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FINAL RULES: MEDICARE INPATIENT HOSPITAL PAYMENT FOR ACUTE AND LONG-TERM CARE HOSPITALS FOR FISCAL YEAR 2017; LONG-TERM CARE HOSPITAL PAYMENTS FOR SEVERE WOUNDS; MODIFICATION OF LIMITATIONS ON REDESIGNATION BY THE MEDICARE GEOGRAPHIC CLASSIFICATION REVIEW BOARD; EXTENSION OF PAYMENTS TO MEDICARE DEPENDENT HOSPITALS AND LOW-VOLUME HOSPITALS

SUMMARY

On August 2, 2016, the Centers for Medicare & Medicaid Services (CMS) released its final rule describing federal fiscal year (FY) 2017 policies and rates for Medicare's prospective payment systems for acute care inpatient hospitals (IPPS) and the long-term care hospital prospective payment system (LTCH PPS). Also as part of this rule, CMS finalized two additional rules addressing hospital payments. All three rules are summarized in this document. They will be published in the *Federal Register* on August 22, 2016.

Note: References in this summary to "the Act" refer to the Social Security Act.

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

CMS estimates that policies and rates in the final rule will increase combined operating and capital payments to the approximately 3,330 acute care hospitals paid under the IPPS by about $746 million in FY 2017 compared to FY 2016. The increase results from an increase of about $680 million in IPPS operating payments and an increase of about $66 million in IPPS capital payments. Although the annual update and other policies would increase operating payments in FY 2017 by approximately $987 million, reductions in Medicare disproportionate share hospital (DSH) and uncompensated care payments ($-178 million), changes in the Hospital Readmissions Reduction Program (-$108 million), and new technology add-on payments ($-20 million compared to $101 million in new technology add-on payments in 2016) reduce the total increase in operating payments to $680 million.[1]

A. Inpatient Hospital Operating Update for FY 2017

IPPS operating payment *rates* will increase for FY 2017 by 0.95 percent for hospitals which successfully report quality measures and are meaningful users of electronic health records (EHR). The payment rate update factors are summarized in the table below.

Factor	Percent Change
FY 2017 inflation (market basket) update	2.7
Multifactor productivity adjustment	-0.3
Additional -0.75 percentage point update adjustment required by the ACA	-0.75
Subtotal – "applicable percentage increase"	*1.65*
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)	*0.95*

The IPPS "applicable percentage increase" applies to the national operating standardized amounts and also to the hospital-specific rates on which some sole community hospitals (SCHs) and Medicare-dependent hospitals are paid. The documentation and coding recoupment adjustment does not apply to the hospital-specific rates of SCHs resulting in a 2.45 percentage point increase for these amounts rather than the 0.95 percentage point increase applicable to the national standardized operating amounts. CMS notes that MACRA requires it to make a 0.5 percent positive adjustment for each of FYs 2018 through 2023 to address the ending in FY 2017 of the documentation and coding recoupment rather than the large one-time positive adjustment that otherwise would have been made in FY 2018 to restore the reductions made in FYs 2014-2017.

[1] New technology add-on payments approved in this rule for five technologies are estimated to increase payments by $29 million, partially offsetting reductions of $49 million resulting from expiring new technology add-on payments for four technologies.

Hospitals that fail to participate successfully in the Hospital Inpatient Quality Reporting (IQR) Program or that 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 or do not successfully submit the required quality data are subject to a one-fourth reduction of the market basket update, which in FY 2017 is a reduction of 0.675 percentage points (prior to FY 2015, such hospitals received a 2 percentage point reduction). The statute additionally requires that the update for any hospital that is not a meaningful EHR user be reduced by three-quarters of the market basket update, which in FY 2017 is a reduction of 2.025 percentage points (the reduction for FY 2016 was one-half the market basket increase).

B. Payment Impacts

While the final FY 2017 standardized amounts received an "applicable percentage increase" of 1.65 percent from the FY 2016 rates, the CMS payment impact analysis shows average per case operating payments increasing 0.9 percent. Importantly, as discussed below, not all policy changes are reflected in this total. For example, reductions in payment due to the effects of policy changes related to disproportionate share hospital (DSH) payments and readmissions reductions are not included in the total. The factors that are included in the impact table of the final rule follow:

Contributing Factor	**National Percent Change**
FY 2017 increase in final rule payment rates (from table above)	+0.95
Frontier hospital wage index floor and out-migration wage adjustment	+0.1*
Other factors including changes in new technology payments and outliers, interactions, and rounding	-0.15
Total	*+0.9*

*The frontier hospital wage index floor increases payments about $58 million to 50 hospitals and the out-migration adjustment increases payments about $30 million to 277 providers.

Table I Impact Analysis

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

Hospital Type	**All Final Rule Changes**
All Hospitals	0.9%
Large Urban	0.8%
Other Urban	1.0%
Rural	1.2%
Major Teaching	1.1%

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

- The impact analysis includes estimates from the Medicare Office of the Actuary that under the final policies for FY 2017, payments for Medicare DSH and uncompensated care will be $178 million lower than in FY 2016. See section IV.F below for details of the policy changes.
- The Hospital Readmissions Reduction Program (HRRP) is estimated to reduce FY 2017 payments to an estimated 2,588 hospitals by $528 million, an additional reduction of $108 million compared to FY 2016.
- The HAC Reduction Program will reduce total IPPS payments by 1 percentage point to an estimated 771 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 $1.8 billion based on hospitals' performance scores.
- With respect to new medical service and technology add-on payments, CMS estimates that changes in these payments will result in a decrease in spending of about $20 million.

Based on the above estimates, the net aggregate effect of policies discussed above but not reflected in the Table 1 impact analysis on payments in FY 2017 will reduce per unit payments by about -$306 million relative to FY 2016.

C. IPPS Standardized Amounts for FY 2017

The final standardized amounts for FY 2017 appear in Tables 1A, 1B, 1C and 1D in the final rule, and are reproduced in the following tables.

FY 2017 FINAL RULE TABLES 1A-1D

TABLE 1A. 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 = 1.65 Percent)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = -0.375 Percent)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 0.975 Percent)		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -1.05 Percent)	
Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor
$3,839.57	$1,677.06	$3,763.08	$1,643.65	$3,814.07	$1,665.92	$3,737.58	$1,632.51

TABLE 1B. 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 = 1.65 Percent)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = -0.375 Percent)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 0.975 Percent)		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -1.05 Percent)	
Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor
$3,420.31	$2,096.32	$3,352.17	$2,054.56	$3,397.59	$2,082.40	$3,329.46	$2,040.63

TABLE 1C. 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	$3,420.31	$2,096.32
[1]For FY 2017, there are no CBSAs in Puerto Rico with a final national wage index greater than 1.				

TABLE 1D. CAPITAL STANDARD FEDERAL PAYMENT RATE	
	Rate
National	$446.81

D. Outlier Payments and Threshold

To qualify for outlier payments for high cost cases, a case must have costs greater than the sum of the prospective payment rate for the DRG, plus IME, DSH and new technology add-on payments, plus the "outlier threshold" or "fixed-loss" amount, which is $22,538 in FY 2016. The sum of these components is the outlier "fixed-loss cost threshold" applicable to a case. To determine whether the costs of a case exceed the fixed-loss cost threshold, a hospital's total covered charges billed for the case are converted to estimated costs using the hospital's cost-to-charge ratio (CCR). An outlier payment for an eligible case is then made based on a marginal cost factor, which is 80 percent of the estimated costs above the fixed-loss cost threshold.

FY 2017 outlier threshold. For FY 2017 the final outlier threshold is $23,570. In FY 2016 it was $22,538.

II. Changes to MS-DRG Classifications and Relative Weights

A. FY 2017 Documentation and Coding Adjustment

For FY 2017, CMS finalizes its proposal to complete the $11 billion recoupment mandated by ATRA by making a -1.5 percent adjustment to the FY 2017 standardized amounts and leaving in place the cumulative -2.4 percent adjustments made for FY 2014 through FY 2016.

B. Add-On Payments for New Services and Technologies

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

CMS is continuing new technology add-on payments in FY 2017 for the:

- CardioMEMS™ HF System
- BLINCYTO™
- LUTONIX® Drug Coated Balloon (DCB) Percutaneous Transluminal Angioplasty (PTA) Catheter
- In.PACT™ Admiral™ Paclitaxel Coated Percutaneous Transluminal Angioplasty (PTA) Balloon Catheter

CMS will discontinue new technology payments for:

- Kcentra™
- Argus® II System
- MitraClip® System
- Responsive Neurostimulator (RNS®) System

2. FY 2017 Applications for New Technology Add-On Payments

CMS received nine applications for new technology add-on payments for FY 2017. It is approving five of the seven applications for new technology add-on payments for FY 2017:

- MAGEC® Spinal Bracing and Distraction System (MAGEC® Spine) MAGEC® Spine
- Idarucizumab
- Defitelio®
- GORE®EXCLUDER® Iliac Branch Endoprosthesis (IBE)
- Vistogard™

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

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

CMS finalized three revisions 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 will implement the revisions beginning with the FY 2017 wage indexes.

B. Method for Computing the FY 2017 Unadjusted Wage Index

The final FY 2017 national average hourly wage, unadjusted for occupational mix is $41.1982.

C. Occupational Mix Adjustment to the FY 2017 Wage Index

The FY 2017 occupational mix-adjusted national average hourly wage is $41.1615. Since section 601 of the Consolidated Appropriations Act, 2016 provided for 100 percent payment based on the national standardized amount for Puerto Rico hospitals, CMS will no longer compute a separate occupational mix-adjusted Puerto Rico-specific average hourly wage.

The FY 2017 wage index uses data collected on the 2013 Medicare Wage Index Occupational Mix Survey. CMS notes that the FY 2019 occupational mix adjustment will require a new survey; CMS's CY 2016 survey is awaiting approval at OMB and can be accessed at: http://www.reginfo.gov/public/do/PRAViewICR?ref_nbr=201512-0938-011.

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 ("Lugar hospitals") that became rural, and hospitals that experienced a decrease in wage index under the new OMB delineations. FY 2017 will be the third and final year of the transition periods. CMS notes that if any affected hospital is approved for any wage index reclassification or redesignation for FY 2017, it will no longer be eligible for the remaining year of the transitional wage index.

E. Rural, Imputed, and Frontier Floors

CMS estimates that the rural floor will increase the FY 2017 wage index for 397 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 adjustment of 0.9930; hospitals located in other urban areas (populations of 1 million or fewer) will experience no change in payments; and urban hospitals in the New England region can expect a 1.0 percent increase in payments, primarily due to the application of the rural floor in Massachusetts and the imputed floor in Rhode Island. The application of the rural floor increases payments by $24 million to Massachusetts. Urban Puerto Rico hospitals will receive a 0.1 percent increase in IPPS payments.

