



PROPOSED RULE: MEDICARE HOSPITAL INPATIENT PROSPECTIVE PAYMENT SYSTEM FOR ACUTE CARE HOSPITALS AND FISCAL YEAR 2018 RATES AND OTHER ISSUES

SUMMARY

On April 14, 2017, the Centers for Medicare & Medicaid Services (CMS) released the FY 2018 proposed for Medicare’s IPPS and LTCH PPS payment systems.

The proposed rule is published in the *Federal Register* on April 28, 2017. Written or electronic comments on the proposals must be submitted to CMS by close of business June 13, 2017. A final rule will be published around August 1, 2017, with the rates and policy changes generally taking effect on October 1, 2017.

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

CMS estimates that policies and rates in the proposed rule would increase combined operating and capital payments to IPPS hospitals by \$3.1 billion in FY 2018. This results from an increase of \$1.8 billion in operating payments and a \$212 million increase in IPPS capital payments. Proposed policies related to DSH, if finalized, would result in an additional \$1.4 billion increase in uncompensated care payments.¹ Additional factors explained in more detail below will reduce the total increase in payments to approximately \$3.1 billion.

A. Inpatient Hospital Operating Update for FY 2018

The proposed rule increases operating payment *rates* by 1.6 percent for hospitals which successfully report quality measures and are meaningful users of EHRs. Other proposed changes to IPPS payments policies that will increase operating payments to approximately 1.7 percent. Proposed changes to Medicare’s uncompensated care payments will increase operating payments by an additional 1.2 percent for DSH hospitals resulting in an aggregate increase in operating payments of 2.9 percent.

The payment rate update factors are summarized in the table below.

Factor	Percent Change
FY 2018 inflation (market basket) update	2.9
Multifactor productivity adjustment	-0.4
Additional -0.75 percentage point update adjustment required by the ACA	-0.75
<i>Subtotal – “applicable percentage increase”</i>	<i>1.75</i>
Documentation and Coding Adjustment Required by 21 st Century Cures Act	+0.4588
“2 Midnight” Adjustment	-0.6
<i>Net increase in national standardized amounts (before application of budget neutrality factors)</i>	<i>1.6088*</i>
*CMS displays this amount as 1.6 percent on page 1692 of the display copy of the final rule. In column 1 of the impact table on page 1687, this figure is 1.5 percent to reflect the lower update for hospitals that are paid in full or part based on hospital-specific rates.	

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)

¹ The display copy of the proposed rule says in multiple places that the total increase in IPPS payments is \$3.1 billion. However, page 1670 says the increase in IPPS operating payments is \$3.8 billion but CMS confirmed that it is a typographical error and should be \$1.8 billion. Further, CMS also reports that uncompensated care payments are increasing \$1.0 billion on page 1670. On page 1725, CMS reports “FY 2018 DSH payments are estimated at approximately \$10.930 billion, or an increase of approximately 14.4 percent from FY 2017 DSH payments (approximately \$9.553 billion).” The difference between \$10.930 billion and \$9.553 billion rounds to \$1.4 billion. CMS’ reference to DSH payments would appear to include DSH plus uncompensated care with CMS estimating the uncompensated care portion of this increase equaling \$1.0 billion and the remainder coming from DSH.

and Medicare-dependent hospitals are paid. The documentation and coding adjustment does not apply to the hospital-specific rates of SCHs resulting in a 1.15 percent increase for these amounts rather than the 1.6 percent increase applicable to the national standardized operating amounts.

Table I Impact Analysis

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

Hospital Type	All Proposed Rule Changes
All Hospitals	1.7%
Large Urban	1.7%
Other Urban	1.8%
Rural	0.8%
Major Teaching	1.6%

The effects of several significant policies are shown or described separately from the rule's distributional impact table including:

- Payments for Medicare DSH and uncompensated care from the proposed rule policies are estimated to be \$1.4 billion higher (a 14.4 percent increase) than in FY 2017. See section V.F below for details of the policy changes.
- CMS estimates that hospital would experience a 2.4 percent increase in capital payments per case or about a \$212 million increase in capital payments in FY 2018 compared to FY 2017.
- The Hospital Readmissions Reduction Program (HRRP) would reduce FY 2018 payments to an estimated 2,591 hospitals by \$564 million, an increase of \$27 million over the estimated FY 2017 savings.
- CMS is unable to provide the estimated impact of the FY 2018 HAC Reduction Program due to an error in the version 6.0 (recalibrated) AHRQ software. CMS anticipates being able to provide this information in the FY 2018 IPPS final rule.
- 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 \$1.9 billion based on hospitals' performance scores.
- With respect to new medical service and technology add-on payments, CMS has not yet determined whether the six applications it received for add-on payments for FY 2018 meet the criteria for the add-on policy. Estimates will be included in the final rule if any are found to be eligible for the new technology add-on payment. New technology add-on payments for four technologies will expire at the end of FY 2017 decreasing spending by approximately \$52 million.

The impact analysis also discusses the effects of proposed policy changes relating to:

- the post-acute care transfer policy (an additional 3 MS-DRGs will be paid using the special payment transfer policy),
- the volume decrease adjustment for SCHs (20 hospitals qualifying based on the proposed methodology changes receiving \$750,000 per hospital with CMS estimating its proposed policy increasing spending by \$15 million),
- expiration of statutory provisions for the low volume hospital adjustment (net reduction of \$311 million with \$314 million in spending reductions from expiration of the statutory methodology and \$3 million increase due to hospitals receiving the previously established methodology).
- implementation of the additional 5-year extension of the Rural Community Hospital Demonstration Program which is budget neutral (CMS sets forth the budget neutrality offset methodology but does not provide the specific budget neutrality offset amount).
- changes to the provider-based status of Indian Health Service and Tribal Facilities and Organizations (no impact because the proposals are in line with CMS' current guidance).
- Hospital-within-hospital policies (no impact because the proposals are in line with CMS' current guidance)
- continued frontier community health integration project demonstration (budget neutral with recoupment among all CAHs if later payments are found to exceed payments that would otherwise have been made).

CMS estimates that the net aggregate effect of these policies would increase IPPS payments by \$3.1 billion in FY 2018.

B. IPPS Standardized Amounts for FY 2018

The four rate categories continue in FY 2018:

- Hospital Submitted Quality Data and is a Meaningful EHR User (applicable percentage increase [i.e., before adjustments] = 1.75 percent)
- Hospital did NOT submit quality data and is a meaningful EHR user (applicable percentage increase = 1.0250 percent)
- Hospital submitted quality data and is NOT a meaningful EHR user (applicable percentage increase = -0.0425 percent)
- Hospital did NOT submit quality data and is NOT a meaningful EHR user (applicable percentage increase = -1.15 percent)

The applicable percentage increases listed above are prior to application of budget neutrality factors to the standardized amount and other non-budget neutral adjustments pertaining to the 2-midnight policy and documentation and coding.

FY 2018 PROPOSED RULE TABLES 1A-1D

	Standardized Operating Amounts Wage Index > 1		Standardized Operating Amounts Wage Index < 1	
	Labor	Non-Labor	Labor	Non-Labor
Submitted Quality Data and Is a Meaningful User	\$3,822.07	\$ 1,773.93	\$3,469.52	\$2,126.48
Did Not Submit Quality Data and Is a Meaningful User	\$3,794.84	\$1,761.29	\$3,444.80	\$2,111.33
Submitted Quality Data and Is Not a Meaningful User	\$3,740.37	\$1,736.01	\$3,395.36	\$2,081.02
Did Not Submit Quality Data and Is a Not Meaningful User	\$3,713.14	\$1,723.37	\$3,370.64	\$2,065.87
Puerto Rico	N/A	N/A	\$3,469.52	\$2,126.48

TABLE 1D. PROPOSED CAPITAL STANDARD FEDERAL PAYMENT RATE	
	Rate
National	\$451.37

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

C. Outlier Payments and Threshold

FY 2018 outlier threshold. CMS proposes an outlier fixed-loss cost threshold for FY 2018 equal to the prospective payment rate for the MS-DRG, plus any IME, empirically justified Medicare DSH payments, estimated uncompensated care payment, and any add-on payments for new technology, plus **\$26,713**.

CMS projects that the final outlier threshold for FY 2018 will result in outlier payments equal to 5.1 percent of operating DRG payments and 6.26 percent of capital payments based on the respective federal rates, and it adjusts the respective operating and capital standardized amounts using the different percentages.

II. Changes to MS-DRG Classifications and Relative Weights

A. Background; MS-DRGs for FY 2017

The FY 2018 proposed rule continues the Medicare severity diagnosis-related group (MS-DRG) classification system used beginning in FY 2008.

B. FY 2018 Documentation and Coding Adjustment

In FY 2018, CMS proposes to begin a six-year process required by statute to restore prior payment adjustments removed from the IPPS rates to recoup \$11 billion in additional IPPS payments attributable to documentation and coding. Under this process, CMS adjusted the standardized amounts to the extent the actuaries estimate that increases in the average case-mix index (CMI) are due to improved medical record documentation and more complete and accurate coding unrelated to real increases in the severity of cases that would require additional hospital resources.

Section 631 of the ATRA, however, requires the Secretary to make a recoupment adjustment or adjustments totaling \$11 billion, the estimated amount of the increase in aggregate payments in FYs 2010, 2011, and 2012 due to delaying the prospective adjustments; the \$11 billion amount is written into the law. The adjustments are to be made over the period FY 2014 through FY 2017. The required ATRA recoupment adjustment is a

one-time recovery of prior payments, not a permanent reduction in payment rates. Therefore, any adjustment made to reduce rates in one year would eventually be offset by a positive adjustment, once the necessary amount of payments is recovered.

FY 2018 Proposal:

Consistent with the 21st Century Cures Act, CMS is proposing to implement the required +0.4588 percentage point adjustment to the standardized amount. CMS is not proposing future adjustments required under section 414 of the MACRA at this time but indicates that it expects to propose positive 0.5 percentage point adjustments to the standardized amounts for FYs 2019 through 2023 (which it must do absent further changes to the law).

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

1. Background

The regulations at § 412.87 specify three criteria for a new medical service or technology to receive add-on payments under the IPPS: (1) the medical service or technology must be new; (2) the medical service or technology must be costly such that the DRG rate otherwise applicable to discharges involving the medical service or technology is determined to be inadequate; and (3) the service or technology must demonstrate a substantial clinical improvement over existing services or technologies.

2. Proposed FY 2018 Status of Technologies Approved for FY 2017 Add-On Payments

CMS' policy is that a medical service or technology may be considered new within 2 or 3 years after the point at which data becomes available which reflects the inpatient hospital code assigned to the new service or technology. CMS' practice has been to begin and end new technology add-on payments on the basis of a FY and it generally follows a guideline that uses a 6-month window before and after the start of the FY to determine whether to extend an add-on payment for an additional fiscal year. In general, CMS extends add-on payments for an additional year only if the 3-year anniversary date of the product's entry onto the US market occurs in the later half of the FY.

For FY 2018, CMS proposes to discontinue new technology add-on payments for:

- CardioMEMS™ HF (Heart Failure) System
- LUTONIX® Drug Coated Balloon (DCB) Percutaneous Transluminal Angioplasty (PTA) Catheter and IN.PACT™ Admiral™ Paclitaxel Coated Percutaneous Transluminal Angioplasty (PTA) Balloon Catheter
- MAGEC® Spinal Bracing and Distraction System (MAGEC® Spine)

CMS proposes to continue new technology add-on payments for:

- Defitelio® (Defibrotide)
- GORE® EXCLUDER® Iliac Branch Endoprosthesis (IBE)
- Praxbind® (Idarucizumab)
- Vistogard™ (Uridine Triacetate)

3. FY 2018 Applications for New Technology Add-On Payments

CMS received nine applications for new technology add-on payments for FY 2018; three applicants withdrew their applications prior to the issuance of this proposed rule. The remaining six are:

- Bezlotozumab (ZINPLAVA™)
- *EDWARDS INTUITY Elite™ Valve System (INTUITY) and LivaNova Perceval Valve (Perceval)*
- *Ustekinumab (Stelara®)*
- *KTE-C19 (Axicabtagene Ciloleucel)*
- *VYXEOS™ (Cytarabine and Daunorubicin Liposome for Injection)*
- *GammaTile™*

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

A. Background

Core-Based Statistical Areas (CBSAs) for the Proposed FY 2018 Hospital Wage Index. CMS will continue to use the latest updates to the current statistical areas that were finalized in the FY 2017 IPPS/LTCH PPS final rule. Those updates were issued on July 15, 2015 (OMB Bulletin No. 15-01).

Codes for Constituent Counties in CBSAs. CBSAs and constituent counties within CBSAs each have unique identifying codes. CMS notes that of the two lists of such codes (i.e., the Social Security Administration (SSA) codes and the Federal Information Processing Standard (FIPS) codes), the SSA codes are no longer maintained and updated. CMS proposes to transition to using only FIPS codes beginning October 1, 2017, and to use the Census Bureau update changes listed below to calculate area wage indexes consistent with the CBSA-based methodologies finalized in the FY 2015 IPPS/LTCH PPS final rule:

- Petersburg Borough, AK (FIPS State County Code 02-195), CBSA 02, was created from part of former Petersburg Census Area (02-195) and part of Hoonah-Angoon Census Area (02-105). The CBSA code remains 02.
- The name of La Salle Parish, LA (FIPS State County Code 22-059), CBSA 14, is now LaSalle Parish, LA (FIPS State County Code 22-059). The CBSA code remains as 14.
- The name of Shannon County, SD (FIPS State County Code 46-113), CBSA 43, is now Oglala Lakota County, SD (FIPS State County Code 46-102). The CBSA code remains as 43.

CMS states that hospitals located in these counties will not be impacted by these changes; they will continue to be considered rural for the hospital wage index.

B. Verification of Worksheet S-3 Wage Data

The proposed wage index values are based on data from FY 2014 submitted cost reports, and include categories of costs paid under the IPPS (and outpatient costs) for salaries and hours from short term, acute care hospitals, home office costs and hours, certain contract labor costs and hours (including direct and certain indirect patient care, pharmacy, lab, and nonteaching physician Part A services), and wage-related costs (including pension costs). As was done for FY 2017, excluded categories of costs are direct and overhead salaries and hours for services not subject to IPPS payment (e.g., SNF and home health services), GME costs (teaching physicians and residents) and certified

registered nurse anesthetists, hospital-based RHCs and FQHCs, and CAHs. CMS notes these data are used to calculate wage indices for other providers of services as well as for prospective payments to IRFs, IPFs, LTCHs, and hospital outpatient services.

CMS calculates the proposed FY 2018 wage index based on wage data of 3,325 hospitals from Worksheet S-3, Parts II and III of the cost report for cost reporting periods beginning on or after October 1, 2013, and before October 1, 2014 (referred to as FY 2014 wage data); the data file used to construct the proposed wage index includes FY 2014 data submitted to CMS as of February 10, 2017.

CMS includes data from facilities that were IPPS hospitals in FY 2014 even if they terminated program participation as hospitals, but it excludes data from CAHs and from IPPS hospitals that converted to CAH status. CMS removed 7 hospitals that converted to CAH status after January 22, 2016. For multicampus hospitals, CMS uses the same methodology as it did for the FY 2017 wage index to allot wages and hours data among the different labor market areas where the campuses are located.

C. Method for Computing the Proposed FY 2018 Unadjusted Wage Index

The proposed FY 2018 national average hourly wage, unadjusted for occupational mix, is **\$42.0043**. CMS no longer computes a separate unadjusted wage index for Puerto Rico.

Clarification of Other Wage-Related Costs in the Wage Index

CMS is concerned by inconsistent reporting of other wage-related costs on Line 18 of Worksheet S-3 as well as by the types of costs being reported on that line. To be considered other wage-related costs that may be reported on Line 18 of Worksheet S-3 and for the wage index, the cost—

- Must be a fringe benefit as described by IRS Publication 15-B, and
- Must be reported to the IRS on employees' or contractors' W-2 or 1099 forms as taxable income.

