South Atlantic	128	1.7	-0.5	-0.1	2.3	-0.2	0.1	1.0
East North Central	115	1.7	-0.4	0.0	1.0	-0.1	0.1	1.2
East South Central	155	1.1	-0.3	0.4	2.2	-0.3	0.1	1.1
West North Central	98	2.2	-0.4	0.0	0.2	-0.1	0.3	1.5
West South Central	160	1.6	-0.4	0.4	1.3	-0.2	0.1	1.2
Mountain	60	1.7	-0.4	0.1	0.2	-0.1	0.2	1.3
Pacific	24	1.9	-0.4	-0.3	1.3	-0.1	0.0	1.3
By Payment Classification:								
Urban hospitals	2,522	0.9	0.0	0.0	-0.1	0.0	0.1	0.9
Large urban areas	1,372	0.9	0.1	0.0	-0.3	-0.1	0.0	0.8
Other urban areas	1,150	1.0	0.0	0.0	0.1	0.2	0.2	1.0
Rural areas	808	1.6	-0.4	0.1	1.4	-0.2	0.1	1.2
Teaching Status:								
Nonteaching	2,266	1.1	-0.2	0.0	0.1	0.1	0.1	0.8
Fewer than 100 residents	815	1.0	0.0	0.0	-0.1	0.0	0.2	0.9
100 or more residents	249	0.9	0.2	0.0	-0.1	-0.2	0.0	1.1
Urban DSH:								
Non-DSH	589	0.9	-0.1	-0.2	0.2	-0.1	0.2	0.8
100 or more beds	1,642	0.9	0.1	0.0	-0.2	0.0	0.1	0.9
Less than 100 beds	363	1.0	-0.3	0.0	-0.5	0.1	0.1	0.7
Rural DSH:								
SCH	240	2.0	-0.6	0.1	0.1	-0.1	0.0	1.4
RRC	325	1.7	-0.3	0.1	1.8	-0.2	0.1	1.3
100 or more beds	29	0.9	-0.4	0.1	2.9	-0.4	0.1	0.6
Less than 100 beds	142	0.8	-0.4	0.2	1.3	-0.4	0.7	0.3
Urban teaching and DSH:								
Both teaching and DSH	898	0.9	0.1	0.0	-0.2	-0.1	0.1	1.0
Teaching and no DSH	109	0.9	0.0	-0.1	1.1	-0.1	0.0	0.6
No teaching and DSH	1,107	1.0	-0.1	0.1	-0.1	0.2	0.1	0.7

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	Number of Hospitals[1]	Hospital Rate Update and Documentation and Coding Adjustment (1)[2]	FY 2017 Weights and DRG Changes with Application of Recalibration Budget Neutrality (2)[3]	FY 2017 Wage Data under New CBSA Designations with Application of Wage Budget Neutrality (3)[4]	FY 2017 MGCRB Reclassifications (4)[5]	Rural and Imputed Floor with Application of National Rural and Imputed Floor Budget Neutrality (5)[6]	Application of the Frontier Wage Index and Out-Migration Adjustment (6)[7]	All FY 2017 Changes (7)[8]
No teaching and no DSH	408	1.0	-0.1	-0.2	-0.4	-0.1	0.2	0.9
Special Hospital Types:								
RRC	189	0.8	-0.1	0.1	1.9	0.1	0.5	1.3
SCH	324	2.1	-0.3	-0.1	0.0	0.0	0.0	1.7
MDH	148	1.7	-0.6	0.0	0.6	-0.1	0.1	1.3
SCH and RRC	126	2.2	-0.3	0.1	0.4	-0.1	0.0	1.8
MDH and RRC	12	2.1	-0.6	-0.1	1.3	-0.1	0.0	2.3
Type of Ownership:								
Voluntary	1,927	1.0	0.0	0.0	0.0	0.0	0.1	0.9
Proprietary	881	1.0	0.0	0.1	0.0	0.0	0.1	0.9
Government	522	1.0	0.0	-0.1	-0.2	0.0	0.1	0.9
Medicare Utilization as a Percent of Inpatient Days:								
0-25	523	0.8	0.1	0.1	-0.4	0.1	0.0	0.9
25-50	2,122	1.0	0.0	0.0	0.0	0.0	0.1	0.9
50-65	545	1.2	-0.2	-0.1	0.6	0.1	0.1	1.0
Over 65	89	1.3	-0.3	0.3	-0.4	0.3	0.2	1.1
FY 2017 Reclassifications by the Medicare Geographic Classification Review Board:								
All Reclassified Hospitals	792	1.1	-0.1	0.0	2.3	-0.1	0.0	1.0

Non-Reclassified Hospitals	2,538	1.0	0.0	0.0	-0.8	0.0	0.1	0.9
Urban Hospitals Reclassified	533	1.0	0.0	-0.1	2.3	-0.1	0.0	0.9
Urban Nonreclassified Hospitals	1,938	0.9	0.1	0.0	-0.9	0.1	0.1	0.9
Rural Hospitals Reclassified Full Year	277	1.7	-0.3	0.1	2.2	-0.2	0.0	1.4
Rural Nonreclassified Hospitals Full Year	489	1.6	-0.4	0.2	-0.2	-0.2	0.3	1.1
All Section 401 Reclassified Hospitals:	69	1.7	-0.2	0.0	0.0	0.0	1.0	1.7
Other Reclassified Hospitals (Section 1886(d)(8)(B))	48	1.2	-0.4	0.1	3.1	-0.3	0.0	0.9

[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 hospital rate update and other adjustments, including the 1.65 percent adjustment to the national standardized amount and the hospital-specific rate (the estimated 2.7 percent market basket update reduced by 0.3 percentage point for the multifactor productivity adjustment and the 0.75 percentage point reduction under the Affordable Care Act), the -1.5 percent documentation and coding adjustment to the national standardized amount and the adjustment of (1/0.998) to permanently remove the -0.2 percent reduction, and the 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 changes to the Version 34 GROUPER, the 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 recalibration budget neutrality factor of 0.999079 in accordance with section 1886(d)(4)(C)(iii) of the Act.

[4] This column displays the payment impact of the 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 wage budget neutrality factor, which is calculated separately from the recalibration budget neutrality factor, and is calculated in accordance with section 1886(d)(3)(E)(i) of the Act. The wage budget neutrality factor is 1.000209.

[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 geographic budget neutrality factor of 0.988224.

[6] This column displays the effects of the 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 rural floor budget neutrality factor (which includes the imputed floor) applied to the wage index is 0.9932. 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 MB delineations, with a budget neutrality factor of 0.999997.

[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 not budget neutral policies.

[8] This column shows the estimated change in payments from FY 2016 to FY 2017.