CMS extends for one additional year (through September 30, 2017) its temporary imputed floor program whereby it imputes a "floor" for states with no rural counties. Under OMB's new labor market area delineations, Delaware, New Jersey and Rhode Island are all-urban states. CMS continues both the original imputed floor methodology (which benefits New Jersey and Delaware) and the alternative, temporary methodology for the benefit of Rhode Island, which has only one CBSA in contrast to 7 in New Jersey and 3 in Delaware.

CMS estimates an aggregate increase in payments in FY 2017 of roughly $10 million for New Jersey hospitals and $17 million for hospitals in Rhode Island. Overall, Delaware will see no net increase in payments (to the nearest million).

CMS continues without modification its frontier floor wage index policies for FY 2017. Thus, fifty hospitals in Montana, Nevada, North Dakota, South Dakota, and Wyoming will receive the frontier floor value of 1.0000 for FY 2017. This provision is not budget neutral, and CMS estimates an increase of approximately $58 million in IPPS operating payments in FY 2017 because of the frontier floor.

F. FY 2017 Wage Index Tables

In the FY 2016 IPPS/LTCH PPS final rule, CMS streamlined and consolidated the wage index tables associated with the IPPS proposed and final rules for FY 2016 and subsequent fiscal years. Prior to that, the wage index tables consisted of 12 tables (Tables 2, 3A, 3B, 4A, 4B, 4C, 4D, 4E, 4F, 4J, 9A, and 9C) that were made available via the Internet on the CMS Web site.

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

1. Finalization of Interim Final Rule on Modification of Limitations on Redesignation by MGCRB

CMS finalized an interim final rule to allow more than one reclassification to apply to urban hospitals redesignated as rural under §412.103 that are simultaneously seeking reclassification through the Medicare Geographic Reclassification Review Board (MGCRB). This change is effective for reclassification applications due to the MGCRB on September 1, 2016, for reclassification first effective for FY 2018. Such hospitals are eligible to use distance and average hourly wage criteria designated for rural hospitals at §412.230(b)(1) and (d)(1).

In addition, effective April 21, 2016, a hospital with an active MGCRB reclassification may simultaneously maintain rural status under §412.103, and receive a reclassified urban wage index during the years of its active MGCRB reclassification. The hospital is still considered rural under section 1886(d) of the Act and for other purposes. CMS also applies this policy when deciding timely appeals before the Administrator for cases that were denied by the MGCRB due to regulations in effect before April 21, 2016, which did not permit simultaneous §412.103 and MGCRB reclassifications.

CMS, in response to comments related to the IFC also clarified a number of issues:

- The rural distance and average hourly wage criteria will be used for hospitals with a §412.103 redesignation.
- The hospital's average hourly wage data will be compared to the average hourly wage of all other hospitals in its urban geographic location using the rural distance and average hourly wage criteria under §412.230(d)(1)(iii)(C).
- A §412.103 rural redesignated hospital can undergo an MGCRB reclassification back to the CBSA in which it is physically located if it meets the criteria for use of an urban area's or

another rural area's wage index at §412.230(d) using the average hourly wage criteria specified for rural hospitals.

- Hospitals may not have dual MGCRB reclassifications.
- Hospitals redesignated as rural under §412.103 may still apply for group reclassification with other urban hospitals located in the same geographically urban area to another urban area via the MGCRB in accordance with §412.234.
- Effective April 18, 2016 (the date of the public display of the IFC) and for future years, hospitals that already have an MGCRB reclassification can receive a §412.103 redesignation without losing their MGCRB reclassification.
- The wage data for a hospital that has both an MGCRB reclassification and a §412.103 redesignation will be included in the post-reclassified wage index of the area to which it is reclassified under the MGCRB rather than the rural area to which it is redesignated under §412.103.

Other MGCRB Reclassification and Redesignation Issues

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.

Currently applications for reclassification must be mailed or delivered to the MGCRB with a copy to CMS (which may not be submitted by fax or other electronic means). For applications for FY 2018 and subsequent years, CMS revises the policy. Applications and supporting documentation to be submitted to the MGCRB will be done by the method that the MGCRB prescribes; however, the application may be sent to CMS by email to wageindex@cms.hhs.gov. CMS notes that it is likely the MGCRB will still require paper applications.

Provisions Relating to Lugar Hospitals

CMS clarifies that a hospital with Lugar status under section 1886(d)(8)(B) of the Act may simultaneously receive an urban to rural reclassification under §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 purposes other than the wage index, a hospital with simultaneous Lugar status and §412.103 reclassification receives payment as a rural hospital.

H. Notification Regarding 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 under section 1886(d)(8)(E) of the Act and regulations. 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 finalizes its proposal to establish the second Monday in June as the "lock-in" date for the list of hospitals with rural status under §412.103 for a fiscal 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 will still be the filing date of the application. If the CMS Central Office is informed of a reclassification status after the second Monday in June, for wage index and budget neutrality purposes, the reclassification will not be reflected in the payment rates until the fiscal year following the next fiscal year.

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

CMS applies 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 final rule reflect the national labor-related share.

For Puerto Rico hospitals, CMS will no longer 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.

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

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

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. In this rule, CMS revises existing regulations at 42 CFR 412.64(d) to reflect the applicable percentage increase for a hospital that does not submit quality data or is not a meaningful user.

FY 2017	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	2.7	2.7	2.7	2.7
Adjustment for Failure to Submit Quality Data	0.0	0.0	-0.675	-0.675
Adjustment for Failure to be a Meaningful EHR User	0.0	-2.025	0.0	-2.025
MFP Adjustment	-0.3	-0.3	-0.3	-0.3
Statutory Adjustment	-0.75	-0.75	-0.75	-0.75
Applicable Percentage Increase Applied to Standardized Amount	1.65	-0.375	0.975	-1.05

For SCHs and MDHs, CMS adopts the same four possible applicable percentage increases shown in the table above. 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.

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

To qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2016, 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—
    - 1.6111, 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; and
- 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.

CMS notes that the median number of discharges for urban hospitals in each census region is greater than the national standard of 5,000; thus 5,000 discharges would be the minimum criteria for all hospitals (other than for osteopathic hospitals which is set at 3,000 discharges).

The median regional CMIs and median regional numbers of discharges are listed in the final rule; they reflect the updated FY 2015 MedPAR file containing data from additional bills received through March 2016.

C. 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.

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.

D. Indirect Medicare Education (IME) Payment Adjustment Factor for FY 2017 (§412.105)

Pursuant to statute,[2] for discharges occurring in FY 2017, CMS continues to apply the IME adjustment factor of 5.5 percent for every approximately 10-percent increase in a hospital's resident-to-bed ratio.

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

1. Eligibility for Empirically Justified Medicare DSH Payments and Uncompensated Care Payments

For FY 2017, CMS continues to make interim DSH payments equal to 25 percent of what the DSH payment would have been absent the ACA changes.

2. Uncompensated Care Payments

In brief, CMS finalizes the following policies for FY 2017 that differ from the FY 2016 policies:

- An average of data derived from three cost reporting periods instead of one cost reporting period will be used (discussed in more detail under Factor 3).
- 14 percent of Medicaid days will be used as a proxy for Medicare SSI days for Puerto Rico hospitals.

Regarding the uncompensated care portion of the DSH payment, for FY 2017 CMS finalizes these policies unchanged from the FY 2016 final rule:

- Low-income insured days will be used as a proxy for uncompensated care costs in FY 2017
- 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.[3]
- 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.

[2] 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.

[3]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.

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;
- 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.

As discussed in more detail in the next section, for FY 2018 and subsequent years, CMS proposed but did not finalize its methodology to incorporate worksheet S-10 data for allocating uncompensated care payments.

Proposed FY 2017 Factor 1

The June 2016 OACT estimate for Medicare DSH payments for FY 2017, before application of the ACA reduction, is $14.397 billion. Based on this, the estimate for empirically justified Medicare DSH payments for FY 2017 after the ACA reduction is $3.599 billion (25 percent of the total amount estimated). Thus, **CMS set FY 2017 Factor 1 at $10.797 billion ($14.397 billion minus $3.599 billion).**

Final FY 2016 Factor 2

For the FY 2017 final rule, CMS used CBO's March 2016 estimates of the effects of the ACA on health insurance coverage[4]. The CBO's March 2016 estimate of individuals under the age of 65 with insurance in CY 2016 is 90 percent and its estimate of this percentage in 2017 is also 90 percent. Thus, the CBO's most recent estimate of the rate of uninsurance in CY 2017 available for the final rule 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 2016 CBO estimate): 90 percent
- CY 2017 rate of insurance coverage (March 2016 CBO estimate): 90 percent
- FY 2016 rate of insurance coverage: (90 percent * .25) + (90 percent * .75) = 90 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 percent
- 1-|((0.10-0.18)/0.18)|= 1- 0.4444=0.5555 (55.56 percent)
- 0.5555 (55.56 percent) - .002 (0.2 percentage points for FY 2017 under section 1886(r)(2)(B)(i) of the Act) = 0.5536 or 55.36 percent
- 0.5536 = Factor 2

[4] https://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2014-04-ACAtables2.pdf

Thus, CMS calculated Factor 2 for the FY 2016 final rule to be 0.5536, or 55.36 percent, and the final uncompensated care amount for FY 2017 to be $10.797 billion multiplied by 0.5536 = $5.977 billion, which is about $429 million less than the FY 2016 uncompensated care payment total of about $6.406 billion; the percentage reduction is 6.7 percent.[5]

Final FY 2017 Factor 3

CMS finalizes its proposal to calculate Factor 3 for FY 2017 using the average of Medicaid and SSI data from three cost reporting periods.

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

CMS is not finalizing its proposal to incorporate Worksheet S-10 data into the computation of Factor 3 for FY 2018 at this time. CMS states that it plans to incorporate the use of Worksheet S-10 data into the calculation no later than FY 2021.

Specifically, CMS states that additional time may be needed to ensure consistency in submission of Worksheet S-10 data when filing their cost reports, such as software edits to flag negative, unusual, or missing data or a missing worksheet S-10. CMS also intends to develop more specific instructions and more uniform protocols for Worksheet S-10 data. CMS will also consider issuance of FAQs and hosting of educational seminars for hospitals and MACs as appropriate, coinciding with the issuance of revised cost report instructions. CMS states that given the 3-to 4-year lag between the ratesetting year and the cost report data that CMS uses to develop these rates, CMS believes that cost reporting periods beginning during FY 2017 would be the first cost reports available that would reflect revised Worksheet S-10 data.

With regard to the commenters' request for additional information about the review process, CMS states that it will provide standardized instructions to the MACs to guide them in determining when and how often a hospital's Worksheet S-10 should be reviewed. This is similar to but not identical to the annual desk review process for the IPPS wage index that many commenters recommended. CMS also elaborated on the following with respect to this process and how it could work. CMS:

- Intends to give consideration to establishing measures to identify "aberrant" data for further review, such as, but not necessarily limited to, hospitals with unusual data on Worksheet S-10, including different CCRs and charges as compared to Worksheet C.
- Will consider a recommendation to instruct MACs to audit selectively the cost reports of hospitals reporting the highest levels of uncompensated care, as well as a random mix of other hospitals by type, location or other criteria as appropriate.
- Will provide instructions to MACs that will include not only general guidance for review, but also, where appropriate, special instructions for review of certain unique categories of hospitals, such as the All Inclusive Rate Providers (AIRPs), and other mostly government-owned hospitals with unique charity care or charging practices.
- Will not make the MACs' review protocol public, as commenters have requested. All CMS desk review and audit protocols are confidential and are for CMS and MAC use only.