CMS further clarifies that other wage-related costs that are not reported to the IRS on employees' or contractors' W-2 or 1099 forms as taxable income, *even if not required to be reported to the IRS according to IRS requirements*, will *not* be included in the wage index. CMS will apply the policy in calculating the wage index for FY 2019, including the FY 2019 desk reviews beginning in September 2017. CMS restates the criteria from the September 1, 1994 IPPS final rule (59 R 45357) for allowing other wage-related costs with clarifications as follows:

“Other Wage-Related Costs. A hospital may be able to report a wage-related cost (defined as the value of the benefit) that does not appear on the core list if it meets all of the following criteria:

- The wage-related cost is provided at a significant financial cost to the employer. To meet this test, the individual wage-related cost must be greater than 1 percent of total salaries after the direct excluded salaries are removed (the sum of Worksheet S-3, Part II, Lines 11, 12, 13, 14, column 4, and Worksheet S-3, Part III, Line 3, Column 4).
- The wage-related cost is a fringe benefit as described by the IRS and is reported to the IRS on an employee's or contractor's W-2 or 1099 form as taxable income.
- The wage-related cost is not furnished for the convenience of the provider or otherwise excludable from income as a fringe benefit (such as a working condition fringe).”

CMS believes that permitting other wage-related costs to be included in the wage index only if they have been reported on the employee's or contractor's W-2 or 1099 form as taxable income is a bright line test that is easy to administer and will ensure consistent treatment of other wage-related costs for all hospitals.

CMS notes that only a small minority of hospitals report other wage-related costs that meet the 1 percent test noted above. CMS believes that reporting these costs may not be an appropriate part of a relative measure of wage costs in a particular market area which may distort the average hourly wage for that area. Additionally, the agency's reviews indicate widely divergent types of costs reported as other wage-related costs which may also compromise the accuracy of the wage index. For these reasons, CMS is considering whether to exclude other wage-related costs in calculating the wage index in the future; **CMS seeks comments on the issue.**

D. Analysis and Implementation of the Proposed Occupational Mix Adjustment and the Proposed FY 2018 Occupational Mix Adjusted Wage Index

The proposed FY 2018 occupational mix-adjusted national average hourly wage is **\$41.9599**. CMS no longer computes a separate proposed occupational mix-adjusted Puerto Rico-specific average hourly wage.

CMS proposes to calculate the occupational mix adjustment factor using the same methodology it used for FYs 2012 through 2017 and to apply the occupational mix adjustment to 100 percent of the FY 2018 wage index. The proposed FY 2018 national average hourly wages for each occupational mix nursing subcategory are as follows:

Occupational Mix Nursing Subcategory	Proposed Average Hourly Wage
National RN	\$38.84760578
National LPN and Surgical Technician	\$22.72715122
National Nurse Aide, Orderly, and Attendant	\$15.94890269
National Medical Assistant	\$17.97139786
<i>National Nurse Category</i>	\$32.84544016

Based on CMSs' analysis of the occupational mix data, the national percentage of hospital employees in the nurse category is again approximately 43 percent (42.6 percent). The proposed wage index values for FY 2018 would increase for a larger percentage of urban areas (54.7 percent) than rural areas (48.9 percent) and would decrease for a larger percentage of rural areas (51.1 percent) than urban areas (45.1 percent).

CMS notes that the FY 2019 occupational mix adjustment will require a new survey which will be based on a calendar year 2016 survey approved by OMB on September 27, 2016 and is available on the CMS website at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files-Items/2016-Occupational-Mix-Survey-Hospital-Reporting-Form-CMS-10079-for-the-Wage-Index-Beginning-FY-2019.html>. The deadline for submission to MACs of completed 2016 surveys is July 3, 2017. Preliminary, unaudited calendar year 2016 survey data will be posted on the CMS website by mid-July 2017, and MACs will revise or verify data elements in the surveys that result in edit failures.

E. Proposed Application of the Rural, Imputed, and Frontier Floors

Rural Floor. CMS notes that the rural floor will increase the FY 2018 proposed wage index for 366 hospitals. CMS projects that, in aggregate, rural hospitals will experience a 0.63 percent decrease in payments as a result of the rural floor budget neutrality requirement; hospitals located in urban areas would 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 proposed rural floor in Massachusetts. CMS expects that 36 urban providers in Massachusetts would receive a rural floor wage index value which increases payments overall to Massachusetts by \$44 million in FY 2018. Urban Puerto Rico hospitals will receive a 0.2 percent increase in IPPS payments.

Proposed Expiration of Imputed Floor Policy. CMS proposes to let this program expire effective October 1, 2017. Under the imputed floor program, CMS imputes a “floor” for states with no rural counties; those states are Delaware, New Jersey and Rhode Island. CMS had expressed concerns about the policy because it creates a disadvantage in applying the wage index to hospitals in states with rural hospitals but no urban hospitals receiving the rural floor. The application of the rural and imputed floors requires transfer of payments from hospitals in states with rural hospitals, where the rural floor is not applied, to hospitals in states where the rural or imputed floor is applied. Discontinuing the imputed floor program would mean that only those states with both rural areas and hospitals located in those rural areas (including any hospital reclassified as rural under § 412.103) would benefit from the rural floor as provided for under statute. CMS also notes that it would exclude the imputed floor as a factor in the national budget neutrality adjustment.

Frontier Floor Wage Index. CMS does not propose any changes to the frontier floor wage index policies for FY 2018. Thus, 52 hospitals in Montana, Nevada, North Dakota, South Dakota, and Wyoming would receive the frontier floor value of 1.0000 for FY 2018. This provision is not budget neutral, and CMS estimates an increase of approximately \$65 million in IPPS operating payments in FY 2018 by reason of the frontier floor.

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

Reclassifications

CMS notes that 375 hospitals were approved for wage index reclassifications starting in FY 2018 by MGCRB, and because such reclassifications are effective for 3 years, a total of 906 hospitals are in a reclassification status for FY 2018 (including those initially approved by the MGCRB for FYs 2016 (257 hospitals) and 2017 (274 hospitals)). Applications for FY 2019 reclassifications are due by **September 1, 2017** which is also the deadline for canceling a previous wage index reclassification withdrawal or termination. Changes to the wage index by reason of reclassification withdrawals, terminations, wage index corrections, appeals and the CMS review process would be incorporated in the final FY 2018 wage index values.

Previously, § 412.256(a)(1) required applications for reclassification to be mailed or delivered to the MGCRB with a copy to CMS. For applications for FY 2018 and subsequent years, CMS revised its policy to require that applications and supporting documentation be submitted to the MGCRB by the method that the MGCRB prescribes, with an electronic copy to CMS. Copies to CMS would be sent by email to wageindex@cms.hhs.gov. The current information collection requirements for MGCRB procedures and criteria expired on February 28, 2017; an extension is required in time for applications due September 1, 2017 for FY 2019 reclassifications. CMS notes that the extension request is

pending at OMB and can be accessed at: https://www.reginfo.gov/public/do/PRAViewICR?ref_nbr=201612-0938-023.

Special Rules for Sole Community Hospital and Rural Referral Center (RRC) Reclassifications

CMS proposes a number of changes to provide greater clarity for hospitals and to provide the MGCRB more time to conduct reviews:

- Under revised § 412.230(a)(3), the deadline for hospitals to submit documentation of SCH or RRC status approval to the MGCRB would be the first business day after January 1.
- Under revised § 412.230(d)(3), a hospital would qualify for the exception if it was ever approved as a RRC. The deadline for submission of documentation of RRC status approval (current or past) would also be the first business day after January 1.

The agency would also make additional conforming changes to other provisions of those regulations.

Additionally, pursuant to the April 21, 2016 IFC hospitals may simultaneously be redesignated as rural under § 412.103 and reclassified under the MGCRB. CMS believes that the existing language of § 412.230(a)(3)(ii) does not clearly address the situation of an SCH or RRC that is redesignated as rural under § 412.103 and reclassified under the MGCRB. Specifically, the regulations indicate that the SCH or RRC is redesignated to the urban area closest to the hospital, and CMS believes that language could be interpreted to mean the hospital's geographic home area or the closest area outside the hospital's geographic home area. CMS proposes to clarify the regulation so that an SCH or RRC under these circumstances may be redesignated to either hospital's geographic home area or the closest area outside the hospital's geographic home area. Specifically, CMS proposes that an SCH or RRC (or both) that qualifies for urban redesignation is redesignated to the urban area closest to the hospital or to the hospital's geographic home area. If the hospital is closer to another rural area, it may seek redesignation to either the closest rural or the closest urban area.

Provisions Relating to Lugar Hospitals

CMS proposes to require a Lugar hospital that qualifies for and accepts the out-migration adjustment (or that no longer wants to accept the out-migration adjustment) to notify CMS within 45 days from the date of public display of the proposed rule.

CMS reminds readers that a request to waive Lugar status that is timely received is valid for the full 3-year period for which the out-migration adjustment applies; however, the hospital may reinstate its urban status for any fiscal year during that 3-year period. CMS clarifies that requests to both waive and reinstate Lugar status may be sent electronically to wageindex@cms.hhs.gov; hospitals should include their CCN and should indicate either "waive Lugar" or "reinstate Lugar" in the subject line.

Proposed Changes to 45-Day Notification Rules.

The regulations indicate that the 45-day period begins on the date of the publication of the hospital IPPS proposed rule in the *Federal Register*. CMS proposes to change the start date of the 45-day period to the date of the public display copy of the hospital IPPS proposed rule at the Office of the Federal Register. **CMS invites comments on the proposal.**

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

Table 2 associated with the proposed rule lists the proposed out-migration wage index adjustments for FY 2018. The “out-migration” adjustment is an adjustment to the hospital wage index based on commuting patterns of hospital employees.² CMS proposes to use the same policies, procedures and computation that were used for the FY 2012 out-migration adjustment, and estimates increased payments of approximately \$39 million in FY 2018 for 248 hospitals receiving the out-migration adjustment. This provision is not budget neutral.

For FY 2018, and until CMS finalizes out-migration adjustments based on the next Census, the outmigration adjustment continues to be derived from the custom tabulation of the American Community Survey (ACS), an official Census Bureau survey, utilizing 2008 through 2012 (5-Year) Microdata.

H. Clarification of Application Deadline for Rural Referral Center (RRC) Classification

The criteria that a hospital must meet to qualify as an RRC are specified in § 412.96 of the regulations. CMS seeks to clarify the timeframes during which applications for RRC status must be submitted. CMS states that a hospital’s application for RRC status must be submitted during the last quarter of the cost reporting period before the first quarter of the hospital’s cost reporting year. If the application is approved, RRC status takes effect beginning with the hospital’s cost reporting period occurring after the last quarter of the cost reporting period in which the hospital submits an application.

CMS also clarifies that while applications for urban-to-rural reclassification under § 412.103 may be submitted at any time, a hospital seeking RRC status based on a rural reclassification under § 412.103 must still submit the application for RRC status during the last quarter of its cost reporting period before the next cost reporting period. If approved, the § 412.103 rural reclassification would be effective as of the date of the application, and the RRC status would be effective beginning with the hospital’s cost reporting period occurring after the last quarter of the cost reporting period in which the hospital submits the application.

I. Proposed Process for Requests for Wage Index Data Corrections

CMS proposes, beginning next year for wage data revisions for the FY 2019 wage index, to require hospitals that wish to challenge the MAC’s handling of wage data on any basis (including a policy, factual, or any other dispute) to request that CMS intervene “by the date in April that is specified as the deadline for hospitals to appeal MAC determinations and request CMS’ intervention in cases where the hospital disagrees with the MAC’s determination (the wage index timetable would be updated to reflect the specified date).”

The FY 2018 wage data files and the 2013 preliminary occupational mix data files were provided on May 16, 2016. CMS posted a public use file (PUF) on January 30, 2017 with wage index data as of January 29, 2017; the PUF also contained a new tab with the Worksheet S-3 wage data and 2013 occupational mix data (if any) of those hospitals deleted from the January 30, 2017 wage data PUF.

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

CMS plans to release the final wage index data PUFs in late April 2017 at the following CMS Web site:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files-Items/FY2018-Wage-Index-Home-Page.html>. CMS notes that these files are made available solely for the limited purpose of identifying any potential errors made by CMS or the MAC in the entry of the final wage index data. If a hospital believes a potential error exists because of these reasons, the hospital is required to send its request and supporting documentation to CMS and to the MAC no later than May 30, 2017. Appeals must be sent by mail and email. Verified corrections will be incorporated into the final wage index in the FY 2018 IPPS/LTCH PPS final rule.

If errors are identified by hospitals after the May 30, 2017 deadline, CMS may make midyear changes to the wage index under the following limited circumstances: 1) the MAC or CMS erred in tabulating its data; and 2) the requesting hospital could not have known about the error, or could not have had an opportunity to correct the error, by the May 30, 2017 deadline for the FY 2018 wage index. If such a correction would change the wage index value for an area, the revised wage index would be effective prospectively from the correction date.

CMS may make wage index value changes retroactive to the beginning of the fiscal year involved only under very limited circumstances, as follows: 1) the MAC or CMS erred in tabulating data; 2) the hospital knew and requested a correction before May 30, 2017 for the FY 2018 wage index; and 3) CMS agreed before October 1 that the error was made and should be corrected. However, this would not apply for a hospital that seeks to revise another hospital's data; nor can the correction be used to revise a prior fiscal year's wage index data. CMS notes that there would also be retroactive effect where a judicial decision reverses a CMS denial of a hospital's wage index revision request.

Process for Data Corrections by CMS after the January PUF

CMS proposes to establish a process for hospitals to request additional review of corrections made by CMS to their wage index data after the display of the January PUF. Specifically, beginning with the FY 2019 wage index development cycle, CMS proposes to use existing appeal deadlines for determinations made by MACs during the desk review process for hospitals to dispute CMS corrections after the January PUF posting that do not arise from a hospital request for a wage data revision. Starting with the existing April appeal deadline, a hospital would dispute CMS adjustments under existing deadlines as follows:

- For CMS adjustments made between the date the January PUF is posted and 14 calendar days before the April appeals deadline, hospitals must dispute the correction by the April appeals deadline.
- For CMS adjustments made between the date that is 13 calendar days before the April appeals deadline and 14 days before the May appeals deadline, hospitals must dispute the correction by the May appeals deadline.
- For CMS adjustments with respect to which hospitals were notified 13 calendar days before the May appeals deadline or later, hospitals may appeal to the PRRB.

Hospitals would have to request the correction by the first applicable deadline. A hospital that fails to meet the procedural deadlines would not have a later opportunity to submit wage index data corrections or to dispute CMS' decision on requested changes. **CMS invites comment on its proposal.**

J. Proposed Labor Market Share for the Proposed FY 2018 Wage Index

CMS proposes to rebase and revise the IPPS market basket reflecting 2014 data for the discharges occurring on or after October 1, 2017. CMS proposes that the revised labor-related share be implemented in a budget neutral manner, but in doing so it assumes all hospitals receive the higher labor-related share of the standardized amount. For FY 2018, CMS proposes to apply the following labor-related share percentages for the national standardized amounts for all IPPS hospitals (including Puerto Rico hospitals):

- 68.3 percent for hospitals with a wage index value greater than 1.0000; and
- 62 percent for hospitals with a wage index value less than or equal to 1.0000.

Tables 1A and 1B in section VI of the Addendum to the proposed rule reflect the proposed national labor-related share.

As the wage index in all areas of Puerto Rico is less than 1.0, all hospitals in Puerto Rico will receive a labor-related share of 62 percent.

IV. Proposed Rebasing and Revising of the Hospital Market Baskets for Acute Care Hospitals

A. Rebasing and Revising the IPPS Market Basket

CMS is using Medicare costs reports that begin on or after October 1, 2013 and before October 1, 2014 for the proposed hospital market basket rebasing. CMS is proposing to use these cost reports because 2014 Medicare cost reports represent the most recent, complete set of Medicare cost report data available to develop cost weights for IPPS hospitals. CMS is using cost reports from IPPS hospitals only (hospitals excluded from the IPPS and CAHs are not included) and is only using Medicare-allowable operating costs that are paid under the IPPS.