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

Other Methodological Considerations for FY 2018 and Subsequent Fiscal Years

Over the past several years, CMS noted that it has received technical comments from stakeholders regarding the timing of reporting charity care and the CCRs used in determining uncompensated care costs. CMS discussed these issues in the proposed rule and how it proposed to incorporate them into the calculation for uncompensated costs for FY 2018 and subsequent years.

Timing of Reporting Charity Care

CMS finalizes its proposal to revise line 20 of Worksheet S-10 to instruct hospitals to report the payment obligation for care "that was written off during this cost reporting period, regardless of when the services were provided." CMS states that this change must be effective prospectively for cost reporting periods beginning on or after October 1, 2016, because line 20 as it currently exists is used to calculate EHR incentive payments (in accordance with the policy stated in the final rule for the Electronic Health Record Incentive Program (75 FR 44456), and instituting a change to the instructions on line 20 without a prospective effective date would constitute retroactive rulemaking. CMS states that additional clarifications regarding charity care exclusions reported in previously filed cost reports may be forthcoming.

F. Hospital Readmissions Reduction Program (HRRP)

1. Addition of CABG Readmissions Measure

For FY 2017, CMS adopts without change from the proposed rule a methodology for the previously-finalized addition of the measure of 30-day, all cause, and unplanned readmissions following CABG. CABG admissions will be identified using the exclusions previously finalized in the FY 2015 IPPS/LTCH PPS final rule. Excluded admissions are 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 continue unchanged, and the established policy for excluding all admissions for patients enrolled in Medicare Advantage continues. The formula for calculating the readmissions adjustment factor is summarized in the chart at the end of this section, which is reproduced from the final rule.

2. Other HRRP Policies

The applicable period for FY 2017 is designated as 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) for FY 2017 will be based on data from the 3-year time period of July 1, 2012 through June 30, 2015.

The floor adjustment factor remains at 0.97, meaning that a hospital subject to the HRRP will have an adjustment factor that is between 1.0 (no reduction) and 0.9700 (greatest possible reduction).

G. Hospital Value-Based Purchasing (VBP) Program

A summary of final measures and domains for selected years appears in Summary Tables VBP-1 and VBP-2 is in the Appendix.

1. VBP Payment in FY 2017

CMS has posted on the FY 2017 IPPS final rule web page (link is on page 1 of this summary, see "FY 2017 Final Rule Tables") a Table 16A 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 and reflects changes based on the March 2016 update to the FY 2015 MedPAR file; these proxies therefore reflect the performance periods, measures, and domain weights in effect for that year. After hospitals have been given an opportunity to review and correct their actual TPSs for FY 2017 (expected in October 2016), CMS will add Table 16B to display the actual value-based incentive payment adjustment factors, exchange function slope, and estimated amount available for the FY 2017 program year.

2. Changes to the PSI 90 Measure for FY 2018

CMS finalizes its proposal 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 have measured performance for the 24-month period July 1, 2014 through June 30, 2016. The finalized period is 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.

3. Announcement of Future Removal of the PSI 90 Measure for 2019

CMS announces its intention to remove the PSI 90 measure from the VBP Program beginning with the FY 2019 program as part of next year's rulemaking because an ICD-10 version of the current PSI 90 measure is not currently being developed.

4. Intention to Propose Modified PSI 90 Measure for Future Years

CMS intends to propose addition of the modified version of PSI 90 to the VBP Program as soon as it is feasible. Specifically, the measure was changed during the 2014 National Quality Forum (NQF) maintenance review. The specific changes are discussed in section IV.I.3 below; CMS was unable to propose this modified version for VBP at this time because the statute requires that VBP Program measures be drawn from the IQR Program and be posted on the Hospital Compare website for one year prior to the start of the VBP Program performance period. Performance standards for VBP Program measures must be established at least 60 days prior to the start of the performance period.

5. Domain Name Change

The name of the Care Coordination and Patient-and Caregiver-Centered Experience of care domain is shortened to Person and Community Engagement, beginning with FY 2019.

6. 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 adopts its proposal 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.

7. New and Modified Measures for FY 2021

Beginning with FY 2021 payment, CMS finalizes its proposal to adopt two new measures and modify the existing pneumonia mortality measure.

New Measures. Two new risk-standardized payment measures are adopted 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 (HF). The measures are 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 finalizes its proposal to adopt a modified version of the pneumonia mortality measure into the VBP Program beginning with FY 2021 payment. 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.

8. Scoring of Efficiency Measures

CMS finalizes its proposal that the AMI and HF payment measures be scored in the same way as the existing MSPB measure. Under the finalized scoring approach, for achievement points, a ratio is 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 will be set at the median spending ratio across all hospitals for the performance period, and the benchmark will be the mean of the lowest decile of spending ratios during the performance period. A hospital will receive the maximum 10 points if it has a ratio at or below the benchmark; it will receive 0 points if it has a ratio above the achievement

threshold. Ratios that fall above the benchmark but at or below the achievement threshold will receive 1 to 9 points using the following formula:

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

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

For more detail on the MSPB scoring methodology, CMS refers readers to the FY 2012 IPPS/LTCH PPS final rule (76 FR 51654 through 51656). CMS codifies the scoring methodology for MSPB and all measures in the Efficiency and Cost Reduction domain at 42 CFR 412.160.

9. New Measure for FY 2022

CMS adopts one additional measure to the Clinical Care domain beginning with FY 2022 payment: Hospital 30-Day, All Cause, Risk-Standardized Mortality Rate following CABG (NQF #2558). Measure specifications are available at the same link provided above for the two new payment measures for FY 2021.

10. Performance and Baseline Periods

The baseline and performance period lengths and the periods finalized for FY 2019, FYs 2020, 2021 and 2022 are shown in the tables below.

Baseline and Performance Periods for FY 2019 and Selected Years			
Domain/Measure	**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 Mortality* THA/TKA*	36-month period (initial 24 month performance period for THA/TKA)	 7/1/09–6/30/12 7/1/10–6/30/13	 7/1/14–6/30/17 1/1/15–6/30/17
Safety** PC-01 and NHSN (CAUTI, CLABSI, SSI, CDI, MRSA)	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
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

Baseline and Performance Periods for FY 2019 and Selected Years			
Domain/Measure	**Period Length**	**FY 2019 Baseline Period**	**FY 2019 Performance Period**
* Previously finalized ** CMS intends to propose removing the current PSI 90 measure from the VBP Program beginning with FY 2019. If it were retained the baseline and performance periods would be July 1, 2011-June 30, 2013 and July 1, 2015- June 30, 2017, respectively. For FY 2018, the performance period for this measure is shortened to 15 months (July 1, 2014 to September 30, 2015) to avoid mixing ICD-9 and ICD-10 data.			

PREVIOUSLY ADOPTED BASELINE AND PERFORMANCE PERIODS FOR THE FY 2020 PROGRAM YEAR

Domain	Baseline period	Performance period
Clinical Care		
• Mortality (MORT-30–AMI, MORT–30–HF, MORT-30–PN)*.	• July 1, 2010–June 30, 2013	• July 1, 2015–June 30, 2018.
• THA/TKA*	• July 1, 2010–June 30, 2013	• July 1, 2015–June 30, 2018.

*Previously adopted baseline and performance periods that remain unchanged (80 FR 49562 through 49563).

PREVIOUSLY ADOPTED AND NEWLY FINALIZED BASELINE AND PERFORMANCE PERIODS FOR THE FY 2021 PROGRAM YEAR

Domain	Baseline period	Performance period
Clinical Care		
• Mortality (MORT-30–AMI, MORT–30–HF, MORT–30–COPD)*.	• July 1, 2011–June 30, 2014	• July 1, 2012–June 30, 2019.
• THA/TKA*	• April 1, 2011–March 31, 2014	• April 1, 2011–March 31, 2019.
• MORT–30–PN (updated cohort)	• July 1, 2012–June 30, 2015	• September 1, 2017–June 30, 2019.
Efficiency and Cost Reduction		
• MSPB	• January 1, 2017–December 31, 2017	• January 1, 2019–December 31, 2019.
• Payment (AMI Payment and HF Payment)	• July 1, 2012–June 30, 2015	• July 1, 2017–June 30, 2019.
Clinical Care		
• Mortality (MORT-30–AMI, MORT–30–HF, MORT–30–COPD)*.	• July 1, 2011–June 30, 2014	• July 1, 2016–June 30, 2019.
• THA/TKA*	• April 1, 2011–March 31, 2014	• April 1, 2016–March 31, 2019.
• MORT–30–PN (updated cohort)	• July 1, 2012–June 30, 2015	• September 1, 2017–June 30, 2019.
Efficiency and Cost Reduction		
• MSPB	• January 1, 2017–December 31, 2017	• January 1, 2019–December 31, 2019.
• Payment (AMI Payment and HF Payment)	• July 1, 2012–June 30, 2015	• July 1, 2017–June 30, 2019.
Clinical Care		
• Mortality (MORT-30–AMI, MORT–30–HF, MORT–30–COPD)*.	• July 1, 2011–June 30, 2014	• July 1, 2016–June 30, 2019.
• THA/TKA*	• April 1, 2011–March 31, 2014	• April 1, 2016–March 31, 2019.
• MORT–30–PN (updated cohort)	• July 1, 2012–June 30, 2015	• September 1, 2017–June 30, 2019.
Efficiency and Cost Reduction		
• MSPB	• January 1, 2017–December 31, 2017	• January 1, 2019–December 31, 2019.
• Payment (AMI Payment and HF Payment)	• July 1, 2012–June 30, 2015	• July 1, 2017–June 30, 2019.

*Previously adopted baseline and performance periods that remain unchanged (80 FR 49562 through 49563).

NEWLY FINALIZED BASELINE AND PERFORMANCE PERIODS FOR THE FY 2022 PROGRAM YEAR

Domain	Baseline period	Performance period
Clinical Care		
• Mortality (MORT-30–AMI, MORT–30–HF, MORT–30–COPD, MORT-30–CABG).	• July 1, 2012–June 30, 2015	• July 1, 2017–June 30, 2020.
• THA/TKA	• April 1, 2012–March 31, 2015	• April 1, 2017–March 31, 2020.
• MORT-30–PN (updated cohort)	• July 1, 2012–June 30, 2015	• September 1, 2017–June 30, 2020.
Efficiency and Cost Reduction		
• MSPB	• January 1, 2018–December 31, 2018	• January 1, 2020–December 31, 2020.
• Payment (AMI Payment, HF Payment)	• July 1, 2012–June 30, 2015	• July 1, 2017–June 30, 2020.