B. Market Basket for Certain Hospitals Presently Excluded from the IPPS

Children's hospitals, PPS-excluded cancer hospitals, religious nonmedical health care institutions (RNHCIs) and hospitals that are located in the U.S. Virgin Islands, Guam, the Northern Mariana Islands and American Samoa are currently excluded from the IPPS and paid based on reasonable costs subject to a rate-of-increase limit per discharge. Due to the small number of these hospitals, CMS has not developed an input price index specific to IPPS excluded hospitals. CMS is currently using the FY 2010-based hospital market basket to update the rate-of-increase limit for these hospitals and is proposing to use the 2014-based hospital market basket for IPPS excluded hospitals.

C. Rebasing and Revised the Capital Input Price Index (CIPPI)

For the FY 2018 IPPS update, CMS is proposing to rebase and revise the CIPPI to a 2014 base year to reflect a more current structure of capital costs for IPPS hospitals. The

proposed 2014-based CIPI was derived using 2014 cost reports for IPPS hospitals, which includes providers whose cost reporting period began on or after October 1, 2013, and prior to September 30, 2014. The CIPI is not being described as FY-based because the data do not reflect only fiscal year data. CMS proposes to follow past practices to rebase and revise the CIPI.

V. Other Decisions and Proposed Changes to the IPPS for Operating System

A. Proposed Changes to MS-DRGs Subject to Postacute Care Transfer and MS-DRG Special Payment Policies (§ 412.4)

1. Proposed Changes for FY 2018

CMS is proposing to make MS-DRGs 987, 988 and 989 newly subject to the MS-DRG special payment methodology. They were previously assigned to the PAC transfer policy.

B. Proposed Change to Volume Decrease Adjustment for Sole Community Hospitals and Medicare-Dependent, Small Rural Hospitals (§ 412.92)

For cost reporting periods beginning on or after October 1, 2017, CMS proposes to change how MACs calculate the volume decrease adjustment for SCHs (and for MDHs if Congress extends the MDH program past September 30, 2017 when it is set to expire). Under the proposal, MACs would compare estimated Medicare revenue for fixed costs to the hospital's fixed costs; in order to estimate the fixed portion of the Medicare revenue, the MACs would apply the ratio of the hospital's fixed costs to total costs, in the cost reporting period when it experienced the volume decrease, to the hospital's total Medicare revenue in that same cost reporting period. By taking the ratio derived from the subset of fixed costs to total costs and applying the same ratio to the MS-DRG payment, CMS states that the sum of a hospital's IPPS payment and its volume decrease adjustment payment would never exceed its total Medicare inpatient operating costs. Thus, CMS proposes to remove the cap calculation from the volume decrease adjustment calculation in future periods.

Effective for cost reporting periods beginning on or after October 1, 2017, CMS also proposes to modify the volume decrease adjustment process with respect to hospital staffing costs; specifically, CMS would no longer require a hospital to explicitly demonstrate that it appropriately adjusted the number of staff in inpatient areas of the hospital based on the decrease in the number of inpatient days. MACs would no longer be required to adjust the volume decrease adjustment payment amount for excess staffing.

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

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

To qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2017, CMS proposes that a rural hospital with fewer than 275 beds available for use must, among other things:

- Have a CMI value for FY 2016 that is at least—
 - 1.6635 (national—all urban), or
 - The median CMI value (not transfer adjusted) for urban hospitals (excluding hospitals with approved teaching programs) calculated by CMS for the census region in which the hospital is located.
- Have as the number of discharges for its cost reporting period that began during FY 2015 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 proposed median regional CMIs and median regional numbers of discharges are listed in the proposed rule and will be revised in the final rule to the extent necessary to reflect the updated FY 2016 MedPAR file containing data from additional bills received through March 2017. A hospital seeking to qualify as an RRC should get its hospital-specific CMI value (not transfer-adjusted) from its MAC.

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

Section 204 of MACRA extended the ACA-revised criteria for the low-volume payment adjustment through FY 2017. Under those criteria for discharges occurring during FY 2017, a hospital qualifies 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.

Assuming that Congress does not amend section 1886(d)(12) to extend or make permanent the ACA-revised criteria, beginning with FY 2018, the preexisting low-volume hospital payment adjustment and qualifying criteria resume. Specifically, for a hospital to qualify for the low-volume payment adjustment, the road mileage qualifying criterion reverts to 25 miles from the nearest subsection (d) hospital, and the discharge qualifying criterion reverts to no more than 200 total discharges—Medicare and non-Medicare. While section 1886(d)(12)(C)(i) of the Act defines a low-volume hospital as having less than 800 discharges, CMS concluded in the FY 2005 IPPS final rule that a 25-percent low-volume adjustment to discharges of all qualifying hospitals with less than 200 discharges was most consistent with the mandate in section 1886(d)(12)(B)(i) of the Act to provide relief for low-volume hospitals where there is empirical evidence that higher incremental costs are associated with low numbers of discharges. Thus, hospitals with more than 200 discharges do not receive the low-volume adjustment. The number of discharges is determined using a hospital's most recently submitted cost report.

A hospital seeking this adjustment must provide written notice and sufficient documentation to its MAC that it meets the discharge and distance requirements applicable for FY 2018 by not later than September 1, 2017, for

the adjustment to apply to discharges occurring during FY 2018. A hospital that qualified as a low-volume hospital for FY 2017 may continue to receive the adjustment in FY 2018 without reapplying if it continues to meet the applicable mileage and discharge criteria (for FY 2018, the pre-ACA criteria). The hospital must send written verification (e.g., using a Web-based mapping tool) to its MAC by September 1, 2017 that it continues to meet the mileage criterion. For requests submitted after September 1, 2017 that are approved, the adjustment will apply prospectively to discharges within 30 days after the MAC approval date.

Proposed Parallel Low-Volume Hospital Payment Adjustment Regarding Hospitals Operated by the Indian Health Service (IHS)

Because CMS considers IHS and Tribal hospitals to be subsection (d) hospitals, CMS proposes to provide an adjustment equal to the low-volume adjustment for an IHS or Tribal hospital whose sole disqualifier for that adjustment is its proximity to a non-IHS hospital, and for a non-IHS hospital whose sole disqualifier is its proximity to an IHS or Tribal hospital.

Specifically, CMS proposes that in applying the mileage criterion for IHS and Tribal hospitals, it would consider only the hospital's proximity to another IHS or Tribal hospital; it would disregard non-IHS hospitals. For non-IHS hospitals, CMS would not consider the hospital's proximity to IHS or Tribal hospitals.

This proposal would apply with respect to discharges occurring in FY 2018 and subsequent fiscal years.

E. Indirect Medical Education (IME) Payment Adjustment (§ 412.105)

Pursuant to statute³, for discharges occurring in FY 2018, CMS would continue to apply the IME adjustment factor of 5.5 percent for every approximately 10-percent increase in a hospital's resident-to-bed ratio.

F. Proposed Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs) for FY 2018 (§ 412.106)

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

For FY 2018, CMS proposes to continue these policies unchanged from the FY 2017 final rule:

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

³ 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.

- o hospitals in Maryland, which are not paid under Section 1886(d) of the Act because the state entered into an agreement with CMS that Maryland hospitals will be paid under the Maryland All-Payer Model.
- MDHs paid under the IPPS federal rate are eligible to receive Medicare DSH payments if their disproportionate patient percentage is at least 15 percent. CMS applies the same process to determine eligibility for Medicare DSH and the uncompensated care payment as it does for all other IPPS hospitals. The policies for MDHs would only apply in FY 2018 if the MDH program is extended by statute, beyond its current expiration date of September 30, 2017. MDHs are paid based on the IPPS Federal rate or, if the hospital's hospital-specific rate is higher than the IPPS Federal Rate, the IPPS Federal rate plus 75 percent of the amount by which the Federal rate is exceeded by the updated hospital-specific rate.

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

2. Uncompensated Care Payments

In the sections below, the data sources and methodologies for computing each of these factors and CMS' proposed policies for FY 2018 is discussed.

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 in absence of ACA.
- Factor 2 reduces the amount based on the reduction in uncompensated care as a result of the ACA
- Factor 3 is a hospital's uncompensated care relative to all uncompensated care provided by all hospitals for a given time period

a. Proposed FY 2018 Factor 1

Factor 1 is the difference between CMS' estimates (as determined by CMSs' Office of the Actuary) of: (1) the amount that would have been paid in Medicare DSH payments for FY 2018 in the absence of the ACA payment provision and (2) the amount of empirically justified Medicare DSH payments that are estimated to be made for FY 2018 taking into account the requirement to reduce Medicare DSH payments by 75 percent.

The January 2017 OACT estimate for Medicare DSH payments for FY 2018, prior to the ACA reduction, is \$16.003 billion. Based on this, the estimate for empirically justified Medicare DSH payments for FY 2018 after the ACA reduction is proposed to be about \$4.001 billion (25 percent of the total amount estimated). Thus, **CMS proposes that FY 2018 Factor 1, which is the difference between these two estimates, would be about \$12.002 billion.** The proposed Factor 1 for 2018 is about \$1.2 billion more than the final Factor 1 for FY 2017.

b. Proposed FY 2018 Factor 2

Factor 2 is based on the percent change in the uninsured, essentially since implementation of the ACA.

For FYs 2014 through 2017, the statute required Factor 2 to be based on data from the Congressional Budget Office (CBO). For FY 2018 and subsequent years, the statute provides greater flexibility in the choice of the data sources to be used in the estimate of the change in the percent of the uninsured. CMS determined that the best source for uninsured estimates is produced by CMS' OACT as part of the development of the National Health Expenditure Accounts (NHEA) which reflects rate of uninsurance⁴ in the U.S. across all age groups and residents (not just legal residents) who usually reside in the 50 states or the District of Columbia.

For the FY 2018 proposed rule, CMS used NHEA data and determined that the uninsured rate for the historical, baseline year of 2013 was 14 percent and for CYs 2017 and 2018 is 8.3 percent and 8.1 percent respectively. As required, the Chief Actuary of CMS certified these estimates.

Using these estimates, CMS calculates the proposed Factor 2 for FY 2018 as follows:

- Percent of individuals without insurance for CY 2013: 14 percent.
- Percent of individuals without insurance for CY 2017: 8.3 percent.
- Percent of individuals without insurance for CY 2018: 8.1 percent.
- Percent of individuals without insurance for FY 2018 $(0.25 \text{ times } 0.083) + (0.75 \text{ times } 0.081)$: 8.15 percent
 $1 - |((0.0815 - 0.14) / 0.14)| = 1 - 0.4179 = 0.5821$ (58.21 percent)
 0.5821 (58.21 percent) - .002 (0.2 percentage points for FY 2018 under section 1886(r)(2)(B)(ii) of the Act) = 0.5801 or 58.01 percent
0.5801 = Factor 2

Thus, **CMS calculated Factor 2 for the FY 2018 proposed rule to be 0.5801, or 58.01 percent, and the proposed uncompensated care amount for FY 2018 to be \$12.001 billion “times” 0.5801 = \$6.962 billion**, which is about \$1 billion more than the FY 2017 uncompensated care payment total of about \$5.97 billion; the percentage increase is 16.5 percent.⁵

c. Proposed FY 2018 Factor 3

(1) Background

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

⁴ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html>

⁵ For FY 2017, CMS determined Factor 2 to be 0.5536 and the amount available for uncompensated care payments for FY 2017 is approximately \$5.977 billion.

For Factor 3, the statute requires the Secretary to determine: (1) the definition of uncompensated care; (2) the data source(s) for the estimated uncompensated care amount; and (3) the timing and manner of computing the amount for each hospital estimated to receive DSH payments.

In FYs 2014-2017, CMS determined Factor 3 based on the utilization of insured low-income patients defined as inpatient days of Medicaid patients plus inpatient days of Medicare SSI patients.

(2) Proposed Data Sources for FY 2018

In a reversal of its decision from last year, CMS proposes to incorporate Worksheet S-10 data from FY 2014 into the calculation of Factor 3 of the uncompensated care payment.

(3) Proposed Time Period for Calculating Factor 3 for FY 2018, Including Methodology for Incorporating Worksheet S-10 Data

CMS proposes to use Worksheet S-10 data for the FY 2014 cost reporting period and the low-income insured day proxy data for the two earlier cost reporting periods. Specifically, for FY 2018 CMS will use:

- Worksheet S-10 data for FY 2014
- Medicaid days from FYs 2012 and 2013 cost reports and FYs 2014 and 2015 SSI ratios.

If CMS continues this approach for FYs 2019 and 2020, this would have the effect of transitioning data from Worksheet S-10 into the calculation of Factor 3. By 2020, the calculation of Factor 3 would be solely determined by data from Worksheet S-10.

For FY 2018, CMS proposes to continue its policies that were finalized in the FY 2015 IPPS/LTCH PPS final rule to address specific issues regarding the process and data to be employed in determining Factor 3 in the case of hospital mergers. CMS publishes a table on the CMS Web site, in conjunction with the issuance of each fiscal year's proposed and final IPPS rules, containing a list of the mergers known to CMS and the computed uncompensated care payment for each merged hospital. Hospitals have 60 days from the date of public display of each year's proposed rule to review the tables and notify CMS in writing of any inaccuracies.⁶

CMS proposes to continue these other policies and procedures in FY 2018 unchanged from the FY 2017 rule.

- Tables published on the CMS website for the FY 2018 proposed rule and forthcoming final rule list Factor 3 levels for all hospitals that CMS projects will receive empirically justified DSH payments in FY 2018 and thus would receive interim uncompensated care payments during the fiscal year. The table also includes Factor 3 levels for the remaining IPPS hospitals that have the potential of receiving a DSH payment in the event that they receive an empirically justified DSH payment for FY 2018 as determined at cost report settlement. Hospitals have 60 days from the date of the proposed rule's public display to review the tables and notify CMS in writing of a change in a hospital's subsection (d) hospital status, such as if a hospital has closed or converted to a CAH. The 60-day period will end June 13. After the publication of the final rule, hospitals will have until August 31, 2017 to review and

⁶ Comments on the list of mergers can be submitted to the CMS inbox at Section3133DSH@cms.hhs.gov.

submit comments on the accuracy of the tables.⁷

- CMS will continue to make interim uncompensated care payments in FY 2018 on a per-discharge basis. The estimated per-discharge amount, which is fixed for a particular hospital and does not vary by case mix, is based on the amount of the uncompensated care payment that CMS calculates for a hospital for a fiscal year divided by the average number of discharges, or claims, in the most recently available three fiscal years of the Medicare claims dataset.
- Cost report settlement will not include reconciliation of the values of Factors 1, 2, or 3 established in the final rule. Reconciliation will only include adjustments for changes in whether the hospital is actually eligible to receive empirically justified DSH payments.

(4) Methodological Considerations for Incorporating Worksheet S-10 Data

Definition of Uncompensated Care. In the 2017 IPPS/LTCH proposed rule, CMS proposed to adopt a definition of uncompensated care that included charity care and non-Medicare bad debt, but did not finalize its definition as part of the FY 2017 rulemaking. CMS reintroduces this proposal in this rule.

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

Cost of charity care (line 23)
+ Cost of non-Medicare bad debt expense (line 29)
Cost of non-Medicare uncompensated care (line 30)

Where:

- Cost of charity care = Cost of initial obligation of patients approved for charity care (line 21) minus partial payment by patients approved for charity care (line 22).
- Cost of non-Medicare bad debt expense = Cost to charge ratio (line 1) times non-Medicare and nonreimbursable bad debt expense (line 28).

Cost report revisions and Worksheet S-10 audits. CMS has made revisions to the cost report instructions and developed an audit process.

Changes to worksheet S-10 were included in Transmittal 10. Transmittal 10 can be downloaded from the CMS website at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2016-Transmittals-Items/R10P240.html>.

⁷ Comments on the accuracy of the table and supplemental data files can be submitted to the CMS inbox at Section3133DSH@cms.hhs.gov

Audit instructions for the MACs are under development and will be provided to the MACs as soon as possible. CMS expects that cost reports beginning in FY 2017 will be the first cost reports for which the Worksheet S-10 data will be subject to a desk review.

3. Impact Analysis

Based on the FFY 2018 proposed rule DSH and uncompensated care payments are estimated to increase approximately 14.4 percent from FY 2017 DSH and uncompensated care payments. Thus, a percent change in DSH payments of less than 14.4 percent indicate that hospitals within that category are projected to experience a smaller increase compared to all hospitals combined, and a percent change of more than 14.4 percent indicates this category of hospitals is doing better than all hospitals combined.