11. Performance Standards

The Appendix includes tables showing the final rule 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.

12. FY 2019 Scoring Methodology, including Domain Weighting

CMS continues 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).

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 made to 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 final 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.

H. Hospital-Acquired Condition (HAC) Reduction Program

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

For 2017, changes were made in the relative weights of Domains 1 and 2; they will shift from 25%/75% respectively to 15%/85% for FY 2017. In addition, beginning in FY 2017 if a hospital does not submit data for a Domain 2 measure, and does not have a waiver to do so, they will receive a maximum score of 10 for that measure and that score will be averaged with the score(s) on other measures.

1. Changes for FY 2017

First, hospitals must have 12 months or more of data in order to have "complete data" to receive a score on the PSI-90 measure. This is in addition to the requirement that defines "complete data" to be three or more discharges for at least one PSI-90 component indicator. That is, hospitals are 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.

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. CMS adopts 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.

2. Change to FY 2018 Measures

CMS adopts refinements to the AHRQ PSI-90 composite safety measure (NQF #0531) for the HAC Reduction Program beginning with FY 2018 payment. 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:

- One of the original eight indicators is removed (PSI 07, central venous catheter-related blood stream infection rate) because of overlap with the NHSN CLABSI measure
- Three indicators are added (PSI 09 postoperative hemorrhage or hematoma rate; PSI 10 physiologic and metabolic derangement rate, and PSI 11 Postoperative respiratory failure rate)
- Two of the original indicators are re-specified (PSI 12 perioperative pulmonary embolism or deep vein thrombosis rate and PSI 15 accidental puncture or laceration rate)
- 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.

3. Change to HAC Reduction Program Scoring

CMS finalizes its proposal 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."

Under the new method, a 'Z-score' will be calculated for each hospital for each measure. The Z-score represents the hospital's distance from the national mean in units of standard deviation, and is calculated using this formula:

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

Under this formula, a poor performing hospital (above the national mean) will earn a positive Z-score and better performing hospitals (below the national mean) will earn a negative Z-score.

The Total HAC score is calculated by averaging the Z-scores on measures in Domain 2, multiplying this average by the weight for Domain 2 and adding it to the Domain 1 score which is the Z-score for the PSI-90 measure, multiplied by the Domain 1 weight. As is the case now, the Total HAC Score will be used to define the top quartile of hospitals subject to the penalty.

Unlike the current decile-based scoring system, however, CMS says the new method will result in continuous scores and avoid the ties that have resulted in CMS not being able to penalize exactly 25 percent of hospitals.

4. Applicable Time Periods for FY 2018 and FY 2019

CMS adopts is proposal to shorten the performance period for the PSI 90 measure for FYs 2018 and 2019. It is modifying its previously adopted policy (42 CFR 412.170) to use a 2-year performance period for the HAC Reduction Program. Specifically, CMS modifies the regulations to permit it flexibility to use a period other than 2 years. For FY 2018 a 15-month performance period will 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 will be used (October 1, 2015 through June 30, 2017) that includes only ICD-10 claims.

5. Request for Comment on Additional Future Measures

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.					

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

Policy Changes Relating to Rural Training Tracks at Urban Hospitals

In the 2017 IPPS/LTCH PPS proposed rule, CMS proposed the following conforming changes for rural training tracks which it finalizes:

- 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 an urban hospital's rural track FTE limit will 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 will be included in the 3-year rolling average and are subject to the IME IRB ratio cap for hospitals with established caps. This is 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 notes that this does not apply to a new rural training track program by an urban hospital that is establishing an FTE cap for the first time. Pursuant to a commenter's request, CMS confirms that a FTE resident cap adjustment for a rural teaching hospital participating in a rural track is only permitted where the approved medical residency training program is a newly established program under CMS criteria.

Effective Date

In the FY 2013 and FY 2015 IPPS/LTCH PPS final rules (where the growth period was expanded from 3 to 5 years), CMS neglected to make conforming changes to the growth window and effective date of FTE limitations for rural track training programs. CMS makes these changes now in §§412.105(f)(1)(x) and 413.79(k) effective for programs started on or after October 1, 2012.

CMS notes that an urban hospital that started a rural track training program on July 1, 2013 would be subject to the current 3-year growth policy in July 2016 (before the effective date of the FY 2017 IPPS/LTCH PPS final rule). For such a hospital, CMS will not apply the FTE limitations after 3 years and instead will set the FTE limitation at the actual number of FTE residents training in the rural track for an additional 2 years (through June 30, 2018), and the rural track FTE limitations are effective with the cost reporting period that coincides or follows the start of the sixth program year.

Effective Notices of Closure of Teaching Hospitals and Opportunity to Apply for Available Slots

CMS provides public notice of three new rounds of ACA section 5506 redistribution of residency slots pursuant to the closure of a teaching hospital as follows:

- Round 8: Closure of Pacific Hospital of Long Beach, CA
- Round 9: Huey P. Long Medical Center, Pineville, LA
- Round 10: St. Joseph's Hospital, Philadelphia, PA

The preamble to the final rule contains tables with identifying information and IME and direct GME caps for each of the closed hospitals. Hospitals wishing to apply for and receive slots from the closed hospitals' teaching caps must submit applications directly to CMS which must be received by October 31, 2016 (90 days after the date of display in the *Federal Register*). Hospitals may apply for any or all of these section 5506 redistribution rounds but must submit separate applications for each round for which it seeks to apply. Applicants must submit a hard copy of the application to the CMS Central Office mailing address and must also send an email to ACA5506application@cms.hhs.gov to notify CMS that it has mailed the hard copy to the Central Office. The preamble shows the precise language CMS expects to see in the email. CMS notes that there is no deadline under the regulations by which CMS must issue final determinations of slots awarded under the section 5506 process, but it will notify applicants of its determinations "as soon as possible". The application and additional guidelines are available at http://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/AcuteInpatientPPS/dgme.html.

J. Hospital and CAH Notification Procedures for Outpatients Receiving Observation Services (§§489.20(y), 405.926(u))

The NOTICE Act[6] requires 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[7] receiving observation services and the implications of that status. CMS finalizes its proposals to implement the Notice Act with a modification to the regulations (relating to the timing of the delivery of the notice), several clarifications of its policies, some changes to the content of the standardized notice itself, and a revised effective date.

Hospitals and CAHs (hereinafter in this section of the summary referred to as hospitals collectively) must use a standardized written notice called the Medicare Outpatient Observation Notice (MOON) which includes all the requisite elements specified in the NOTICE Act. Specifically, the MOON includes the following information:

- An explanation that the individual is an outpatient—not an inpatient;

[6] The Notice of Observation Treatment and Implication for Care Eligibility Act, Public Law 114-42.
[7] 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.

- An explanation of 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);
- An explanation of the implications of receiving observation services as an outpatient, such as Medicare cost-sharing requirements and eligibility for skilled nursing facility (SNF) care;
- A blank section that a hospital may use for additional information; and
- A dedicated signature area to acknowledge receipt and understanding of the notice.

The explanations in the MOON must be in standardized language (using plain language written for beneficiary comprehension). CMS will provide guidance for the oral notification in Medicare manual provisions.

Effective Date. Because CMS revised the content of its proposed MOON in response to comments, the notice is undergoing the Paperwork Reduction Act (PRA) approval process at OMB. Stakeholders have 30 days in which to comment on the revised notice (which is available at https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10611.html?DLPage=1&DLEntries=10&DLSort=1&DLSortDir=descending). CMS anticipates that final PRA 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 at: https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html and in an HPMS memorandum to Medicare Advantage (MA) plans. Upon OPM approval, hospitals will have 90 days to fully implement use of the MOON.

Notice Recipients

Under the final rule, the written and oral notices must be furnished 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 must still receive the notice. Enrollees in a MA plan, or in other Medicare health plans, must 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.

Many commenters suggested that CMS expand the scope beyond Medicare beneficiaries; CMS declines to require an expanded scope since the law speaks only to Medicare beneficiaries. Other comments raised notice requirements under state law (regardless of payor or whether the beneficiary received observation services); CMS emphasizes that it is implementing the NOTICE Act which requires oral and written notice prescribed by the agency to Medicare beneficiaries. CMS leaves it to hospitals to determine whether the MOON will meet requirements under state law, if applicable; CMS also points to the "Additional Information" field in the MOON to provide additional information which may satisfy state law requirements (though again CMS leaves it to hospitals to make that determination).

CMS also acknowledges that cost-sharing for patients in observation status will change if they are admitted as inpatients and that outpatient services furnished during the 3-day payment window[8]

[8] See Chapter 3, Section 40.3 and Chapter 4, Section 10.12 of the Medicare Claims Processing Manual (Pub. 100-4).

before an inpatient admission are subject to Part A cost-sharing. CMS notes that if an individual who receives more than 24 hours of outpatient observation services and who is admitted as an inpatient before the MOON is delivered, the Additional Information field of the MOON should explain potential Part A cost-sharing and must be annotated with the date and time of the inpatient admission. CMS also clarifies that the duty to furnish NOTICE Act written and oral notices to Medicare beneficiaries applies whether or not the services are payable under Title XVIII (such as when Medicare is a secondary payor).

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

Timing of Notice Delivery

Notice must be given no later than 36 hours after the outpatient observation services begin, but it may be required to be furnished sooner where the individual is to be transferred, discharged or admitted as an inpatient before the end of the 36 hour period. In these cases, the MOON must be provided before transfer, discharge or inpatient admission. CMS notes that observation services are initiated when ordered by a physician (or a nonphysician practitioner authorized by state licensure law and hospital staff bylaws to admit patients or to order outpatient services) as documented in the patient medical record. In the case of a Condition Code 44 situation,[9] the MOON must be provided within the timeframes described above, and the period for outpatient observation services begins upon the physician order.

CMS makes one significant change from its proposal; CMS agrees with commenters that nothing in the NOTICE Act precludes a hospital from delivering the notice before the patient has received more than 24 hours of outpatient observation services. However, CMS encourages hospitals not to deliver the MOON at the initiation of observation services; it is concerned that patients may be preoccupied by the medical condition that occasioned the visit to the hospital or could be overwhelmed by the number of hospital notices and the amount of paperwork to focus on the information being conveyed by the MOON. CMS also notes that the ability to furnish the notice before 24 hours does not alter the 36-hour deadline noted above.

CMS cites section 20.6, Chapter 6, of the Medicare Benefit Policy Manual for the definition of observation services; these are "a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital."

Commenters sought clarification on a number of issues relating to the beginning of outpatient observation services for purposes of the 24-hour timeframe. CMS responds that the start of

[9] 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.

observation services is the clock time (as documented in the patient's medical record) at which observation services are initiated in accordance with the physician's or nonphysician practitioner's order. CMS also states that observation time will be measured as the elapsed time in hours (rather than billed time) beginning at the clock time documented in the medical record. CMS notes that observation time ends when all medically necessary observation services are completed (which could be before discharge or coincide with discharge or inpatient admission). CMS clarifies that, to the extent a medical resident is authorized under state licensure law and hospital staff bylaws to order outpatient observation services, the 24-hour time period begins once the observation services are initiated pursuant to the resident's order.

With respect to possible interaction with the 2-Midnight policy, CMS clarifies that the NOTICE Act requirements do not impact or change current requirements and guidance under the 2-Midnight policy. Hospitals must comply with requirements under both the NOTICE Act and the 2-Midnight rules.

CMS also confirms that hospitals must retain a signed copy of the MOON though the agency does not require any specific method of storage (i.e., in paper or electronic form).

Oral Notice. Noting that it believes hospitals are familiar with what is required of them in providing oral explanations of written notices, CMS indicates that it will provide further guidance for oral notification in Medicare manual provisions. CMS emphasizes that staff must be available to provide a verbal explanation of the MOON and to answer questions. Video presentations would be acceptable as long as staff is available to answer questions.

Signature Requirements. The MOON must be signed to acknowledge receipt and understanding by the individual or by a person acting on the individual's behalf. Where the individual or person refuses to sign, the MOON must be signed by the hospital staff member who presents the notice, and must include the staff member's name and title, a certification statement that the notice was presented, and the date and time the notice was presented. CMS does clarify that signature of the MOON attests to both receipt and comprehension of the notice. However, CMS does not address a number of questions from commenters (e.g., inability to sign due to medical or mental condition, patient under duress, lack of standards to assure patient competency, etc.); it states that additional instructions will be provided, if necessary, in the CMS Internet Only Manual.

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

The Medicare-Dependent, Small Rural Hospital (MDH) Program 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 MA enrollees toward the 60 percent utilization requirement.

Hospitals eligible for payments for costs associated with IME, DGME or DSH 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 or DSH 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.

L. Adjustment to IPPS Rates Resulting from 2-Midnight Policy

CMS finalizes the following proposals are a result of it's inappropriate .2 percent reduction to IPPS payments as a result of the two mid-night rule:

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

CMS proposed 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.

For hospitals that are parties to *Shands Jacksonville Medical Center, Inc. v. Burwell* and related cases, CMS will adjust the 1.006 increase factor for FY 2017 by a uniform factor to pay interest pursuant to section 1878(f)(2) of the Act.

V. Changes to the IPPS for Capital-Related Costs

National Capital Federal Rate for FY 2017. Under the final rule for FY 2017 the national capital federal rate ($438.75 in FY 2016) will increase by 1.84 percent, to total $446.81. Effective January 1, 2016 a special capital rate for hospitals located in Puerto Rico no longer applies.

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

	FY 2016	FY 2017	Change	Percent Change
Update Factor	1.0130	1.009	1.009	0.9
GAF/DRG Adjustment Factor	0.9976	0.9991	0.9991	-0.09
Outlier Adjustment Factor	0.9365	0.9386	1.0022	0.22
Permanent 2-midnight Policy	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	$446.81	1.0184	1.84

VI. Changes for Hospitals Excluded from the IPPS

Rate-of-Increase in Payments to Excluded Hospitals for FY 2017

Based on IHS Global Insight Inc.'s 2016 second quarter forecast, CMS sets a 2.7 rate-of-increase percentage for FY 2017 to the target amount for cancer hospitals, children's hospitals, religious nonmedical health care institutions (RNHCIs), and for short-term acute care hospitals located in the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. The FY 2017 rate-of-increase percentage is applied to the FY 2016 target amounts to calculate the FY 2017 target amounts for these hospitals. CMS continues to use the percentage increase in the FY 2010-based IPPS operating market basket to update the target amounts.

Critical Access Hospitals

The Frontier Community Health Integration Project (FCHIP) Demonstration[10] is designed to develop and test new models of care by CAHs located in frontier areas of certain states (i.e., Alaska, Montana, Nevada, North Dakota, and Wyoming). The FCHIP is a 3-year demonstration which limits participation to no more than four states; provides broad waiver authority; and requires budget neutrality. CMS will permit enhanced reimbursement under the FCHIP for telemedicine, nursing facility, ambulance, and home health services.

CMS intends for the demonstration to maintain budget neutrality on its own terms; reduced transfers and admissions to other health care providers may offset any increase in payments under the waivers. However, due to the small size of the demonstration, CMS is concerned that the estimated savings may not offset the increased costs; thus, it will, if necessary, implement a contingency budget neutrality plan. Specifically, CMS would recoup any additional expenditures attributable to the FCHIP through a reduction in payments to CAHs nationwide—not just those participating in the FCHIP demonstration. The contingency plan would require a final budget neutrality estimate based on the entire demonstration period (August 1, 2016 through July 31, 2019) and would require recoupment of any costs over 3 cost reporting periods, beginning with CY 2020. CMS estimates the payment recoupment will not exceed 0.03 percent of CAHs' total Medicare reimbursement within a fiscal year.

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

A. Background

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)

[10] The FCHIP Demonstration was authorized by section 123 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275).

- 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 finalizes updates for LTCHs using a process that is generally consistent with prior regulatory policy and that cross-links to relevant IPPS provisions. Key changes for FY 2017 include actions by CMS to:

- Rebase and revise the current 2009-based LTCH-specific market basket using 2013 Medicare LTCH cost report data ("2013-Based LTCH Market Basket");
- Modify the "25-Percent Threshold Policy" Payment Adjustments;
- Refine the Payment Adjustment for "Subclause II" LTCHs; and
- Establish temporary exclusion from the site neutral payment rate for certain severe wound cases.

B. Rebasing of the LTCH Market Basket

1. FY 2017 Labor-Related Share

FY 2017 labor-related share by cost category is shown below with changes for the cost categories relative weights from FY 2016.

Labor-Related Share Relative Importance (in percent)			
Cost Category	FY 2016 Final Labor-Related Share *	FY 2017 Final Labor Related Share	Change FY 2016 to FY 2017
Wages and Salaries	44.6	46.5	-0.1
Employee Benefits	8.1	7.3	-0.8
Professional Fees: Labor-Related	2.2	3.5	1.3
Administrative/Business Support Services	0.5	0.9	0.4
Installation, Maintenance, and Repair Services	---	2.1	***
All Other: Labor-Related Services	2.5	1.9	-0.6
Subtotal	57.9	62.2	4.3
Labor-Related Portion of Capital Costs (46%)	4.1	4.3	0.2
Proposed Total Labor-Related Share	**62.0**	**66.5**	**4.5**

* Federal Register, 80 FR 49478, uses 2009-based market basket

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

CMS previously adopted a regulatory provision that would apply 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 regulatory provision was first adopted in the FY 2005 IPPS final rule and is known as the "25-percent threshold policy." Under this policy, the LTCH would receive Medicare payment at an IPPS comparable amount rather than the LTCH PPS amount for any discharges above the 25-percent threshold. 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 (grandfathered hospitals-within-hospitals).

Until now, CMS has been precluded by statute from implementing the 25-percent threshold policy. The most recent statutory preclusion was mandated in the Pathway for Sustainable Growth Rate (SGR) Reform Act (Pub.L. 113-67) (Section 1206(b)(1)(A)) and is set to expire at the end of FY 2016 reporting periods. Anticipating that expiration, CMS proposed and adopts in this rule a new, unified "25-percent threshold policy" through a combination of actions that incorporate many of the existing policy provisions:

- Creates the new policy effective October 1, 2016 at new §412.538 that would sunset the existing policy (§412.534 and §412.536). Sections 412.534 and 412.536 respectively create an independent set of rules for: 1) LTCHs and satellites of LTCHs that are in the same building or campus of an IPPS hospital; and 2) LTCHs and satellites of LTCHs that are not in the same building or campus of an IPPS hospital. CMS is eliminating the separate provisions for each category of hospital and replacing it with a single provision (§412.538) that applies to both categories. The main difference between these two categories of hospitals concerns when the moratorium on application of the 25-percent policy expires for each category of hospitals. The moratorium expires for cost reporting periods beginning on or after July 1, 2016 for hospitals and satellites that are not within the same building or on the same campus as an IPPS hospital. It expires for cost reporting periods beginning on or after October 1, 2016 for hospitals and satellites that are within the same building or on the same campus policy as an IPPS hospital. The provisions were initially adopted at different times as well and were effective for cost reporting periods beginning on or after July 1 or October 1 depending on whether the hospital was within or on the same campus as an IPPS hospital. CMS also makes conforming changes to §412.522(c)(2) and (§412.525(d)(5).
- Like the existing policy, the new policy applies to both LTCH PPS standard federal rate cases and site-neutral payment cases and not to "subclause (II) LTCHs" or "grandfathered hospitals-within-hospitals."
- LTCH discharges that reach outlier status at the referring hospital will neither be subject to an IPPS comparable payment above the 25 percent threshold nor counted as having been admitted from the referring hospital to count towards the 25 percent threshold.
- 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 above the 25-percent 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 (collectively referred to in this summary as the "IPPS comparable amount").

- The existing definition of the IPPS equivalent amount will be codified at new § 412.538(f).
    - Only discharges above the 25 percent threshold will be paid at the IPPS comparable amount. Other discharges are not affected and will be paid at the LTCH federal standard rate.
    - Like outlier cases at the referring hospital, Medicare Advantage discharges will not count towards the 25-percent threshold.
    - The adjustment to pay based on the IPPS comparable amount would occur at cost report reconciliation since the determination of whether the LTCH exceeded the 25-percent threshold would not be known until after the cost reporting period ends.
- The current threshold applicable to rural LTCHs at 50 percent is continued, as is the current threshold range for special treatment of LTCHs located in an MSA with an MSA-dominant referring hospital.
    - The threshold is the same percentage of discharges accounted for by the dominant hospital within the MSA but no less than 25 and no more than 50 percent. The same threshold continues to apply to all of that LTCH's referring hospitals.
- For LTCHs with multiple locations that 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.

CMS revised its final rule policy to apply to any discharges occurring on or after October 1, 2016, in a cost reporting period for which the hospital is no longer subject to any statutory moratorium on the full implementation of the current 25-percent threshold policy

D. 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. In short, if the beneficiary has at least one covered benefit day during the inpatient stay, the entire stay (up to when the patient becomes an outlier) will be paid by Medicare as a PPS payment and the LTCH cannot charge Medicare for inpatient days when benefits are exhausted. For FY 2017, CMS will 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. Further, beneficiary charges by "subclause (II) LTCHs" will 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. In short, the stay will not be paid like a PPS case and will instead be paid like under TEFRA meaning that the beneficiary

could be charged for each day in the hospital after the beneficiary has exhausted inpatient benefits.

E. Final LTCH PPS Standard Federal Payment Rate for FY 2017

1. Annual Market Basket Update

Using the new 2013-based LTCH market basket, the full market basket increase for the LTCH PPS is 2.8 percent for FY 2017 based on IGI's second quarter 2016 forecast. CMS will reduce the full market basket for multifactor productivity by 0.3 percentage points and an additional statutory adjustment of 0.75 percentage point. The final FY 2017 update to the LTCH standard federal payment rate annual update thereby becomes 1.754 percent (2.8 – 0.3 – 0.75 = 1.75).