Rural hospitals are projected to receive a larger percentage increase in DSH and uncompensated care payments (31.2%) than urban hospitals (13.6%) in FY 2018 compared to FY 2017. Hospitals in the Pacific region (California, Oregon, and Washington) are the most negatively affected, with urban hospitals projected to receive a 3.3 percent increase and rural hospitals projected to receive a 8.9 percent decrease in payment, on average. In contrast, urban hospitals in the West South Central region (Arkansas, Louisiana, Oklahoma, and Texas) are projected to receive a 27.8 percent increase, and rural hospitals in this region are expected to receive a 93.6 percent increase, on average.

G. Medicare-Dependent, Small Rural Hospital Program (§ 412.108)

Section 205 of MACRA extended the MDH Program through the end of FY 2017. Thus, absent another statutory extension of the MDH program, beginning with discharges occurring on or after October 1, 2017, all hospitals that previously qualified for MDH status will be paid based on the Federal rate.

CMS notes that for an MDH to receive SCH status effective October 1, 2017, it must apply for SCH status at least 30 days before the MDH program expires (i.e., before September 1, 2017). The MDH must also specify that if approved as an SCH, the SCH status would be effective October 1, 2017. If the MDH applies after the September 1, 2017 deadline, the usual effective date rules would be 30 days after the date of CMS' written notice of approval.

H. Hospital Readmissions Reduction Program: Proposed Updates and Changes (§§ 412.150 through 412.154)

The Hospital Readmissions Reduction Program reduces payments to Medicare PPS hospitals having readmissions exceeding an expected level. The payment reductions are based on a formula that compares each hospital's payments for actual readmissions (risk-adjusted) to payments based on an estimate of that hospital's expected readmissions (also risk-adjusted). The list of conditions to which the HRRP applies in FY 2017 is:

- acute myocardial infarction (AMI);
- heart failure (HF); pneumonia (PN);
- total hip arthroplasty (THA)/total knee arthroplasty (TKA);
- chronic obstructive pulmonary disease (COPD);
- coronary artery bypass surgery (CABG) – for the first time

The HRRP formula includes a payment adjustment floor of 0.9700, meaning that a hospital subject to the HRRP receives an adjustment factor that is between 1.0 (no reduction) and 0.9700 (or a greatest possible reduction of 3 percent of base operating DRG payments). Hospital-specific excess readmissions ratios are posted on the *Hospital Compare* website as early as October of the applicable fiscal year. Hospitals are given a 30-day review and correction period before these data are made public.

1. HRRP Policies for FY 2018

FY 2018 CMS proposes to retain the same six conditions and the same methodology for calculating the HRRP reduction.

Applicable Period. Excess readmissions ratios and the payment adjustment for FY 2018 would be based on data from the 3-year period of July 1, 2013 through June 30, 2016. The 3-year period for 2017 is July 1, 2012 through June 30, 2015. For the final rule, the March update of each of the respective fiscal year MedPAR files will be used; for modeling purposes in the proposed rule, for claims within FY 2016, the December 2016 MedPAR update is used.

Extraordinary Circumstances Exceptions. Hospitals may request an extraordinary circumstance exception to the HRRP and other quality programs under certain circumstances. The details of these policies vary among the hospital quality reporting and value-based purchasing programs, and proposes three changes to the HRRP extraordinary circumstances exceptions policies that would align it with the hospital IQR program.

- Requests would not have to be signed by the facility's CEO, but could instead be signed by another appropriate designated contact.
- CMS will strive to complete reviews of extraordinary circumstances exception requests within 90 days of receipt.
- If CMS determines that a systemic problem with its data collection systems directly affected the ability of facilities to submit data, it would grant exceptions to affected facilities and communicate this decision through routine communication channels.

2. Payment Adjustment Methodology for FY 2019

The 21st Century Cures Act requires changes to the HRRP payment adjustment methodology beginning in FY 2019. Specifically, the Secretary is directed to assign hospitals to peer groups based on the proportion of Medicare inpatients who are full-benefit Medicare and Medicaid dual eligibles,⁸ and to develop a methodology that allows for separate comparisons for hospitals within these groups.

CMS invites comments on its proposals for implementing the 21st Century Cures Act modifications to the HRRP, and also on the various alternatives it considered in developing its proposals.

⁸ These are individuals who are entitled to Medicare Part A benefits and who meet the definition of full benefit dual eligible individual under section 1935(c)(6) of the Social Security Act, which for a state for a month is an individual who— (i) has coverage for the month for covered part D drugs under a Part D prescription drug plan or an MA-PD plan; and (ii) is determined eligible by the state for full Medicaid benefits for such month under section 1902(a)(10)(A) or 1902(a)(10)(C), by reason of section 1902(f), or under any other category of eligibility for full Medicaid benefits under this title, as determined by the Secretary.

Identification of dual eligibles. CMS proposes to identify dual eligible beneficiaries using data from the Medicare Modernization Act (MMA) file of dual eligibility, which states submit monthly to CMS. CMS proposes that a beneficiary would be counted as a full-benefit dual patient if they were identified as having full-benefit dual status in the state MMA files for the month during which they were discharged from the hospital.

Proportion of dual eligible inpatient stays, CMS proposes that the number of stays attributed to dual eligibles would be divided by the total number of inpatient stays by beneficiaries enrolled in fee-for-service Medicare or Medicare Advantage.

Data period. CMS proposes to use the HRRP 3-year applicable period in calculating the proportion of dual eligible stays. An alternative it considered and seeks comment on is using the latest 1-year period, which would emphasize the most recent hospital experience.

Assigning Hospitals to Peer Groups. Under the proposal, hospitals would be grouped by quintiles (five peer groups).

Payment Adjustment Formula. Using the five peer groups, CMS will to calculate the payment adjustment using a peer group-specific threshold in place of the current formula, which compares a hospital's excess readmission ratio (ERR) to a threshold of 1.000 as shown in the following equation for calculating the payment adjustment where "payment" refers to base operating DRG payments and dx refers to a condition:

$$\text{Current payment adjustment (P) = } 1 - \min\{.03, \sum_{dx} \frac{\text{Payment}(dx) * \max\{(\text{ERR}(dx) - 1.0000), 0\}}{\text{All payments}}\}$$

3. Impact Analysis

In the regulatory impact analysis appended to the proposed rule, CMS estimates that 2,591 hospitals would be penalized under the HRRP in FY 2018; with reductions totaling \$564 million, \$27 million more than the estimated savings.

I. Hospital Value-Based Purchasing (VBP) Program: Proposed Policy Changes

Several changes are proposed for the Hospital VBP Program including the removal (in FY 2019) and replacement (in FY 2023) of the PSI-90 patient safety composite measure; the addition of a pneumonia payment measure beginning with FY 2022 payment; changes to scoring of the efficiency domain; and modifications to the extraordinary circumstances exceptions policy.

A summary of VBP Program measures and domains for selected years appears in Summary Table VBP-1 at the end of this section.

1. Background and Discussion of Social Risk Factors

CMS estimates that the total amount available for VBP Program payments in FY 2017 is approximately \$1.9 billion. This approximately equals 2.0 percent of base operating DRG payments.

In this proposed rule, CMS repeats the discussion of accounting for social risk factors that was also included in the section of the rule on the HRRP. This discussion is summarized. With specific reference to the VBP Program, CMS also notes that the December 2016 ASPE report includes an analysis of the Medicare Spending per Beneficiary (MSPB) measure, and that this measure is currently undergoing review at the NQF as part of the 2-year socioeconomic trial period. Further, CMS notes that the acute myocardial infarction (AMI) payment and heart failure (HF) payment measures adopted for the VBP Program were recently re-endorsed by the NQF without modification regarding social risk factors.

2. VBP Payment in FY 2018

CMS has posted on the [FY 2018 IPPS proposed rule web](#) page a Table 16 which includes proxy hospital-specific value-based incentive payment adjustment factors for FY 2018 based on hospitals' TPSs from the FY 2017 Hospital VBP Program; these proxies therefore reflect the performance periods, measures, and domain weights in effect for that year.

In the final rule, CMS will publish a Table 16A which reflects changes based on the March 2017 update to the FY 2016 MedPAR file. After hospitals have been given an opportunity to review and correct their actual TPSs for FY 2018 (expected in October 2017), 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 2018 program year.

3. Removal of the PSI 90 Measure for FY 2019

CMS proposes to remove the PSI 90 composite patient safety measure from the VBP Program beginning with FY 2019 payment. As discussed below, CMS also proposes in this rule to adopt the modified version of this measure beginning with FY 2023 payment. The reason for the proposed removal of PSI 90 is that an ICD-10 version of the current measure is not being developed, which means that CMS could not calculate performance scores for this measure for FY 2019.

4. New Measure for FY 2022

Beginning with FY 2022 payment, CMS proposes to add a hospital-level, risk standardized 30-day pneumonia episode of care payment measure to the VBP Program. This measure was adopted for the IQR Program for payment beginning in FY 2018 and CMS intends that performance data will be posted on *Hospital Compare* in July 2017, with a performance period to begin in August 2018.

Baseline/Performance Periods: CMS proposes that:

- FY 2022: A shorter performance period will allow the measure to be adopted sooner.
 - o 23-month performance period (August 1, 2018-June 30, 2020)
 - o 36-month baseline period (July 1, 2013-June 30, 2016)
- FY 2023:
 - o 35 month performance period (August 1, 2018-June 30, 2021)
 - o 36-month baseline period would remain July 1, 2013-June 30, 2016
- FY 2024:
 - o 36-month performance period beginning on July 1st 5 years prior to the applicable fiscal year and ending on the June 30th 2 years prior.
 - o The baseline period would begin July 1st 10 years prior to the applicable fiscal year and end on the June 30th 7 years prior.

5. Addition of the Patient Safety and Adverse Events Composite for FY 2023

CMS proposes to add the Agency for Healthcare Research and Quality (AHRQ) Patient Safety and Adverse Events composite measure (NQF#0531) to the VBP Program beginning with FY 2023. This measure is also referred to as “modified PSI 90,” and was adopted for the IQR Program beginning with the FY 2018 payment determination. CMS intends that public reporting on the measure begin in July 2017. This measure is a composite of 10 AHRQ patient safety indicators⁹.

Baseline/Performance Periods: CMS proposes that:

- FY 2023: Baseline period shortened to permit early adoption of the measure using only ICD 10 claims.
 - o 21-month baseline period for this measure (October 1, 2015-June 30, 2017)
 - o 24-month performance period (July 1, 2019-June 30, 2021).
- FY 2024 and subsequent years: Baseline and performance periods of 24 months.
 - o The baseline period would begin on July 1st 8 years prior to the payment year and end on the June 30th 6 years prior. (For example, for 2024 the baseline period would be July 1, 2016-June 30, 2018.)
 - o The performance period would begin on July 1st 4 years prior to the payment year and end on the June 30th 2 years prior.

6. Performance and Baseline Periods

CMS previously adopted performance and baseline periods for most VBP Program measures based on length; the specific time periods are therefore automatically updated each year. The proposed rule includes the tables below that display the previously adopted and proposed baseline and performance periods for each fiscal year beginning with 2019 through 2023.

⁹ The ten indicators included in the modified PSI 90 composite measure are: PSI-3 (pressure ulcer rate), PSI-6 (iatrogenic pneumothorax), PSI-8 (Postoperative hip fracture rate), PSI-9 postoperative hemorrhage or hematoma rate, PSI-10 physiologic and metabolic derangement rate, and PSI-11 Postoperative respiratory failure 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).

PREVIOUSLY ADOPTED BASELINE AND PERFORMANCE PERIODS FOR THE FY 2019 PROGRAM YEAR

Domain	Baseline period	Performance period
Person and Community Engagement:		
• HCAHPS Survey	• January 1, 2015–December 31, 2015	• January 1, 2017–December 31, 2017.
Clinical Care:		
• Mortality (MORT–30–AMI, MORT–30–HF, MORT–30–PN).		
• THA/TKA	• July 1, 2009–June 30, 2012	• July 1, 2014–June 30, 2017.
	• July 1, 2010–June 30, 2013	• January 1, 2015–June 30, 2017.
Safety:*		
• PC–01 and NHSN measures (CAUTI, CLABSI, SSI, CDI, MRSA).	• January 1, 2015–December 31, 2015	• January 1, 2017–December 31, 2017.
Efficiency and Cost Reduction:		
• MSPB	• January 1, 2015–December 31, 2015	• January 1, 2017–December 31, 2017.

* As discussed in section V.J.3.b. of the preamble of this proposed rule, we are proposing to remove the current PSI 90 measure beginning with the FY 2019 program year. As a result, the previously finalized performance and baseline periods for this measure are not included in this table.

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

Domain	Baseline period	Performance period
Person and Community Engagement:		
• HCAHPS Survey	• January 1, 2016–December 31, 2016	• January 1, 2018–December 31, 2018.
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.
Safety:*		
• PC–01 and NHSN measures (CAUTI, CLABSI, SSI, CDI, MRSA).	• January 1, 2016–December 31, 2016	• January 1, 2018–December 31, 2018.
Efficiency and Cost Reduction:		
• MSPB	• January 1, 2016–December 31, 2016	• January 1, 2018–December 31, 2018.

* As discussed in section V.J.3.b. of the preamble of this proposed rule, we are proposing to remove the current PSI 90 measure beginning with the FY 2019 program year. As a result, the previously finalized performance and baseline periods for this measure are not included in this table.

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

Domain	Baseline period	Performance period
Person and Community Engagement:		
• HCAHPS Survey	• January 1, 2017–December 31, 2017	• January 1, 2019–December 31, 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.
• MORT–30–PN (updated cohort)	• July 1, 2012–June 30, 2015	• September 1, 2017–June 30, 2019.
• THA/TKA	• April 1, 2011–March 31, 2014	• April 1, 2016–March 31, 2019.
Safety:*		
• PC–01 and NHSN measures (CAUTI, CLABSI, SSI, CDI, MRSA).	• January 1, 2017–December 31, 2017	• January 1, 2019–December 31, 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.

* As discussed in section V.J.3.b. of the preamble of this proposed rule, we are proposing to remove the current PSI 90 measure beginning with the FY 2019 program year. As a result, the previously finalized performance and baseline periods for this measure are not included in this table.

PREVIOUSLY ADOPTED AND PROPOSED BASELINE AND PERFORMANCE PERIODS FOR THE FY 2022 PROGRAM YEAR

Domain	Baseline period	Performance period
Person and Community Engagement:		
• HCAHPS Survey	• January 1, 2018–December 31, 2018	• January 1, 2020–December 31, 2020.
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.
• MORT–30–PN (updated cohort)	• July 1, 2012–June 30, 2015	• September 1, 2017–June 30, 2020.
• THA/TKA	• April 1, 2012–March 31, 2015	• April 1, 2017–March 31, 2020.
Safety:*		
• PC–01 and NHSN measures (CAUTI, CLABSI, SSI, CDI, MRSA).	• January 1, 2018–December 31, 2018	• January 1, 2020–December 31, 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.
• PN Payment**	• July 1, 2013–June 30, 2016	• August 1, 2018–June 30, 2020.

* As discussed in section V.J.3.b. of the preamble of this proposed rule, we are proposing to remove the current PSI 90 measure beginning with the FY 2019 program year. As a result, the previously finalized performance and baseline periods for this measure are not included in this table.

** As discussed in section V.J.4.a. of the preamble of this proposed rule, we are proposing to adopt the PN Payment measure beginning with the FY 2022 program year.