For LTCHs failing to submit data to the LTCH Quality Reporting Program (QRP), the annual update is reduced by another 2.0 percentage points to -0.25 percent (1.75 – 2.0 = -0.25).

2. Area Wage Level Adjustment

As in prior years, CMS is applying an area wage level budget neutrality factor to the standard federal payment rate. Using existing methodology, described in detail in the final rule, CMS determined the budget neutrality factor to be 0.999593.

3. FY 2017 LTCH Standard Federal Payment Rate Calculation

For LTCHs successfully reporting data to the LTCH QRP:

FY 2017 payment rate = $41,762.85 (FY 2016 payment rate) * 1.0175 (market basket update of 1.75 percent) * 0.999593 (area wage budget neutrality factor) = $42,476.41

For LTCHs <u>not</u> reporting data to the LTCH QRP:
FY 2017 payment rate = $41,762.85 (FY 2016 payment rate) * 0.9975 (market basket update of -0.25 percent) * 0.998723 (area wage budget neutrality factor) = $41,641.49

4. High-Cost Outlier (HCO) Case Payments

For FY 2017, CMS finalizes a fixed-loss amount of $23,681, equal to the FY 2017 IPPS fixed-loss amount. The fixed-loss amount for site neutral cases will be $23,570, also equal to the FY 2017 IPPS fixed loss amount. The fixed-loss amount is significantly higher than the FY 2016 amount of $16,423.

5. LTCH PPS Updates Related to IPPS DSH Payment Adjustment Methodology

For FY 2017, the DSH amount equals 66.52 percent of the operating Medicare DSH payment amount, based on the statutory Medicare DSH payment formula prior to the amendments made by the ACA adjusted to account for reduced payments for uncompensated care resulting from expansion of the insured population under the ACA. Under the LTCH PPS, the "IPPS

comparable amount" is applied to SSO cases and the "IPPS equivalent amount" is utilized in the 25-percent threshold policy.

F. Impact of 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 payment rate and policy changes, for all LTCHs from FY 2016 to FY 2017, will result in a decrease of 7.1 percent or $363 million in aggregate payments (from $5.134 billion to $4.771 billion). This estimated decrease in payments reflects the projected increase in payments to LTCH PPS standard federal payment rate cases of approximately $24 million and the projected decrease in payments to site neutral payment rate cases of approximately $388 million under the new dual-rate LTCH PPS payment rate structure required by the statute beginning in FY 2016. A table summarizing the impact of the final changes to the LTCH PPS for FY 2017 can be found in the Appendix.

2. Tables

The complete set of tables providing detail on the proposed LTCH PPS for FY 2017 is at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/LTCHPPS-Regulations-and-Notices-Items/LTCH-PPS-CMS-1655-F.html?DLPage=1&DLEntries=10&DLSort=3&DLSortDir=descending
The information at that link provides:

- Table 8C: LTCH PPS Statewide Average Cost-to-Charge Ratios
- Table 11: Proposed MS-LTC-DRGs, relative weights, geometric average length of stay, SSO threshold, and IPPS comparable threshold for FY 2017
- Tables 12A: Proposed LTCH PPS Wage Index for Urban Areas for FY 2017
- Tables 12B: Proposed LTCH PPS Wage Index for Rural Areas for FY 2017
- Table 13A: Composition of proposed low-volume quintiles for MS-LTC-DRGs for FY 2017
- Table 13B: Proposed no volume MS-LTC-DRG crosswalk for FY 2017
- LTCH PPS FY 2017 Proposed Impact File

G. Temporary Exception to the Site Neutral Payment Rate under the LTCH PPS for Certain Severe Wound Discharges from Certain LTCHs

Section 231 of the Consolidated Appropriations Act (CAA) of 2016 provides a temporary exception for certain wound care discharges from the application of site neutral payment under the LTCH PPS. To implement the exception, CMS creates definitions and processes to enable some LTCH cases with "severe wounds" to qualify for the CAA exception and thereby to be paid at the standard federal payment rate. Section 231 did not establish an effective date but does mandate expiration of the exception on January 1, 2017.

1. Definition of an LTCH identified by BBA section 4417(a)

The temporary exception enacted in CAA section 231 is available for use when a beneficiary with a severe wound is discharged from an LTCH that is "identified by section 4417(a) of the Balanced

Budget Act of 1997." CMS defined this term during rulemaking for the Medicaid and SCHIP Extension Act of 2007 (MMSEA, (Pub.L. 110-173) and plans to utilize the same definition under the CAA. BBA 4417(a) LTCHs are grandfathered hospitals-within-hospitals (HwHs) operating under terms and conditions as they did prior to October 1, 2003 and who are exempt from CMS separateness and control requirements.

2. Definition of rural

To qualify for the CAA section 231 site neutral payment rate exception, a 4417(a) LTCH must also be located in a rural area. "Rural area" is defined as any area outside an urban area (urban area being defined as any area within a Metropolitan Statistical Area as defined by the OMB). Relatedly, the IFC allows grandfathered LTCH HwHs to apply to their CMS Regional Offices for reclassification to be treated as rural. If granted, the rural reclassification would apply only to the severe wound site neutral payment rate exception (i.e., rural reclassification would not apply to other policies such as the 25-percent threshold policy or wage index determination). CMS projects that two rural LTCHs would qualify for the CAA section 231 severe wound site neutral payment rate exception, but CMS MACs will be verifying eligibility criteria.

3. Definition of "severe wound"

CAA section 321 further provides that the site neutral payment exception for a 4417(a), rural LTCH is only applicable to payments for beneficiaries whose discharge claims provide evidence of severe wounds. The CAA defines a "severe wound" as a wound with one of the following descriptors:

- Stage 3 wound
- Stage 4 wound
- Unstageable wound
- Non-healing surgical wound
- Infected wound
- Fistula
- Osteomyelitis
- Wound with morbid obesity

These descriptors (except Infected wound or Wound with morbid obesity) can be identified on discharge claims by ICD-10 diagnosis codes. A list of relevant ICD-10 diagnosis codes compiled by CMS medical officers can be found in the table "Severe Wound Diagnosis Codes by Category for Implementation of Section 231 of Public Law 114-113" posted on the CMS website under regulation CMS-2664-IFC at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/index.html.

Sufficiently specific ICD-10 diagnosis codes are not available for the descriptors Infected wound or Wound with morbid obesity. CMS therefore is adopting the following definitions:

- Infected Wound: a wound with infection requiring complex, continuing care including local wound care occurring multiple times a day.

- Wound with morbid obesity: a wound in those with morbid obesity that require complex, continuing care including local wound care occurring multiple times a day.

CMS will operationalize these definitions using "payer-only" condition codes. An LTCH with a qualifying patient will inform its MAC which will add the condition code to the claim for processing. The claim will then be paid at the standard federal rate. If substantially more LTCHs are found to be eligible for the CAA section 231 site neutral payment rate exception or the exception is extended for a longer period of time, CMS plans to revisit the propriety of using a payer-only condition code and to consider alternatives.

VIII. Quality Data Reporting Requirements for Specific Providers and Suppliers

In this section of the final rule, changes are made to the quality reporting programs that apply to acute inpatient hospital stays, PPS-exempt cancer hospitals, long-term care hospitals, and inpatient psychiatric facilities. In addition, with modification from the proposed rule, changes are made to align hospital quality reporting requirements with the meaningful use requirements under the Health Information Technology for Economic and Clinical Health (HITECH) Act.

A. Hospital Inpatient Quality Reporting (IQR) Program

The final measure set for FY 2019 includes a total of 54 mandatory measures; 46 are specified, and 8 eCQMs are selected by the hospital from a list of 15. Table VIII in the Appendix shows the final measure set for FY 2019, and for reference, the previously adopted IQR Program measure sets for the FY2016, FY 2017, and FY 2018 payment determinations are also included.

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

CMS adopts its proposal to remove 15 measures from the IQR Program beginning with the FY 2019 payment determination, shown in the table below. (The table lists 17 measures because for two measures both the chart-abstracted and electronic versions are removed.) Among the total are:

- 13 electronic clinical quality measures (eCQMs) which are also removed from the EHR Incentive Program (section VIII.E below). Five of these eCQMs are "topped out," one is removed because CMS says performance does not improve patient outcomes, and 7 are removed because CMS says it is no longer feasible to implement the measure specifications. In addition, CMS believes that removal of these measures will allow hospitals to focus on a smaller set of eCQMs while keeping the programs aligned.
- 2 chart-abstracted measures which CMS reports are "topped out." These 2 measures have eCQM versions that are also removed.
- 2 structural measures, which CMS acknowledges do not provide information on patient outcomes.

All of these measures are retained for the FY 2018 payment determination.

Measures Removed 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 modifies the 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. As with these other measures, the patient cohort is expanded 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.

Modified PSI 90. CMS adopts 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 discussion (section IV.I.3). The modifications include changes in the component indicators and reweighting of the indicators to include assessment of the patient harm from adverse events as well as the volume of these events.

The reporting period for the modified PSI 90 measure is 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. That is, periods would be established to avoid overlap between ICD-9 and ICD-10 data in the same performance period. For FY 2018, the reporting period will be 15 months (July 1, 2014 through September 30, 2015) and for FY 2019 it will be 21 months (October 1, 2015 through June 30, 2017).

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

CMS adopts 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 clinical episode payment measures are 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 rule includes detailed discussion of each of these measures, and further information on the three proposed payment measures is available on the QualityNet.org website at: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228775612741.

4. Reporting of Electronic Clinical Quality Measures for FY 2019

For the FY 2017 reporting period/FY 2019 payment determination and the FY 2018 reporting period/FY 2020 payment determination, hospitals must submit a full year of data on 8 self-selected IQR Program eCQMs (which will total 15) by February 28, 2018 for FY 2019 payment and by February 28, 2019 for FY 2020 payment. CMS notes its intention to require hospitals to report on all eCQMs "in the near future."

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

CMS did 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. These remain unchanged.

With respect to electronically-specified measures, CMS finalizes the following requirements:

- The eCQM data certification process previously adopted for the CY 2016 reporting period /FY 2018 payment determination is 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 FY 2017 reporting/FY 2019 payment, hospitals must submit eCQM data via QRDA I files as previously required; they may use a third party to submit QRDA I files on their behalf; and they may either use abstraction or pull the data from non-certified sources in

order to input the data into CEHRT for capture and reporting QRDA I. This latter provision recognizes that hospitals are in transition and are still undergoing time consuming and labor intensive process of data mapping their EHR systems. This is because required data elements such as diagnostic studies and reports are often found as free text in clinical notes or documents attached to the medical records rather than capturing them directly from the EHR record. Hospitals are encouraged to work with vendors to overcome any issues in QRDA I submission.

- For the CY 2018 reporting period/FY 2020 payment determination, the 2015 edition of CEHRT is required.
- The data submission deadline beginning with the CY 2017 reporting period/FY 2019 payment determination is the end of 2 months following the close of the reporting period calendar year. For example, for the FY 2019 payment determination the deadline is 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. As noted earlier, CMS intends to open the data receiving system in late spring 2017 to allow hospitals and vendors the option of reporting quarterly or semiannually rather than waiting for the data submission deadline to report the full year of data. Hospitals are encouraged to submit QRDA I files early.

In this final rule CMS aligns the IQR Program with the Medicare and Medicaid EHR Incentive Programs by removing 13 eCQMs, requiring submission of 8 self-selected eCQMs out of the 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, 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). The policy to require use of 2015 CEHRT for the FY 2018 reporting/FY 2020 payment finalized for the IQR Program but is not at this time adopted for the Medicare and Medicaid EHR Incentive Programs.

6. Data Validation

CMS finalizes an update to the data validation process beginning in the spring of CY 2018 in order to incorporate validation of eCQM data for the FY 2020 payment determination. In addition to continuing the current validation processes for chart-abstracted measures, which involves a selection of 600 hospitals, CMS will randomly select 200 hospitals for eCQM data validation. A smaller number of hospitals may ultimately participate in the eCQM validation process, however, to the extent that selected hospitals meet proposed exclusion criteria. Specifically, CMS will exclude any hospital also selected for chart-abstracted measure validation and hospitals that have been granted an extraordinary circumstances exception from eCQM reporting requirements for the applicable reporting period.

- 32 cases (individual patient-level reports) from the QRDA I file submitted by a selected hospital will be randomly selected for validation. The Medicare Clinical Data Abstraction Center will request that the hospital submit patient sufficient patient level information from the medical record for each of the 32 cases within 30 days. The 30-day requirement is consistent with that for chart-abstracted and NHSN data validation procedures. Sufficient data includes but is not be limited to patient arrival date and time, admission

date, and discharge data. The data will be submitted in PDF file format through QualityNet using secure file transfer.

- For the FY 2020 payment determination, hospitals will pass validation and be eligible for a full payment update (if other IQR Program requirements are met) if they submitted at least 75 percent of sampled eCQM medical records in a timely and complete manner. The accuracy of the eCQM data will not affect the hospital's validation score. This is in contrast to the data validation requirements for chart-abstracted measures under which a hospital must attain at least a 75 percent *validation score* in order to be eligible for a full payment update.
- Hospitals will be reimbursed $3.00 per chart submitted under eCQM validation, which is the same amount paid under the chart-abstracted data validation process.
- Hospitals are encouraged to test eCQM submissions prior to annual reporting using the CMS pre-submission validation application (PSVA) tool, which can be downloaded from the secure section of the QualityNet website. CMS believes this will help reduce submission errors due to improperly formatted files and identify inconsistencies in data mapping.

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

In this rule, CMS finalizes its proposals to the measure set for FY 2019. First, the existing measure Radiation Dose Limits to Normal Tissues (NQF #0382) is updated to reflect updated specifications endorsed by the NQF subsequent to adoption of the measure.

One new claims-based measure is added 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 adopts several changes. First, public display of CLABSI and CAUTI data, scheduled for 2017, will be deferred due to the low volume of data. Second, CMS public reporting of the measure External Beam Radiotherapy for Bone Metastases will begin in 2017. The exact timing would be announced via the CMS website and listserv. Third, with respect to the measure Radiation Dose Limits to Normal Tissues scheduled for public reporting in 2016, given adoption of the measure updates, public display of the updated measure will begin as soon as feasible after the 2017 data collection period ends.

A table in the Appendix lists PCHQR program measures and public display timelines.

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

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.

1. LTCHQR Program Measures for FY 2018

In addition to continuing the 12 measures previously adopted for the LTCHQR Program measure set for the FY 2018 payment determination, CMS adds four new measures in this rule. Three of the measures will begin with the FY 2018 payment determination and the fourth with the FY 2020 payment determination. Previously adopted and proposed measures for FY14 to FY18 are shown in a table in the Appendix. With respect to each new measure CMS says that it plans to provide initial confidential feedback to LTCHs prior to public reporting.

Medicare Spending per Beneficiary. This measure of Medicare spending per beneficiary for post-acute care is specific to the LTCH setting, and is labeled "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. Similarly, a MSPB-PAC episode (for a home health agency, for example, or another LTCH) may begin during the post-treatment (see below) portion of an MSPB-PAC LTCH episode.

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 new 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 discharge status codes (01,06,81, and 86) as home or self-care, with or without home health services. CMS is developing similar measures across PAC settings. 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.

Preventable Readmissions. The third measure that will begin with FY 2018 payment assesses 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 will be used to calculate the measure. For the FY 2018 payment determination, the performance

period will be CYs 2016 and 2017. CMS responds to numerous comments regarding the measure specifications and risk adjustment.

2. New LTCH QRP Measure for FY 2020

CMS adopts one new measure to begin with the FY 2020 payment determination: Drug Regiment Review Conducted with Follow-up for Identified Issues PAC. Using three standardized items from the LTCH CARE data set, the measure reports 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 will be used to calculate measure performance. For later years, data for a full calendar year will be used.

3. Data Submission and Validation

CMS publishes the specific data submission timelines for each of the FY 2018 quality measures, and adopts one change. With respect to the measure Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay) (NQF #0680), beginning with FY 2019 payment the data collection and submission will be required year-round to include all patients who were in the facility during the influenza vaccination season (October - March).

For the newly adopted drug regiment measure (begins with FY 2020 payment) the initial year the measure will be based on data collected for the second, third and fourth calendar quarters of 2018; a calendar year cycle will be used for later years.

4. Public Reporting

CMS adopts its proposal to add 4 more measures to the set of measures made available for public reporting beginning in FY 2017 pending availability of data. These are the measures regarding MRSA, *C.Difficile*, flu vaccine coverage among healthcare personnel, and percentage of residents receiving the flu vaccine.

In this rule CMS finalizes its proposal that confidential quality measure feedback reports (LTCH QM Reports) will be available to each LTCH using the CASPER system. These will be updated monthly as new data become available (for some measures refresh is quarterly or annually). Data will be previewed for 30 days prior to public reporting. (CMS reminds readers that LTCHs will not have opportunity to modify underlying data after submission. CMS believes that the 4.5 month time frame for data submission and correction is sufficient.

5. Exception and Extension policies

CMS finalizes its proposal to extend the timing for submission of requests for exception and extension from the LTCH QRP from 30 days to 90 days from the date of a qualifying event.

D. Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program

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

- The existing measure "Screening for Metabolic Disorders" is 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.
- 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 assesses 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 is used to calculate the rates. The measure was submitted for NQF endorsement in January 2016 and in July it received a committee recommendation for endorsement; final action is anticipated this fall.

The IPQRF Program measures for FY 2019 can be found in a table in the Appendix.

With respect to FY 2017, CMS proposes that it may provide IPFs with data mid-September 2016, before the start of the fiscal year, so that it can be posted in December 2016.

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 2.025 percentage points in the update factor for FY 2017.

In order to align measures with the IQR Program, CMS removes 13 CQMs from the set of those available for reporting by eligible hospitals and CAHs under the Medicare and Medicaid EHR Incentive Programs. 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 therefore 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 8 of the available 16 CQMs. (Note that the outpatient measure would not count for the IQR Program.) Electronic reporting occurs through the QualityNet portal.

In this rule, the following reporting criteria for hospitals and CAHs participating in the Medicare EHR Incentive Programs in 2017 are finalized:

- For eligible hospitals and CAHs reporting CQMs by attestation, the data submission period for CY 2017 (for the required four calendar year quarters) is from January 1, 2018 to February 28, 2018. For those demonstrating meaningful use for the first time in 2017, attestation during that same data submission period is made for any continuous 90-day reporting period.
- For eligible hospitals and CAHs reporting CQMs electronically, the data submission period for CY 2017 (for the required four calendar year quarters) ends February 28, 2018. Responding to comments suggesting that providers be able to report quarterly, CMS will provide for a longer data submission period than the January-February 2018 period envisioned in the proposed rule. It will re-open its data receiving system in late spring of 2017 to receive QRDA I test and production files for the 2017 reporting period submissions. This will allow hospitals and vendors flexibility in submitting data quarterly, semi-annually or annually. Providers and vendors are encouraged to submit data early and to use one of the presubmission testing tools for electronic reporting, such as the Pre-Submission Validation Application available from the secure portal of the qualitynet.org website.
- These reporting periods apply for Medicaid, but states determine data submission methods and deadlines.

Appendix – Readmission Adjustment Factor Formulas

FORMULAS TO CALCULATE THE READMISSIONS ADJUSTMENT FACTOR FOR FY 2017

Aggregate payments for excess readmissions = [sum of base operating DRG payments for AMI x (Excess Readmissions Ratio for AMI-1)] + [sum of base operating DRG payments for HF x (Excess Readmissions Ratio for HF-1)] + [sum of base operating DRG payments for PN x (Excess Readmissions Ratio for PN-1)] + [sum of base operating DRG payments for COPD) x (Excess Readmissions Ratio for COPD-1)] + [sum of base operating DRG payments for THA/TKA x (Excess Readmissions Ratio for THA/TKA-1)] + [sum of base operating DRG payments for CABG x (Excess Readmissions Ratio for CABG-1)].
Note: If a hospital's excess readmissions ratio for a condition is less than/equal to 1, there are no aggregate payments for excess readmissions for that condition included in this calculation.

Aggregate payments for all discharges = sum of base operating DRG payments for all discharges.

Ratio = 1- (Aggregate payments for excess readmissions/Aggregate payments for all discharges).

Proposed Readmissions Adjustment Factor for FY 2017 is the higher of the ratio or 0.9700.

Based on claims data from July 1, 2012 to June 30, 2015 for FY 2017.