PREVIOUSLY ADOPTED AND PROPOSED BASELINE AND PERFORMANCE PERIODS FOR THE FY 2023 PROGRAM YEAR

Domain	Baseline period	Performance period
Person and Community Engagement:		
• HCAHPS Survey	• January 1, 2019–December 31, 2019	• January 1, 2021–December 31, 2021.
Clinical Care:		
• Mortality (MORT–30–AMI, MORT–30–HF, MORT–30–COPD, MORT–30–CABG, MORT–30–PN (updated cohort)).	• July 1, 2013–June 30, 2016	• July 1, 2018–June 30, 2021.
• THA/TKA	• April 1, 2013–March 31, 2016	• April 1, 2018–March 31, 2021.
Safety:		
• PC–01 and NHSN measures (CAUTI, CLABSI, SSI, CDI, MRSA).	• January 1, 2019–December 31, 2019	• January 1, 2021–December 31, 2021.
• Patient Safety and Adverse Events (Composite)*.	• October 1, 2015–June 30, 2017	• July 1, 2019–June 30, 2021.
Efficiency and Cost Reduction:		
• MSPB	• January 1, 2019–December 31, 2019	• January 1, 2021–December 31, 2021.
• Payment (AMI Payment, HF Payment) ..	• July 1, 2013–June 30, 2016	• July 1, 2018–June 30, 2021.
• PN Payment**	• July 1, 2013–June 30, 2016	• August 1, 2018–June 30, 2021.

* As discussed in section V.J.4.b. of the preamble of this proposed rule, we are proposing to adopt the Patient Safety and Adverse Events (Composite) measure beginning with the FY 2023 program year.

** As discussed in section V.J.4.a. of the preamble of this proposed rule, we are proposing to adopt the PN Payment measure beginning with the FY 2022 program year.

In addition to the new measures, two changes are proposed related to baseline and performance periods.

1) HF and AMI Payment Measures:

- a. CMS previously adopted a 24-month performance period and a 36-month baseline period for FY 2021 and a 36-month baseline and performance periods for FY 2022.
- b. In this rule, CMS proposes that for FY 2023 and future years, a 36-month performance period would be used that runs from July 1st five years prior to the program year to June 30th two years prior to the program year. The 36-month baseline period would begin July 1st 10 years prior to the program year and end June 30th 7 years prior.

- 2) Clinical Care Domain: CMS proposes to adopt baseline and performance periods of 36 months for FY 2023 and later years.
- Specifically, for the mortality measures, for FY 2023 the proposed baseline period would begin on July 1st of the year 10 years prior to the payment year and end on June 30th of the year 7 years prior.
 - The performance period would begin July 1st of the year 5 years prior to the payment year and end on June 30th of the year 2 years prior.
 - For the THA/TKA complications measure, the baseline and performance periods would be the same except that they would begin on April 1st of the applicable year and end on March 31st three years later.

7. Performance Standards

The proposed rule includes the tables below that display the previously adopted and proposed numeric performance standards for VBP Program measures for FY 2020 - FY 2023. For measures in the efficiency and cost reduction domain, performance standards are based on performance period data and therefore numeric standards for these measures cannot be published in advance.

PREVIOUSLY ADOPTED AND PROPOSED PERFORMANCE STANDARDS FOR THE FY 2020 PROGRAM YEAR: SAFETY, CLINICAL CARE, AND EFFICIENCY AND COST REDUCTION DOMAINS #

Measure short name	Achievement threshold	Benchmark
Safety Domain ♦		
CAUTI **†	0.806	0.000.
CLABSI **†	0.797	0.000.
CDI **†	0.876	0.090.
MRSA Bacteremia **†	0.794	0.000.
Colon and Abdominal Hysterectomy SSI **†	• 0.784	• 0.000.
	• 0.775	• 0.000.
PC-01 *	0.005952	0.000000.
Clinical Care Domain		
MORT-30-AMI ±	0.853715	0.875869.
⁷⁹ We note that the mortality measures in the Hospital VBP Program use survival rates rather than mortality rates; as a result, higher values indicate better performance on these measures.		
Measure short name	Achievement threshold	Benchmark
MORT-30-HF ±	0.881090	0.906068.
MORT-30-PN ±	0.882266	0.909532.
THA/TKA **±	0.032229	0.023178.
Efficiency and Cost Reduction Domain		
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.

PROPOSED PERFORMANCE STANDARDS FOR THE FY 2020 PROGRAM YEAR: PERSON AND COMMUNITY ENGAGEMENT DOMAIN *±

HCAHPS survey dimension	Floor (percent)	Achievement threshold (percent)	Benchmark (percent)
Communication with Nurses	49.26	78.99	87.17
Communication with Doctors	46.91	80.31	88.56
Responsiveness of Hospital Staff	35.92	65.16	80.05
Communication about Medicines	23.44	63.41	73.94
Hospital Cleanliness & Quietness	37.21	65.81	79.29
Discharge Information	65.60	87.36	92.04
Care Transition	21.20	51.12	62.56
Overall Rating of Hospital	35.46	71.35	85.01

* We renamed this domain from Patient- and Caregiver-Centered Experience of Care/Care Coordination domain to Person and Community Engagement domain beginning with the FY 2019 program year, as discussed in the FY 2017 IPPS/LTCH PPS final rule (81 FR 56984).

± The performance standards displayed in this table were calculated using one quarter (Q4) CY 2015 data and three quarters (Q1, Q2, and Q3) CY 2016 data. We will update this table's performance standards using four quarters of CY 2016 data in the final rule.

PREVIOUSLY ADOPTED PERFORMANCE STANDARDS FOR THE FY 2021 PROGRAM YEAR

Measure short name	Achievement threshold	Benchmark
Clinical Care Domain		
MORT-30-AMI ±	0.860355	0.879714.
MORT-30-HF ±	0.883803	0.906144.
MORT-30-PN (updated cohort) †	0.836122	0.870506.
MORT-30-COPD ±	0.923253	0.938664.
THA/TKA ±	0.031157	0.022418.
Efficiency and Cost Reduction Domain		
MSPB *±	Median Medicare Spending Per Beneficiary ratio across all hospitals dur- ing the performance pe- riod.	Mean of the lowest decile Medicare Spending Per Beneficiary ratios across all hospitals during the performance period.
AMI Payment *±	Median Hospital-Level, Risk-Standardized Pay- ment Associated with a 30-Day Episode-of-Care across all hospitals dur- ing the performance pe- riod.	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 *±	Median Hospital-Level, Risk-Standardized Pay- ment Associated with a 30-Day Episode-of-Care across all hospitals dur- ing the performance pe- riod.	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.

† After publication of the FY 2017 IPPS/LTCH PPS final rule, we determined there was a display error in the performance standards for this measure. We have since undertaken a technical update for these performance standards in order to ensure that hospitals have the correct performance standards for the applicable performance period. The corrected performance standards are displayed here.

PREVIOUSLY ADOPTED AND PROPOSED PERFORMANCE STANDARDS FOR THE FY 2022 PROGRAM YEAR

Measure short name	Achievement threshold	Benchmark
Clinical Care Domain		
MORT-30-AMI ±	0.861793	0.881305.
MORT-30-HF ±	0.879869	0.903608.
MORT-30-PN (updated cohort) ±	0.836122	0.870506.
MORT-30-COPD ±	0.920058	0.936962.
MORT-30-CABG ±†	0.968210	0.979000.
THA/TKA ±	0.029833	0.021493.

PREVIOUSLY ADOPTED AND PROPOSED PERFORMANCE STANDARDS FOR THE FY 2022 PROGRAM YEAR—Continued

Measure short name	Achievement threshold	Benchmark
Efficiency and Cost Reduction Domain		
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.
AMI Payment ±	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 ±	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.
PN Payment **	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.

† After publication of the FY 2017 IPPS/LTCH PPS final rule, we determined there was a display error in the performance standards for this measure. Specifically, the Achievement Threshold and Benchmark values, while accurate, were presented in the wrong categories. We have corrected this issue in the table above, and the correct performance standards are displayed here.

* Lower values represent better performance.

Scored the same as the MSPB, AMI Payment, and HF Payment measures, as discussed in section V.J.4.a.(2) of the preamble of this proposed rule.

PROPOSED PERFORMANCE STANDARDS FOR THE FY 2023 PROGRAM YEAR

Measure short name	Achievement threshold	Benchmark
Clinical Care Domain		
MORT-30-AMI	0.866548	0.885499.
MORT-30-HF	0.881939	0.906798.
MORT-30-PN (updated cohort)	0.840138	0.871741.
MORT-30-COPD	0.919769	0.936349.
MORT-30-CABG	0.968747	0.979620.
THA/TKA *	0.027428	0.019779.

Efficiency and Cost Reduction Domain

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.
AMI Payment **	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 **	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.
PN Payment **	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.

** Scored the same as the MSPB, AMI Payment, and HF Payment measures, as discussed in section V.J.4.a.(2) of the preamble of this proposed rule.

8. Scoring Methodology

For FY 2020, scores each of the four domains (Safety, Clinical Care, Efficiency and Cost Reduction, and Person and Community Engagement) will continue to be weighted equally at 25 percent of the TPS. Previously adopted rules continue to require hospitals have a score on at least 3 domains to receive a TPS and prescribing the proportional reweighting of domains when only 3 are used to calculate a TPS.

Several changes to domain scoring policies are proposed to begin in FY 2019.

- 1) Safety Domain: the number of measures for which a hospital must have a score to receive a domain score would be reduced from three to two measures. This reflects the proposed removal of the PSI 90 safety composite measure from that domain.
- 2) Efficiency and Cost Reduction Domain:
 - a. Hospitals currently must have a score for the MSPB measure to receive a score for the Efficiency and Cost Reduction domain. CMS proposes to modify the requirement to allow hospitals with a score of any one of the domain measures to receive a domain score.
 - b. CMS proposes that hospitals must report at least 25 cases per measure to receive a measure score beginning with FY 2021. That is, the same 25 case minimum that applies to the MSPB measure would also apply to the condition-specific payment measures included in that domain.
 - c. CMS proposes that the MSPB measure would receive a weight of 50 percent and the other condition-specific payment measures would account for the remaining 50 percent. If a hospital only meets the case minimum for the MSPB measure, that measure would receive a weight of 100 percent. If a hospital does not meet the case minimum for the MSPB measure, but meets the minimum for at least one of the condition-specific measures, these measures would be

given a weight of 100 percent, with multiple measures being weighted equally. If a hospital meets the case minimum for the MSPB measure and only a subset of the condition-specific measures, the MSPB measure would receive a weight of 50 percent and the condition-specific measures would be weighted equally for a total of 50 percent of the score. The result of these proposed policies and the overall 25 percent domain weight would be that for a hospital with a score for the MSPB measure, that measure would constitute between 12.5 and 25 percent of the hospital's TPS.

- 3) *Patient Safety and Adverse Events Composite*: CMS proposes in FY 2023, a hospital would need to report at least three cases on any one component indicator during the baseline period in order to receive an improvement score and three cases on any component indicator during the performance period in order to receive an achievement score. These are the same minimums that apply to the current PSI 90 measure.

Summary Table VBP-1: Measures and Domains for selected payment years <i>Proposals in italics</i>						
Measure	2017	2018	2019/ 2020	2021	2022	2023
Clinical Care–Process (<i>removed beginning 2018</i>)						
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 (<i>labeled as ‘Clinical Care’ beginning 2018</i>)						
Acute Myocardial Infarction (AMI) 30-day mortality rate	X	X	X	X	X	X
Heart Failure (HF) 30-day mortality rate	X	X	X	X	X	X
Pneumonia (PN) 30- day mortality rate	X	X	X	X	X	X
Complication rate for elective primary total hip arthroplasty/total knee arthroplasty			X	X	X	X
Chronic Obstructive Pulmonary Disease (COPD) 30-day mortality rate				X	X	X
CABG 30-day mortality rate					X	X

Safety						
AHRQ PSI–90 patient safety composite	X	X	Proposed for Removal			
Patient Safety and Adverse Events composite						Proposed
Central Line Associated Blood Stream Infection (CLABSI)	X	X	X	X	X	X
Catheter Associated Urinary Tract Infection (CAUTI)	X	X	X	X	X	X
Surgical Site Infection: Colon Abdominal hysterectomy	X	X	X	X	X	X
Methicillin-Resistant Staphylococcus Aureus (MRSA) Bacteremia	X	X	X	X	X	X
Clostridium Difficile infection (CDI)	X	X	X	X	X	X
Perinatal Care: elective delivery < 39 completed weeks gestation (moved from Clinical Care – Process)	In Clinical Care – Process domain	X	X	X	X	X
Patient and Caregiver Centered Experience of Care/Care Coordination (Person and Community Engagement)						
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)						
8 Dimensions: • Communication with Nurses • Communication with Doctors • Responsiveness of Hospital Staff • Pain Management (before 2018) * • Communication About Medicines • Cleanliness and Quietness of Hospital Environment • Discharge Information • Overall Rating of Hospital • 3-Item Care Transition measure (beginning 2018)	X	X	X	X	X	X
Efficiency and Cost Reduction						
Medicare Spending per Beneficiary	X	X	X	X	X	X
AMI payment per 30-day episode				X	X	X
HF payment per 30-day episode				X	X	X
Pneumonia (PN) payment per 30-day episode					Proposed	
*The pain management component of HCAHPS was removed beginning with the FY 2018 payment determination.						

J. Proposed Changes to the Hospital-Acquired Condition (HAC) Reduction Program

CMS proposes time periods for the FY 2020 HAC Reduction Program measures; seeks comments on possible future measures; seeks comments on application of social risk factors; seeks comments on adjusting certain HAC Reduction Program measures for disability and medical complexity; and proposes changes to the extraordinary circumstances exceptions beginning in FY 2018. For FY 2020, hospitals whose HAC rates are in the highest quartile will have their IPPS payments reduced by 1 percent.

1. Data Collection Time Periods for FY 2020 HAC Reduction Program Measures

For FY 2020, CMS proposes that a two-year period be used for all the program measures. Under the new proposal, for FY 2020:

- Domain 1 Patient Safety and Adverse Events composite measure: July 1, 2016 through June 30, 2018
- Domain 2 CDC NHSN: calendar years 2017 and 2018.

2. Accounting for Social Risk Factors in the HAC Reduction Program

CMS repeats its earlier discussions of accounting for social risk factors (summarized above) in quality reporting and value-based purchasing programs. Specific to the HAC Reduction Program, however, CMS notes that many of the measures represent “never events” which it believes should not be influenced by social risk factors. Instead risk-adjustment for these measures should account for differences in patient age, gender, comorbidities and complications in order to assess clinical differences among patients and among hospitals.

3. Extraordinary Circumstances Exceptions: CMS made the same changes as those discussed above in the readmissions section.

Summary Table: HAC Reduction Program Measures, Performance Periods, and Domain Weights (Proposals in italics)						
	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Domain 1: AHRQ Patient Safety Indicators						
PSI-90 composite (see note)	X	X	X			
Patient Safety and Adverse Events Composite/modified PSI 90 (see note)				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	7/1/16-6/30/18
Domain 1 weight	35%	25%	15%	*	*	*
Domain 2: CDC HAI Measures						
Central Line-associated Blood Stream Infection (CLABSI)	X	X	X	X	X	X
Catheter-associated Urinary Tract Infection (CAUTI)	X	X	X	X	X	X

Summary Table: HAC Reduction Program Measures, Performance Periods, and Domain Weights (Proposals in italics)						
	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Surgical Site Infection (SSI): ◦ SSI Following Colon Surgery ◦ SSI Following Abdominal Hysterectomy		X	X	X	X	X
Methicillin-resistant staphylococcus aureus (MRSA)			X	X	X	X
Clostridium difficile			X	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	1/1/17- 12/31/18
Domain 2 weight	65%	75%	85%	*	*	*
*In this rule CMS did not propose or discuss weightings for FY 2018; presumably the intent is to continue the current scoring methodology.						
Note: 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). The Patient Safety and Adverse Events composite “modified PSI 90” removed PSI 07, central venous catheter-related blood stream infection rate; added PSI 09 postoperative hemorrhage or hematoma rate, PSI 10 physiologic and metabolic derangement rate, and PSI 11 Postoperative respiratory failure rate; re-specified the PSI 12 perioperative pulmonary embolism or deep vein thrombosis rate and the PSI 15 accidental puncture or laceration rate; and changed the weighting of component indicators.						

K. Rural Community Hospital Demonstration Program

1. Background

In the proposed rule, CMS distinguishes among hospitals participating in the demonstration during different periods by cohort as follows:

- Cohort 1 refers to the 7 originally participating hospitals (selected in 2004 or 2008) that ended their scheduled 5-year periods of performance on a rolling basis during FY 2015 under the ACA extension.
- Cohort 2 refers to the 14 hospitals that began participating in the demo under the ACA authority and ended their scheduled 5-year periods of performance on a rolling basis from April 30, 2016 through December 31, 2016. (CMS notes that one hospital in Cohort 2 closed in October 2015).
- Cohort 3 refers to newly selected participating hospitals under the 21st Century Cures Act mandate beginning in FY 2018.

2. Proposed Implementation of 21st Century Cures Act Provisions

a. Proposed Terms of Continuation for Previously Participating Hospitals

Because the 21st Century Cures Act was enacted in December 2016, there is a gap (of between 2 and 23 months) between the end date of participation of most of the participating hospitals in the RCH demonstration

and the enactment of the 21st Century Cures Act additional 5-year extension; the 21st Century Cures Act does not address this issue. CMS proposes for previously participating hospitals (i.e., hospitals in Cohorts 1 and 2) that seek to participate during the 21st Century Cures Act 5-year extension period, that the start date for the performance period for these hospitals would be the start of the first cost reporting period on or after October 1, 2017 following the announcement of the additional hospitals selected for the demonstration (i.e., hospitals in Cohort 3).

b. Solicitation for Additional Participants

On April 17, 2017, CMS released its solicitation for Cohort 3 participants in the RCH demonstration; eligible hospitals will have until May 17, 2017 to submit applications. Under the law, CMS must give priority to rural community hospitals located in one of 20 States with the lowest population densities. CMS determined that the 20 States to which priority must be given are: Alaska, Arizona, Arkansas, Colorado, Idaho, Iowa, Kansas, Maine, Mississippi, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Vermont, and Wyoming. CMS will also consider population density of the State in which the rural community hospital is located, and will also consider the impact of hospital closures in rural areas of the State during the preceding 5-year period. CMS hopes to finalize the selection process by June 2017.

L. Payments for Services in Inpatient and Outpatient Settings

1. Adjustment to IPPS Rates Resulting from 2-Midnight Policy for FY 2018

Hospitals that closed or converted to other hospital types and were no longer being paid under the IPPS in FY 2017 were not compensated by the one-time adjustment of +0.6 percentage points to compensate hospitals for the inappropriate .2% reduction in IPPS payments that occurred from FFY 2014 – 2016. After consideration of the public comments received, CMS agreed to address the situation of closed or converted hospitals as part of the cost report settlement process. CMS indicates that these hospitals should identify themselves to their MACs so that the appropriate cost report adjustment can be applied.

M. Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations

CMS proposes to remove the April 7, 2000 limitation in order to qualify for grandfathering concluding that IHS policies and procedures (for example, as specified in the Indian Health Manual available on the IHS website at: <https://ihs.gov/aboutihs/indianhealthmanual/>) regarding the planning, operation, and funding of such facilities and organizations are resulting in appropriate Medicare payments.

CMS is also proposing to make a technical change to the billing reference in § 413.65(m) by replacing “were billed” with “are billed using the CCN of the main provider and with the consent of the main provider” to make regulation text more consistent with our current rules that require these facilities to comply with all applicable Medicare conditions of participation that apply to the main provider.

Under CMS’s proposal, a facility or organization operated by the IHS or a Tribe will be considered to be a department of a hospital operated by the IHS or a Tribe if it furnishes only hospital outpatient services that are

billed using the CMS Certification Number (CCN) of the main provider with the consent of the main provider, and it also meets one of the conditions in §413.65(m)(1) through (3).

VI. Changes to the IPPS for Capital-Related Costs

National Capital Federal Rate for FY 2017. For FY 2017, CMS established a national capital Federal rate of \$446.79. Under the proposed rule, CMS proposes to increase the national capital Federal rate for FY 2018 by 1.03 percent as detailed in the table below. As a result of this update and the proposed budget neutrality factors discussed below, CMS proposes a national capital Federal rate **of \$451.37 for FY 2018**. The factors accounting for the proposed FY 2018 update factor to the capital federal rate are summarized in the following table, and the other adjustments are shown in a separate table below.

PROPOSED CMS FY 2018 UPDATE FACTOR TO THE CAPITAL FEDERAL RATE	
Capital Input Price Index* (FY 2014-based CPI)	1.2
Intensity	0.0
Case-Mix Adjustment Factors: ¹	
Real Across DRG Change	0.5
Projected Case-Mix Change	0.5
<i>Subtotal</i>	1.2
Effect of FY 2016 Reclassification and Recalibration	0.0
Forecast Error Correction	0.0
<i>Total Proposed Update</i>	1.2

¹The adjustment for change in case-mix is the difference between the projected real increase in case-mix and projected total increase in case-mix. As these figures are the same—that is, there is no increase in case mix due to documentation and coding—CMS is making no adjustment for case mix factors.

As noted with respect to operating payments in section I.C above, effective January 1, 2016, separate rates for hospitals located in Puerto Rico no longer applies. Puerto Rico hospitals will receive the national capital Federal rate.

Exception Payments. The proposed rule would continue the policy under which a hospital may request an additional payment if the hospital incurs unanticipated capital expenditures in excess of \$5 million due to extraordinary circumstances beyond the hospital’s control.

New Hospitals. Medicare defines a “new hospital” as a hospital that has operated for less than 2 years. CMS notes that a new hospital is paid 85% of its Medicare allowable capital-related reasonable costs through the first 2 years of operation unless the new hospital elects to receive full prospective payment based on 100 percent of the federal rate.

VII. Proposed Changes for Hospitals Excluded from the IPPS

A. Proposed Rate-of-Increase in Payments to Excluded Hospitals for FY 2018

CMS proposes to set a 2.9 percent rate-of-increase for FY 2018 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 2018 rate-of-increase percentage would be applied to the FY 2017 target amounts to calculate the FY 2018 target amounts for these hospitals.

B. Proposed Revisions to Hospital-within-Hospital Regulations (HwH)

The HwH regulations are applicable to all hospitals not paid under the IPPS and are designed such that a non-IPPS hospital cannot occupy space in a building also used by another hospital or in one or more separate buildings located on the same campus as buildings used by another hospital without meeting specific criteria that will identify it as a separate and independent hospital from the hospital that is within. These regulations are intended to prevent hospitals from creating units within the hospital that are not authorized by the statute solely to get paid under another and more favorable payment system. For instance, an HwH could be a non-IPPS hospital (e.g. a LTCH) that is located within an IPPS hospital or a non-IPPS hospital (e.g. a LTCH) located within another type of IPPS hospital (e.g. an inpatient rehabilitation facility (IRF)).

CMS proposes to limit application of the HwH regulations only to non-IPPS hospitals located within IPPS hospitals effective October 1, 2017. CMS premises this proposal on the belief that the policy concerns that underlie the existing HwH regulations (that is, inappropriate patient shifting and hospitals acting as illegal de facto units) are sufficiently moderated in situations where IPPS-excluded hospitals are co-located with each other but not IPPS hospitals. CMS indicates that since the HwH regulations were adopted, LTCHs, IRFs and inpatient psychiatric facilities (IPFs) are no longer paid on a reasonable cost-basis as was the case when HwH regulations were adopted. Under CMS' proposal, the separateness and control requirements that currently apply to all HwHs would only apply to IPPS-excluded HwHs that are co-located with IPPS hospitals. CMS proposes to revise the introductory language of § 412.22(e) to reflect this proposed change beginning on or after October 1, 2017.

CMS is proposing to revise the requirements at § 412.22(e)(1)(v), which outlines performance of basic hospital functions, effective for fiscal years prior to FY 2018. CMS only describes these provisions by reference to their CFR citation and does not provide a narrative explanation of the provisions it is changing. § 412.22(e)(1)(v)(A) requires an HwH to perform the basic functions of a hospital through the use of its own employees or under contract with entities other than the hospital that it is within or a third entity that controls both entities. CMS indicates this provision is duplicative of CMS' interpretative guidance that relate to provisions within the hospital conditions of participation (CoPs) and proposes that the provision would sunset on September 30 2017.

§ 412.22(e)(1)(v)(B) limits the costs of services that an HwH obtains under contract with hospital occupying space in the same building or campus or a third entity that controls both hospitals to no more than 15 percent of the hospital's total inpatient operating costs. CMS believes these payment requirements could be interpreted to conflict with the requirements under the hospital CoPs, which do not provide for a minimum cost threshold

regarding the services the HwH obtains from the hospital within which it is occupying space. CMS proposes to eliminate this provision effective October 1, 2017. CMS does not believe there are payment policy concerns that would justify imposition of regulatory requirements on the performance of basic hospital functions for HwHs that are more stringent than under the Interpretative Guidance for the hospital CoPs.

C. Critical Access Hospitals (CAHs)

1. Physician Certification Requirement for Payment of Inpatient CAH Services under Medicare Part A

CMS indicates that the physician “96-hour” certification requirement is statutory so it does not have discretion to modify it through regulation. However, CMS is proposing to minimize the burden of the certification requirement on CAHs by providing notice that CMS will direct Quality Improvement Organizations (QIOs), Medicare Administrative Contractors (MACs), the Supplemental Medical Review Contractor (SMRC), and Recovery Audit Contractors (RACs) to make the CAH 96-hour certification requirement a low priority for medical record reviews conducted on or after October 1, 2017.

Absent concerns of probable fraud, waste, or abuse, these contractors will not conduct medical record reviews of the 96-hour certification requirement. Reviews by other entities, including, but not limited to, Zone Program Integrity Contractors (ZPICs), the Office of Inspector General, and the Department of Justice will continue as appropriate. Quality reviews and automated reviews (for example, those reviews that do not involve medical records) will also continue as appropriate.

QIOs and MACs may continue to conduct medical record review of CAH claims for the purposes of verifying compliance with other requirements, such as beneficiary complaints, quality of care reviews, higher weighted DRG reviews, readmission reviews, and the requirement that procedures be medically necessary. Under the revised instructions to contractors, CAHs will not receive any medical record requests from MACs, RACs, QIO, or SMRCs related to the 96-hour certification unless CMS or its contractors find evidence of gaming or a failure to comply with CMS’ provider screening and revalidation requirements or if medical review is needed for other issues.

IX. Quality Data Reporting Requirements for Specific Providers and Suppliers

In this section of the final rule, changes are proposed for 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, changes are proposed to the meaningful use requirements under the Health Information Technology for Economic and Clinical Health (HITECH) Act.

A. Hospital Inpatient Quality Reporting Program

CMS proposes several changes to the Hospital IQR Program, including refinements to two existing measures for the FY 2020 payment determination, a proposed new voluntary readmission measure, and with respect to electronic clinical quality measures (eCQMs), a reduction in both the required number of measures that hospitals must report and in the number of reporting quarters for eCQMs. One proposed refinement would modify the risk adjustment of the stroke mortality measure to include stroke severity information from the

NIH Stroke Scale, and the other would change the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey questions regarding patient pain. A number of possible future measures are discussed in detail.

With the proposed changes in eCQM reporting, the measure sets for FYs 2019 and 2020 would include a total of 50 mandatory measures; 46 that are specified, and 4 eCQMs selected by the hospital from a list of 15 available eCQMs. Table VIII at the end of this section shows the previously adopted measure sets beginning with FY 2017 and the proposed changes for FYs 2019 and 2020.

1. Refinements to Existing Measures for the FY 2020 Payment Determination and Subsequent Years

CMS proposes to make refinements to two existing IQR Program measures, beginning with the FY 2020 payment determination.

HCAHPS Pain Management. The pain management questions on the HCAHPS survey would be modified to focus on the hospital's communication with patients about the patients' pain during the inpatient stay, and the composite measure would be renamed "Communication About Pain." The changes are proposed to address concern that the existing questions put pressure on hospital staff to prescribe more opioids in order to achieve higher scores on this dimension. Responding to these concerns, CMS previously removed the pain management dimension from VBP Program scoring beginning in FY 2018, but retained these question in the HCAHPS for purposes of the IQR Program.

Under the proposal, the new questions would be applicable to patients beginning with January 1, 2018 discharges. Public reporting of HCAHPS measures require four consecutive quarters of data, meaning that the first public reporting of the new measure on *Hospital Compare* would be in October 2019. The last public reporting of the current pain management questions would be in October 2018, and the intervening *Hospital Compare* updates would not include either the Pain Management or the Communication about Pain dimensions.

Finally, CMS states that if this proposal to adopt the Communication about Pain composite measure is not finalized, it would continue to use the current Pain Management composite in the HCAHPS survey for IQR Program.

Refinements to the Stroke Mortality Measure. CMS proposes refinements to the 30-day stroke mortality measure for the FY 2023 payment determination that would include the National Institutes of Health (NIH) Stroke Scale in the measure risk adjustment and make other changes. The NIH Stroke Scale is described as a 15-item neurologic examination stroke scale used to provide a quantitative measure of stroke-related neurologic deficit.

In addition to including the NIH Stroke Scale, the proposed refinements would reduce the number of risk adjustment variables overall from 42 to 20. Further, CMS notes that in October 2016 ICD-10-CM codes for the NIH Stroke Scale were implemented, and therefore the risk adjustment can be modified for this with minimal data collection burden for hospitals.

The NQF reviewed the refined risk adjustment version of this measure early in 2016, but did not endorse it.

CMS proposes to provide hospitals with dry-run results on the refined measure in the confidential hospital feedback reports prior to implementation of the measure for FY 2023. It anticipates using claims data for discharges occurring between October 1, 2017 and June 30, 2020 for the dry run calculations which would be provided during calendar year 2021. These data would not be publicly reported.

2. Voluntary Hybrid Hospital-Wide Readmission (HWR) Measure with Claims and Electronic Health Record Data

CMS proposes a new measure for voluntary reporting, the Hybrid Hospital-Wide Readmission Measure with Claims and Electronic Health Record (EHR) Data. This measure would combine claims data with patient data extracted from hospital EHRs, and was endorsed by the National Quality Forum in December 2016 (NQF #2879). The cohort and outcome for this measure are identical to those used for the existing hospital-wide all-cause unplanned readmission measure currently in the IQR Program.

CMS is considering proposing this measure as a required IQR program measure as early as the FY 2023 payment determination (CY 2021 reporting period), and therefore requiring hospitals to submit core clinical data elements from EHRs as early as 2020 to support a dry run of the measure.

Under the proposal, voluntary reporting of data on this measure would occur for discharges from January 1, 2018 through June 30, 2018. Hospitals that participate would receive confidential reports on the completeness and accuracy of the EHR data submission results and the CMS-calculated Hybrid HWR measure results for the performance period. The report would provide detailed information about the patients in the measure cohort with an unplanned readmission within 30 days of hospital discharge, including the patients' clinical risk factors drawn from claims and EHR data.

3. Reporting of eCQMs

CMS modifies previously finalized policies for reporting of eCQMs in 2017 for the FY 2019 payment determination and reporting in 2018 for the FY 2020 payment determination. Specifically, in both cases the number of required measures is reduced and the number of calendar quarters for which reporting is required is decreased. These proposals are made to align with the proposed Medicare and Medicaid EHR Incentive Program changes described in section IX.E (summarized below).

Under the proposal, for the 2017 reporting period (FY 2019 payment) hospitals would have to report on at least six of the available eCQMs instead of the eight previously finalized, and the reporting period would be two self-selected quarters of data instead of the full calendar year reporting. CMS notes that although the FY 2018 IPPS/LTCH final rule will not be published until August 2017, the data submission deadline for 2017 reporting is February 28, 2018, which it says gives hospitals sufficient time to adjust to the new requirements should they be finalized.

For 2018 reporting (FY 2020 payment) CMS similarly proposes to reduce the number of required measures from eight to six; but in this case the reporting period would be modified from a full calendar year to the first

three quarters of calendar year 2018. CMS notes that the six measures chosen for reporting by a hospital in 2018 could be different than those chosen for reporting in 2017.