Appendix – Summary of VBP Final Measures and Domains

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

Summary Table VBP-1: Measures and Domains for selected payment years					
Measure	**2017**	**2018**	**2019/ 2020**	**2021**	**2022**
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 – Summary of VBP Final Measures and Domains

SUMMARY TABLE VBP-2. Comparison of Final Hospital VBP Program Measures and Domains for FYs 2016 and 2017		
Measure	**2016 Domain**	**2017 Domain**
AMI-7a Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	Clinical Process of Care	Clinical Care–Process
IMM-2 Influenza Immunization	Clinical Process of Care	Clinical Care–Process
PN-6 Initial Antibiotic Selection for CAP in Immunocompetent Patient	Clinical Process of Care	Removed
SCIP-Inf-2 Prophylactic Antibiotic Selection for Surgical Patients.	Clinical Process of Care	Removed
SCIP-Inf-3 Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time	Clinical Process of Care	Removed
SCIP Inf-9 Urinary Catheter Removal on Postoperative Day 1 or 2	Clinical Process of Care	Removed
SCIP-Card-2 Surgery Patients on a Beta Blocker Prior to Arrival That Received a Beta Blocker During the Perioperative Period	Clinical Process of Care	Removed
SCIP-VTE-2 Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery	Clinical Process of Care	Removed
Perinatal Care: elective delivery < 39 completed weeks gestation		Clinical Care–Process
Acute Myocardial Infarction (AMI) 30-day mortality rate	Outcome	Clinical Care–Outcomes
Heart Failure (HF) 30-day mortality rate	Outcome	Clinical Care–Outcomes
Pneumonia (PN) 30- day mortality rate	Outcome	Clinical Care–Outcomes
AHRQ PSI – 90 patient safety composite	Outcome	Safety
Central Line Associated Blood Stream Infection (CLABSI)	Outcome	Safety
Catheter Associated Urinary Tract Infection (CAUTI)	Outcome	Safety
Surgical Site Infection: Colon, Abdominal hysterectomy	Outcome	Safety
Methicillin-Resistant Staphylococcus Aureus (MRSA) Bacteremia		Safety
Clostridium Difficile (C.Diff)		Safety
HCAHPS (8 dimensions)	Patient Experience of Care	Person and Community Engagement (renamed)
Medicare Spending per Beneficiary	Efficiency	Efficiency and Cost Reduction

Appendix – FY19 Performance Standards

PREVIOUSLY ADOPTED AND NEWLY FINALIZED PERFORMANCE STANDARDS FOR THE FY 2019 PROGRAM YEAR: SAFETY, CLINICAL CARE, AND EFFICIENCY AND COST REDUCTION MEASURES

Measure ID	Description	Achievement threshold	Benchmark
Safety Measures			
CAUTI*	National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure.	0.464	0.000
CLABSI*	National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure.	0.427	0.000
CDI*	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset *Clostridium Difficile* Infection (CDI) Outcome Measure.	0.816	0.012
MRSA Bacteremia*	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure.	0.823	0.000
Colon and Abdominal Hysterectomy SSI**.	American College of Surgeons—Centers for Disease Control and Prevention (ACS–CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure.	• 0.832 • 0.698	• 0.000 • 0.000
PC–01*	Elective Delivery	0.010038	0.000000
PSI 90*±	Patient Safety for Selected Indicators (Composite)	0.840335	0.589462
Clinical Care Measures			
MORT–30–AMI±	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (AMI) Hospitalization.	0.850671	0.873263
MORT–30–HF±	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Heart Failure (HF) Hospitalization.	0.883472	0.908094
MORT–30–PN±	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Pneumonia Hospitalization.	0.882334	0.907906
THA/TKA*±	Hospital-Level Risk-Standardized Complication Rate (RSMR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA).	0.032229	0.023178
Efficiency and Cost Reduction Measure			
MSPB*	Payment-Standardized Medicare Spending Per Beneficiary (MSPB)	Median Medicare Spending Per Beneficiary ratio across all hospitals during the performance period.	Mean of the lowest decile Medicare Spending Per Beneficiary ratios across all hospitals during the performance period.

*Lower values represent better performance.
±Previously adopted performance standards.

Appendix – FY20 & FY21 Performance Standards

PREVIOUSLY ADOPTED PERFORMANCE STANDARDS FOR CERTAIN CLINICAL CARE DOMAIN AND SAFETY DOMAIN MEASURES FOR THE FY 2020 PROGRAM YEAR

Measure ID	Description	Achievement threshold	Benchmark
Safety Domain			
PSI 90*	Patient Safety for Selected Indicators (Composite)	0.778761	0.545903

PREVIOUSLY ADOPTED PERFORMANCE STANDARDS FOR CERTAIN CLINICAL CARE DOMAIN AND SAFETY DOMAIN MEASURES FOR THE FY 2020 PROGRAM YEAR—Continued

Measure ID	Description	Achievement threshold	Benchmark
Clinical Care Domain			
MORT–30–AMI	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (AMI) Hospitalization.	0.853715	0.875869
MORT–30–HF	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Heart Failure (HF) Hospitalization.	0.881090	0.906068
MORT–30–PN	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Pneumonia Hospitalization.	0.882266	0.909532
THA/TKA*	Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA).	0.032229	0.023178

*Lower values represent better performance.

PREVIOUSLY ADOPTED AND NEWLY FINALIZED PERFORMANCE STANDARDS FOR THE FY 2021 PROGRAM YEAR

Measure ID	Description	Achievement threshold	Benchmark
Clinical Care Measures			
MORT–30–AMI±	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (AMI) Hospitalization.	0.860355	0.879714.
MORT–30–HF±	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Heart Failure (HF) Hospitalization.	0.883803	0.906144.
MORT–30–PN±	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Pneumonia Hospitalization.	0.886443	0.910670.
MORT–30–COPD±	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization.	0.923253	0.938664.
THA/TKA*±†	Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA).	0.031157	0.022418.
Efficiency and Cost Reduction Measures			
AMI Payment*#	Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Acute Myocardial Infarction (AMI).	Median Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care across all hospitals during the performance period.	Mean of the lowest decile Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care across all hospitals during the performance period.
HF Payment*#	Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Heart Failure (HF).	Median Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care across all hospitals during the performance period.	Mean of the lowest decile Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care across all hospitals during the performance period.

±Previously adopted performance standards.
*Lower values represent better performance.

Appendix – FY22 Performance Standards

NEWLY FINALIZED PERFORMANCE STANDARDS FOR THE FY 2022 PROGRAM YEAR

Measure ID	Description	Achievement threshold	Benchmark
Clinical Care Measures			
IORT–30–AMI	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following (RSMR) Acute Myocardial Infarction (AMI) Hospitalization.	0.861793	0. 881305.
IORT–30–HF	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Heart Failure (HF) Hospitalization.	0.879869	0.903608.
IORT–30–PN (updated cohort).	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Pneumonia Hospitalization.	0.836122	0.870506.
IORT–30–COPD	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization.	0.920058	0.936962.
HA/TKA *	Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA).	0.029833	0.021493.
IORT–30–CABG	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery.	0.979000	0.968210.
Efficiency and Cost Reduction Measures			
MI Payment *#	Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Acute Myocardial Infarction (AMI).	Median Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care across all hospitals during the performance period.	Mean of the lowest decile Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care across all hospitals during the performance period.
F Payment *#	Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Heart Failure (HF).	Median Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care across all hospitals during the performance period.	Mean of the lowest decile Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care across all hospitals during the performance period.

*Lower values represent better performance.
Finalized to be scored the same as the MSPB measure, as discussed in section IV.H.4.a.(3) of the preamble of this final rule.

Appendix – FY17 Impact of FY17 LTCH PPS Final Changes

Summary of Impact of Final 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	+0.7%
By Location:		
Rural	21	+0.3%
Urban	399	+0.7%
By Ownership Type:		
Voluntary	78	+0.3%
Proprietary	325	+0.8%
Government	17	+0.5%
By Region		
New England	13	+0.8%
Middle Atlantic	26	+1.4%
South Atlantic	63	+0.2%
East North Central	69	+0.6%
East South Central	34	+0.0%
West North Central	29	+0.02%
West South Central	128	+0.4%
Mountain	33	+0.72%
Pacific	25	+2.2%
*More detail is available in Table IV, "Impact of Payment Rate and Policy Changes to LTCH PPS Payments for Standard Federal Payment Rate Cases, For FY 2017," (see page 2389 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.		

Appendix - IQR Program for FY16-19 Payment Determination

Table VIII. IQR Program Measures for Payment Determination in FYs 2016 – 2019 **X= Mandatory measure**				
	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	Removed
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	Removed
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	
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 of 28 eCQMs	Must report 8 of 15 eCQMs **The 15 eCQMs remaining for 2019 are:** **AMI-8a CAC-3 ED-1 ED-2 EHDI-1a PC-01 PC-05 STK-02 STK-03 STK-05 STK-06 STK-08 STK-10 VTE-1 VTE-2**
AMI-7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival				
AMI-8a Timing of Receipt of Primary Percutaneous Coronary Intervention (PCI) (NQF #0163)				
AMI-10 Statin at discharge				
PN-6 Appropriate initial antibiotic selection				
STK-2 Antithrombotic therapy for ischemic stroke (NQF #0435)				
STK-3 Anticoagulation therapy for Afib/flutter (NQF #0436)				
STK-4 Thrombolytic therapy for acute ischemic stroke				
STK-5 Antithrombotic therapy by end of hospital day 2 (NQF #0438)				
STK-6 Discharged on statin (NQF #0439)				
STK-8 Stroke education				
STK-10 Assessed for rehabilitation services (NQF #0441)				
VTE-1 VTE prophylaxis (NQF #0371)				
VTE-2 ICU VTE prophylaxis (NQF #0372)				
VTE-3 VTE patients with anticoagulation overlap therapy				
VTE-4 VTE patients receiving un-fractionated Heparin with doses/labs monitored by protocol				
VTE-5 VTE discharge instructions				
VTE-6 Incidence of potentially preventable VTE				
SCIP INF-1 Prophylactic antibiotic received within 1 hour prior to surgical incision				
SCIP-INF-2 Prophylactic antibiotic selection for surgical patients				
SCIP–INF-9 Postoperative urinary catheter removal on postoperative day 1 or 2 with day of surgery being day zero				
ED-1 Median time from ED arrival to departure from the emergency room for patients admitted to the hospital (NQF#0495)				
ED-2 Median time from admit decision to time of departure from the ED for patients admitted to the inpatient status (NQF #0497)				
PC-01 Elective delivery < 39 completed weeks gestation (NQF #0469)				
PC-05 Exclusive breast milk feeding (NQF #0480)				
Healthy term newborn				
EDHI-1a Hearing screening prior to hospital discharge				
CAC- 3 Children's asthma care – 3				
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
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				X
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				X
Cholecystectomy/Common Duct Exploration episode-based payment				X
Spinal Fusion clinical episode-based payment				X
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	Removed
Participation in a Systematic Clinical Database Registry for General Surgery	X	X	X	Removed
Safe Surgery Checklist Use	X	X	X	X
Hospital Survey on Patient Safety Culture			X	X

Appendix – PCHQR Program Measures for 2019

PCHQR Program Measures for 2019	
Measure	**Public Display**
Safety and Healthcare Associated Infection	
NHSN CLABSI (NQF #0139)	Deferred
NHSN CAUTI (NQF #0138)	Deferred
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
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 (NQF #0166)	2016
Clinical Effectiveness	
External Beam Radiotherapy for Bone Metastases (NQF#1822)	2017
Claims-Based Outcomes	
Admissions and ED Visits for Patients Receiving Outpatient Chemotherapy	
*Updates to this measure are adopted in this rule, and will be displayed as soon as feasible after the CY 2017 data collection.	

Appendix – FY14 – FY18 LTCHQR Program Measures

LTCHQR Program Measures				
Measure Title	**FYs 2014 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	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				X
Discharge to Community PAC LTCH				X
Preventable Readmissions 30 Days Post LTCH Discharge				X
Drug Regimen Review Conducted with Follow-up				Adopted for 2020

Appendix – FY19 IPFQR Measures

IPFQR Program Measures for FY 2019	
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

Appendix: IPPS Regulatory 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

	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]
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

	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

	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]
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.

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