4. Possible New Quality Measures and Measure Topics for Future Years

CMS describes in detail a list of measures it is considering for future addition to the IQR Program and invites comments. The measures are:

- Quality of Informed Consent Documents for Hospital-Performed Elective Procedures. This measure uses abstractors employing a validated tool to abstract and score (on a scale from 0 to 20) information from informed consent documents. The measure would report the proportion of a hospital's informed consent documents that meet a standard.
- Four End of Life Measures for Cancer Patients. These are four NQF-endorsed measures which the MAP has supported for inclusion in the PPS-Exempt Cancer Hospital Quality Reporting Program. The measures are:
 - o The Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (EOLChemo) (NQF #0210);
 - o The Proportion of Patients Who Died from Cancer Not Admitted to Hospice (EOL-Hospice) (NQF #0215);
 - o The Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than Three Days (EOL-3DH) (NQF #0216);
 - o The Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life (EOL-ICU) (NQF #0213).

CMS notes that the measure of patients receiving chemotherapy in the last 14 days of life has been finalized for inclusion in the Merit Based Incentive Payment Program (MIPS).

- Two Nurse Staffing Measures.
 - o Skill Mix (Registered Nurse [RN], Licensed Vocational/Practical Nurse [LVN/LPN], Unlicensed Assistive Personnel [UAP], and Contract) (Nursing Skill Mix) Measure (NQF #0204)
 - o Nursing Hours per Patient Day Measure (NQF #0205) are NQF-endorsed measures reviewed by the MAP in 2014.
- Additional eQMs for the IQR and EHR Incentive Programs. CMS identifies 11 potential new eQMs which address behavioral health issues that it says are relevant to understanding the quality of care given to inpatient psychiatric patients treated in an acute care hospital.

eQMs for Future Consideration in the Hospital IQR and Medicare and Medicaid EHR Incentive Programs
Safe Use of Opioids – Concurrent Prescribing
Malnutrition Measures
Completion of a Malnutrition Screening within 24 Hours of Admission

eCQMs for Future Consideration in the Hospital IQR and Medicare and Medicaid EHR Incentive Programs
Completion of a Nutrition Assessment for Patients Identified as At-Risk for Malnutrition within 24 Hours of a Malnutrition Screening
Nutrition Care Plan for Patients Identified as Malnourished after a Completed Nutrition Assessment
Appropriate Documentation of a Malnutrition Diagnosis
Tobacco Use Measures
Tobacco Use Screening (TOB-1)
Tobacco Use Treatment Provided or Offered (TOB-2)/Tobacco Use Treatment ((TOB-2a)
Tobacco Use Treatment Provided or Offered at Discharge (TOB-3)/Tobacco Use Treatment at Discharge (TOB-3a)
Substance Use Measures
Alcohol Use Screening (SUB-1)
Alcohol Use Brief Intervention Provided or Offered (SUB-2)/Alcohol Use Brief Intervention (SUB-2a)
Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge (SUB-3)/Alcohol & Other Drug Use Disorder Treatment at Discharge (SUB-3a)

5. Request for Comments on Public Display of Measures Stratified by Dual Eligible Status

CMS seeks comments on potential options for confidential or public reporting of the pneumonia readmission and mortality measures stratified by patient dual eligibility status. CMS is considering these options for reporting as early as the summer of 2018 using data from the 2019 reporting period (July 1, 2014 through June 30, 2017).

Under the proposal, initially hospitals would receive a confidential report that would allow them to target any disparities in care through quality improvement efforts. In future years, the stratified data would be posted on *Hospital Compare*.

Under the potential methodology, in the confidential report, CMS would provide the hospital with odds ratios that quantify the increased odds of readmission for dual eligible patients at a given hospital after accounting for other risk factors.

6. Extraordinary Circumstances Exceptions Policy CMS proposes to modify the IQR Program extraordinary circumstances exceptions (ECE) policy in order to align it with similar policies in other CMS quality programs. The proposed revised regulatory text appears below. Finally, CMS clarifies that it will strive to complete its review of each request within 90 days of receipt.

42 CFR 412.140(c)(2) Extraordinary circumstances exceptions. CMS may grant an exception with respect to quality data reporting requirements in the event of extraordinary circumstances beyond the control of the hospital. CMS may grant an exception as follows:

(i) For circumstances not relating to the reporting of electronic clinical quality measure data, a hospital participating in the Hospital IQR Program that wishes to request an exception with respect to quality data reporting requirements must submit its request to CMS within 90 days of the date that the extraordinary circumstances occurred. For circumstances relating to the reporting of electronic clinical quality measures, a hospital participating in the Hospital IQR Program that wishes to request an exception must submit its request to CMS by April 1 following the end of the reporting calendar year in which the extraordinary circumstances occurred. Specific requirements for submission of a request for an exception are available on [QualityNet.org](https://www.qualitynet.org).

(ii) CMS may grant an exception to one or more hospitals that have not requested an exception if: CMS determines that a systemic problem with CMS data collection systems directly affected the ability of the hospital to submit data; or if CMS determines that an extraordinary circumstance has affected an entire region or locale.

Table VIII. IQR Program Measures for Payment Determination in FYs 2017 – 2020

X= Mandatory measure *Proposals in italics*

	2017	2018	2019	2020
Chart-Abstracted Process of Care Measures				
AMI-7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival	X	Removed		
STK-1 VTE prophylaxis	X	Removed		
STK-4 Thrombolytic therapy for acute ischemic stroke	X	X	Removed	
STK-6 Discharged on statin	X	Removed		
STK-8 Stroke education	X	Removed		
VTE-1 VTE prophylaxis*	X	Removed		
VTE-2 ICU VTE prophylaxis	X	Removed		
VTE-3 VTE patients with anticoagulation overlap therapy	X	Removed		
VTE-5 VTE discharge instructions	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	X
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-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 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)	voluntary reporting of eCQMs for (16 of the 28 eCQMs listed across three NQS domains)	Must report at least 4 of 28 eCQMs	<i>Proposal: Must report 6 of 15 eCQMs (8 of 15 were previously finalized)</i> The 15 eCQMs: 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	

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				
Healthcare-Associated Infection 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	X
Readmission/ Coordination of Care				
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	X
<i>Hybrid (claims+EHR) hospital-wide readmission</i>				<i>Voluntary</i>
Excess days in acute care after hospitalization for AMI		X	X	X
Excess days in acute care after hospitalization for HF		X	X	X
Excess days in acute care after hospitalization for PN			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
THA/TKA complications	X	X	X	X
Efficiency/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	X
Pneumonia payment per 30-day episode of care	X	X	X	X
THA/TKA payment per 30-day episode of care		X	X	X
Kidney/UTI clinical episode-based payment			X	X
Cellulitis clinical episode-based payment			X	X
Gastrointestinal hemorrhage clinical episode-based payment			X	X
Aortic Aneurysm Procedure clinical episode-based payment			X	X

Cholecystectomy/Common Duct Exploration episode-based payment			X	X
Spinal Fusion clinical episode-based payment			X	X
Patient Experience of Care				
HCAHPS survey + 3-item Care Transition Measure	X	X	X	X**
Structural Measures				
Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care	X	X	Removed	
Participation in a Systematic Clinical Database Registry for General Surgery	X	X	Removed	
Safe Surgery Checklist Use	X	X	X	X
Hospital Survey on Patient Safety Culture		X	X	X
*Refinements to the stroke mortality measure, including addition of the NIH Stroke Scale score to risk adjustment are proposed beginning with the FY 2023 payment determination, with a dry run in 2021.				
**CMS proposes to replace the HCAHPS Pain Management questions with new questions on Communication about Pain beginning with the FY 2020 payment determination.				

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

In this rule, CMS proposes to remove three cancer-specific clinical process measures because it has determined they are topped out, and to add four end-of-life cancer care measures, beginning with the FY 2020 payment year. The table at the end of the section shows the specific measures proposed for removal and addition. The MAP supported inclusion of the four end-of-life care measures in the PCHQR Program in its 2017 recommendations to CMS.

Six measures are discussed as possible future additions to the PCHQR Program. They include five patient-reported outcome measures relating to localized prostate cancer and a measure of unplanned readmissions. They are:

- Localized Prostate Cancer: Vitality;
- Localized Prostate Cancer: Urinary Incontinence;
- Localized Prostate Cancer: Urinary Frequency, Obstruction, and/or Irritation;
- Localized Prostate Cancer: Sexual Function;
- Localized Prostate Cancer: Bowel Function; and
- 30 Day Unplanned Readmissions for Cancer Patients.

PCHQR Program Measures for 2020 (<i>Proposals in italics</i>)	
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)	
NHSN 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 <i>Remove from measure set</i>
Combination chemotherapy is considered or administered within 4 months. of diagnosis to certain breast cancer patients (NQF #0559)	2014 <i>Remove from measure set</i>
Adjuvant hormonal therapy for certain breast cancer patients (NQF #0220)	2015 <i>Remove from measure set</i>
Clinical Process/Oncology Care	
Oncology-Radiation Dose Limits to Normal Tissues (NQF #0382)	2016

PCHQR Program Measures for 2020 (<i>Proposals in italics</i>)	
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
<i>The Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (EOLChemo) (NQF #0210)</i>	
<i>The Proportion of Patients Who Died from Cancer Not Admitted to Hospice (EOL-Hospice) (NQF #0215)</i>	
Intermediate Clinical Outcomes	
<i>The Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than Three Days (EOL-3DH) (NQF #0216)</i>	
<i>The Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life (EOL-ICU) (NQF #0213)</i>	
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	

C. Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program

In this rule, CMS proposes the following changes to the IPFQR Program:

- Effective beginning October 1, 2017, measure removal and retention factors and a definition for “topped out” measures would be adopted consistent with those used in the IQR Program.
- One new measure would be added beginning with the FY 2020 payment determination: Medication Continuation Following Inpatient Psychiatric Discharge. It has been recommended for endorsement by the NQF Standing Committee and is awaiting a final NQF decision.
- Beginning with the FY 2019 CMS proposes that the 45-day submission period would begin at least 30 days following the end of the data collection period, and that the exact dates would be determined through subregulatory guidance.
- The deadline for an IPF to submit a Notice of Participation (NOP) or withdrawal from the program would coincide with the end of the data submission period. That is, NOPs and withdrawals would be accepted any time prior to the end of the data submission period before the payment determination year. For example, if the end of the data submission period for FY 2019 payment determination, as announced through subregulatory guidance, was June 15, 2018, that would also be the deadline for NOPs and withdrawals.
- The extraordinary circumstances exceptions policy would be modified to align with other quality programs.
- If CMS determines that a systemic problem with its data collection systems directly affected the ability of facilities to submit data, it would grant exceptions to affected facilities and communicate this decision through routine communication channels.

CMS also seeks comment on accounting for social risk factors in the IPFQR Program. The discussion parallels that included in other sections of the proposed rule pertaining to other quality reporting programs.

IPFQR Program Measures for FY 2020 (<i>Proposals in Italics</i>)	
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)
	Transition Record with Specified Elements Received and Discharged Patients (NQF #0647)
	Timely Transmission of Transition Record (NQF #0648)
	Screening for Metabolic Disorders
	Influenza Vaccination Coverage Among Healthcare Personnel
	Assessment of Patient Experience of Care
	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)
	Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an IPF (NQF #2860)
	<i>Medication Continuation following Inpatient Psychiatric Discharge</i>

D. Clinical Quality Measurement for Eligible Professionals (EPs) Participating in the Medicaid EHR Incentive Program in 2017

CMS proposals in this section apply to eligible professionals (EPs) participating in the Medicaid EHR Incentive Program.

1. Proposed Modification to the CQM Reporting Period for EPs

2017. CMS proposes to change the CQM reporting period for EPs who report CQMs electronically in the Medicaid EHR Incentive Program for 2017 to a minimum of any continuous 90-day period during CY 2017. However, the reporting period for EPs who report CQMs by attestation and who demonstrated meaningful use in a previous program year under the EHR Incentive Program would remain one full year; for EPs

demonstrating meaningful use for the first time, the reporting period remains any continuous 90-day period regardless of submission method.

2018. The CQM reporting period for the Medicaid EHR Incentive Program in 2018 for EPs who demonstrated meaningful use in a previous program year would remain one full year (which aligns with the MIPS performance period for MIPS eligible clinicians). CMS notes that it would revisit the Medicaid EHR Incentive Program policies if changes are made to the MIPS performance period.

2. Proposed Modifications to CQM Reporting Requirements for Medicaid EPs under the Medicaid EHR Incentive Program

CMS proposes to align the specific CQMs available for EPs under the Medicaid EHR Incentive Program with those available to clinicians participating in MIPS who submit CQMs through EHRs. For 2017, the CQMs on the list of available CQMs for reporting from an EHR under MIPS in 2017 are available to EPs under the Medicaid EHR Incentive Program for 2017. That list of 53 CQMs is a subset of the 64 CQMs currently available under the Medicaid under the Medicaid EHR Incentive Program.

CMS also proposes to remove the requirement for EPs to report on CQMs across 3 of the 6 National Quality Strategy domains; it believes this change will improve alignment with data submission criteria for the MIPS quality performance category. For 2017, Medicaid EPs would be required to report on any six measures “that are relevant to” the EPs scope of practice. CMS would continue allowing zero denominators to be reported for EPs to meet the EHR Incentive Program CQM reporting requirements.

E. Changes to the Medicare and Medicaid EHR Incentive Programs

1. Proposed Revisions to EHR Reporting Period in 2018

CMS proposes to modify the EHR reporting periods for 2018 for all participants (new and returning) attesting to CMS or to a State Medicaid agency to a minimum of any continuous 90-day period within CY 2018.

The applicable incentive payment year and payment adjustment years for the 2018 EHR reporting period, and the attestation deadlines and other related program requirements, would remain the same. While CMS expects that the majority of EPs, eligible hospitals and CAHs will be ready to use 2015 Edition CEHRT in CY 2018, it acknowledges that a more than 25 percent of EPs and 15 percent of hospitals may not be ready.

2. 21st Century Cures Act Exception to the Medicare Payment Adjustment for Decertified EHR Technology

CMS proposes to implement those provisions beginning with the CY 2018 payment adjustment for EPs, the FY 2019 payment adjustment year for eligible hospitals, and the FY 2018 payment adjustment year for CAHs; it believes applying it to earlier payment adjustment years would be costly and administratively burdensome.

Generally, to qualify for the exception,

1. The CEHRT must be decertified during the 12-month period preceding the applicable EHR reporting period for the payment adjustment year or during that applicable EHR reporting period.

2. The EP, eligible hospital or CAH must apply for the exception (in a form and manner CMS establishes) and must, in the application, demonstrate both (i) the intention to attest for a certain EHR reporting period and (ii) a good faith effort to adopt and implement another CEHRT in advance of that EHR reporting period.

EPs may qualify for the exception for the CY 2018 payment adjustment year which is the final year of payment adjustments for EPs for meaningful use under section 1848(a)(7)(A) of the Act. The application would be due October 1, 2017 or a later date if CMS specifies one.

Eligible hospitals may qualify for the exception beginning with the FY 2019 payment adjustment year. The application would be due July 1 of the year before the applicable payment adjustment year. Thus, for the FY 2019 payment adjustment year, the application would be due July 1, 2018 or a later date if CMS specifies one.

CAHs may qualify for the exception beginning with the FY 2018 payment adjustment year. The application would be due November 30 after the end of the applicable payment adjustment year. Thus, for the FY 2018 payment adjustment year, the application would be due November 30, 2018 or a later date if CMS specifies one.

CMS notes that in no case may an EP, eligible hospital or CAH be granted an exemption from the payment adjustment based on significant hardship or decertified EHR technology for more than 5 years.

3. Ambulatory Surgical Center (ASC)-based EPs

Section 16003 of the 21st Century Cures Act excludes for 2017 and 2018 an EP who furnishes substantially all of his or her covered professional services in an ASC from the payment adjustment for the meaningful use requirement under section 1848(a)(7)(A) of the Act. Determination of whether an EP is ASC-based may be based on site of service or an attestation; it shall be made without regard to employment or billing arrangements between the EP and any other supplier or provider of services. The exception will apply for at least 3 years; when CMS determines through rulemaking that CERHT applicable to the ASC setting is available, the exception will cease to apply as of the first year that begins after that determination.

The statute does not define what percentage of services constitutes “substantially all” covered professional services; CMS proposes two alternative percentage thresholds:

- 75 percent of professional services in sites of service identified as an ASC setting in the calendar year that is two years before the payment adjustment year (this is the same level as applies to hospital-based MIPS eligible clinicians); or
- 90 percent of professional services in sites of service identified as an ASC setting in the calendar year that is two years before the payment adjustment year (this is the same level as applies to hospital-based EPs for the EHR Incentive Programs).

CMS proposes to use Place of Service (POS) Code 24 to identify services furnished in an ASC.

X. Proposed Revisions of Medicare Cost Reporting and Provider Requirements

A. Electronic Signature and Submission of the Certification and Settlement Summary Page of the Medicare Cost Report

Proposed Changes Relating to Electronic Signature on the Certification and Settlement Summary Page of the Medicare Cost Report:

CMS is proposing to revise § 413.24(f)(4)(iv) to allow providers to use an electronic signature that may be placed on the signature line of the certification statement and may be (1) any format of the original signature that contains the first and last name of the provider's administrator or chief financial officer (for example, photocopy or stamp) or (2) an electronic signature that must be the first and last name of the provider's administrator or chief financial officer entered in the provider's electronic program. To indicate the provider's election to sign the certification statement with an electronic signature, CMS is proposing to add an electronic signature checkbox placed immediately after the certification statement and above the signature line on the Certification and Settlement Summary page

Only when the checkbox is checked would the signature line be accepted with an electronic signature. By signing the certification statement with an electronic signature on the Certification and Settlement Summary page, the signatory would be attesting that its electronic signature was executed with the intent to sign the certification statement, that the electronic signature is being submitted in lieu of an original signature, and additionally that the electronic signature has the same legal effect as an original signature.

CMS is further proposing that if the provider signs the certification statement with an electronic signature, the provider also may submit the Certification and Settlement Summary page electronically to the contractor at the same time and in the same manner in which the Medicare cost report is submitted.

The electronic signature on the certification statement is optional. CMS' proposal would allow providers to continue to sign the certification statement with an original signature on a hard copy of the Certification and Settlement Summary page. However, if the provider chooses to do so, this page would have to be mailed to its contractor.

B. Clarification of Limitations on the Valuation of Depreciable Assets Disposed of on or after December 1, 1997

CMS clarifies that the elimination of the gain or loss for depreciable assets applies to assets a provider disposes of by sale or scrapping on or after December 1, 1997, regardless of whether the asset is scrapped, sold as an individual asset of a Medicare participating provider, or sold incident to a provider's change of ownership.

cfXI. Proposed Changes Relating to Survey and Certification Requirements

A. Proposed Revisions to the Application and Re-Application Procedures for National Accrediting Organizations, Provider and Supplier Conditions, and Posting of Survey Reports and Acceptable Plans of Corrections

Making Accrediting Organization Survey Information for Facilities Public Available:

CMS is proposing to add a new standard at § 488.5(a)(21) to require that each national AO applying or reapplying for CMS-approval of its Medicare provider or supplier accreditation program provide a statement acknowledging that it agrees to make all Medicare provider or supplier final accreditation survey reports (including statements of deficiency findings) as well as acceptable PoCs publicly available on its website within 90 days after such information is made available to those facilities for the most recent 3 years. This provision would include all triennial, full, follow-up, focused, and complaint surveys, whether they are performed onsite or offsite.

Accrediting Organizations and Advanced Diagnostic Imaging

CMS is also proposing to amend § 414.68 to make a parallel change to the one above for AO's that evaluate facilities that perform advanced diagnostic imaging. CMS proposal will require that each national advanced diagnostic imaging AO that applies or reapplies for CMS approval of its Medicare advanced diagnostic imaging accreditation program must provide a statement acknowledging that it agrees to make all Medicare advanced diagnostic imaging final accreditation survey reports as well as acceptable PoCs publicly available on its website within 90 days after such information is made available to the supplier of advanced diagnostic imaging services for the most recent 3 years. This provision would apply to all full, follow-up, focused, and complaint surveys, regardless of whether they are performed onsite or offsite.

B. Proposed Changes to Termination Public Notice Requirements for Certain Providers and Suppliers

CMS is proposing to remove the regulatory language specifying public notice of terminations for FQHCs, RHCs, ASCs, and OPOs to be exclusively in newspapers. Instead, CMS is proposing to allow for flexibility for the CMS Regional Offices and the providers or suppliers to post public notices through a manner in which the maximum number of community individuals and beneficiaries would be informed. This may include, but is not limited to State website postings, facility websites, or local news and social media channels. It would not preclude publication in local newspapers. This proposal for termination notices to the public for RHCs, FQHCs, ASCs, and OPOs would align with the termination notices CMS currently has set forth for all other providers and suppliers.

CMS is also considering allowing voluntarily terminating providers and suppliers the same public notice platform used for involuntary notices in order to meet their regulatory public notice requirements. This could include media venues such as website postings and press releases through the use of CMS Regional press officers.

Appendix: IPPS Regulatory Impact Analysis Table

TABLE I.—IMPACT ANALYSIS OF PROPOSED CHANGES TO THE IPPS FOR OPERATING COSTS FOR FY 2018

	Number of Hospitals ¹	Proposed Hospital Rate Update and Adjustments (1) ²	Proposed FY 2018 Weights and DRG Changes with Application of Recalibration Budget Neutrality (2) ³	Proposed FY 2018 Wage Data with Application of Wage Budget Neutrality (3) ⁴	FY 2018 MGCRB Reclassifications (4) ⁵	Proposed Rural Floor with Application of National Rural Floor Budget Neutrality (5) ⁶	Proposed Application of the Frontier Wage Index and Out-Migra- tion Adjustment (6) ⁷	Expiration of MDH Status (7) ⁸	All Proposed FY 2018 Changes (8) ⁹
All Hospitals	3292	1.5	0	0	0	0	0.1	-0.1	1.7
By Geographic Location:									
Urban hospitals	2491	1.6	0	0	-0.1	0	0.1	0	1.8
Large urban areas	1349	1.6	-0.1	0	-0.4	-0.1	0	0	1.7
Other urban areas	1142	1.6	0	0	0.3	0.2	0.2	-0.1	1.8
Rural hospitals	801	1.3	0.3	0.1	1.4	-0.2	0.2	-0.9	0.8
Bed Size (Urban):									
0-99 beds	638	1.5	0.4	0.1	-0.6	0.1	0.2	-0.7	1.2
100-199 beds	765	1.6	0.2	0.1	-0.1	0.2	0.2	-0.1	1.9
200-299 beds	445	1.6	0.1	0	0.1	0	0.1	0	1.7
300-499 beds	431	1.6	0	0	-0.1	0	0.1	0	1.8
500 or more beds	212	1.5	-0.3	0	-0.2	-0.1	0.1	0	1.7
Bed Size (Rural):									
0-49 beds	313	1.2	0.5	0	0.4	-0.1	0.3	-1.6	0.1
50-99 beds	285	1.3	0.3	0	0.6	-0.2	0.2	-2.2	-0.8
100-149 beds	117	1.3	0.3	0	1.3	0	0.2	-0.1	1.4
150-199 beds	46	1	0.2	0.1	1.8	-0.2	0.1	0	1.7
200 or more beds	40	1.4	0.1	0.2	2.9	-0.2	0	0	2
Urban by Region:									
New England	114	1.6	0.1	-0.4	1.3	1	0	-0.2	1.6
Middle Atlantic	315	1.6	0	-0.1	0.4	-0.3	0.1	0	1.2
South Atlantic	404	1.6	0	0.1	-0.4	-0.3	0	-0.1	1.9
East North Central	385	1.6	0.1	0	-0.2	-0.3	0	0	2
East South Central	147	1.6	0	-0.1	-0.3	-0.2	0	0	1.7
West North Central	160	1.5	-0.1	0.4	-0.8	-0.3	0.7	-0.1	2
West South Central	378	1.6	0	0.5	-0.5	-0.3	0	-0.1	2.1
Mountain	162	1.5	0	-0.2	0	0.3	0.3	0	1
Pacific	375	1.5	-0.1	-0.3	-0.2	0.9	0.1	0	2

	Number of Hospitals ¹	Proposed Hospital Rate Update and Adjustments (1) ²	Proposed FY 2018 Weights and DRG Changes with Application of Recalibration Budget Neutrality (2) ³	Proposed FY 2018 Wage Data with Application of Wage Budget Neutrality (3) ⁴	FY 2018 MGCRB Reclassifications (4) ⁵	Proposed Rural Floor with Application of National Rural Floor Budget Neutrality (5) ⁶	Proposed Application of the Frontier Wage Index and Out-Migra- tion Adjustment (6) ⁷	Expiration of MDH Status (7) ⁸	All Proposed FY 2018 Changes (8) ⁹
Puerto Rico	51	1.6	-0.4	1.4	-1	0.2	0.1	0	1.3
Rural by Region:									
New England	20	1.3	0.2	1.1	2.2	-0.3	0.2	-2.1	1.2
Middle Atlantic	53	1.2	0.4	0	1.1	-0.2	0.2	-1.7	-0.1
South Atlantic	125	1.2	0.3	-0.1	1.8	-0.2	0.2	-0.8	0.4
East North Central	115	1.3	0.2	-0.3	1.2	-0.2	0.1	-1.7	-0.4
East South Central	154	1.5	0.4	0.1	2.4	-0.3	0.1	-0.3	1.6
West North Central	97	1.2	0.1	0	0.1	0.2	0.3	-0.3	1.2
West South Central	154	1.3	0.4	0.3	1.7	-0.3	0.2	-0.7	1.3
Mountain	59	1	0.3	-0.1	0.2	-0.1	0.3	0	1.4
Pacific	24	1.1	0.2	0	1	0.1	0	0	1.2
By Payment Classification:									
Urban hospitals	2391	1.6	0	0	-0.2	0	0.1	0	1.8
Large urban areas	1363	1.6	-0.1	0	-0.4	-0.1	0	0	1.7
Other urban areas	1028	1.6	0	0	0.1	0.2	0.2	0	1.8
Rural areas	901	1.4	0.1	0.1	1.4	0	0.2	-0.7	1.2
Teaching Status:									
Nonteaching	2211	1.5	0.2	0	0.2	0.1	0.1	-0.3	1.6
Fewer than 100 residents	835	1.6	0.1	0	-0.1	0	0.2	0	1.8
100 or more residents	246	1.5	-0.3	-0.1	-0.1	-0.1	0	0	1.6
Urban DSH:									
Non-DSH	561	1.6	0	0	-0.2	-0.1	0.2	-0.4	1.3
100 or more beds	1563	1.6	0	0	-0.2	0	0.1	0	1.8
Less than 100 beds	357	1.5	0.4	0.1	-0.1	0.1	0.1	-0.1	2.1
Rural DSH:									
SCH	259	1.1	0.2	0	0	0	0	0	1.2
RRC	271	1.4	0.1	0.2	1.7	0	0.3	-0.3	1.9
100 or more beds	41	1.6	0.2	0.3	1.6	-0.1	0.1	0	1.7
Less than 100 beds	240	1.5	0.7	0	0.6	-0.3	0.7	-4.7	-3.2
Urban teaching and DSH:									
Both teaching and DSH	870	1.6	-0.1	-0.1	-0.3	-0.1	0.1	0	1.7
Teaching and no DSH	94	1.6	-0.1	0	-0.4	-0.2	0.1	0	1.2

	Number of Hospitals ¹	Proposed Hospital Rate Update and Adjustments (1) ²	Proposed FY 2018 Weights and DRG Changes with Application of Recalibration Budget Neutrality (2) ³	Proposed FY 2018 Wage Data with Application of Wage Budget Neutrality (3) ⁴	FY 2018 MGCRB Reclassifications (4) ⁵	Proposed Rural Floor with Application of National Rural Floor Budget Neutrality (5) ⁶	Proposed Application of the Frontier Wage Index and Out-Migration Adjustment (6) ⁷	Expiration of MDH Status (7) ⁸	All Proposed FY 2018 Changes (8) ⁹
No teaching and DSH	1050	1.6	0.2	0	0	0.3	0.1	0	2
No teaching and no DSH	377	1.6	0	0.1	-0.4	-0.1	0.2	0	1.9
Special Hospital Types:									
RRC	243	1.6	0.1	0.2	2.1	-0.1	0.4	-0.4	1.9
SCH	317	1.1	-0.1	0	-0.1	0.2	0	0	1
SCH and RRC	129	1.1	0	0.1	0.3	0	0	0	1.3
Type of Ownership:									
Voluntary	1914	1.5	0	0	0	0	0.1	-0.1	1.6
Proprietary	862	1.6	0.2	0.1	0.1	0	0.1	-0.1	1.9
Government	514	1.5	0	0	-0.2	0.2	0.1	-0.1	1.6
Medicare Utilization as a Percent of Inpatient Days:									
0-25	509	1.5	0	0	-0.4	0.2	0	0	1.6
25-50	2113	1.6	0	0	0	0	0.1	-0.1	1.8
50-65	535	1.5	0.1	0.1	0.6	0	0.1	-0.5	1.2
Over 65	135	1.5	0.6	0.1	-0.5	0.4	0.3	-3.7	-1.5
FY 2018 Reclassifications by the Medicare Geographic Classification Review Board:									
All Reclassified Hospitals	900	1.5	0.1	0.1	1.9	-0.1	0	-0.1	1.7
Non-Reclassified Hospitals	2392	1.6	0	0	-0.9	0	0.2	-0.1	1.7
Urban Hospitals Reclassified	629	1.6	0.1	0.1	1.9	0	0	-0.1	1.7
Urban Nonreclassified Hospitals	1814	1.6	-0.1	-0.1	-0.9	0	0.1	0	1.8
Rural Hospitals Reclassified Full Year	271	1.3	0.2	0	2.3	-0.1	0	-0.5	1.2

	Number of Hospitals ¹	Proposed Hospital Rate Update and Adjustments (1) ²	Proposed FY 2018 Weights and DRG Changes with Application of Recalibration Budget Neutrality (2) ³	Proposed FY 2018 Wage Data with Application of Wage Budget Neutrality (3) ⁴	FY 2018 MGCRB Reclassifications (4) ⁵	Proposed Rural Floor with Application of National Rural Floor Budget Neutrality (5) ⁶	Proposed Application of the Frontier Wage Index and Out-Migration Adjustment (6) ⁷	Expiration of MDH Status (7) ⁸	All Proposed FY 2018 Changes (8) ⁹
Rural Nonreclassified Hospitals Full Year	482	1.3	0.4	0.1	-0.2	-0.2	0.4	-1.5	0.1
All Section 401 Reclassified Hospitals:	148	1.5	0	0.3	1.4	0.1	0.3	-0.6	1.7
Other Reclassified Hospitals (Section 1886(d)(8)(B))	48	1.5	0.6	0.3	3.3	-0.3	0	-1.1	1.1

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 2016, and hospital cost report data are from reporting periods beginning in FY 2013 and FY 2014.

² This column displays the payment impact of the proposed hospital rate update and other proposed adjustments, including the proposed 1.75 percent adjustment to the national standardized amount and the hospital-specific rate (the estimated 2.9 percent market basket update reduced by 0.4 percentage point for the proposed multifactor productivity adjustment and the 0.75 percentage point reduction under the Affordable Care Act), the 0.4588 percent adjustment to the national standardized amount required under section 15005 of the 21st Century Cures Act and a factor of (1/1.006) to remove the temporary one-time adjustment made in FY 2017 to address the effects of the 0.2 percent reduction in effect for FYs 2014 through 2016 related to the 2-midnight policy.

³ This column displays the payment impact of the proposed changes to the Version 35 GROUPPER, the proposed changes to the relative weights and the recalibration of the MS-DRG weights based on FY 2016 MedPAR data in accordance with section 1886(d)(4)(C)(iii) of the Act. This column displays the application of the proposed recalibration budget neutrality factor of 0.997573 in accordance with section 1886(d)(4)(C)(iii) of the Act.

⁴ This column displays the payment impact of the proposed update to wage index data using FY 2014 and 2013 cost report data and the OMB labor market area delineations based on 2010 Decennial Census data. This column displays the payment impact of the application of the proposed wage budget neutrality factor, which is calculated separately from the proposed recalibration budget neutrality factor, and is calculated in accordance with section 1886(d)(3)(E)(i) of the Act. The proposed wage budget neutrality factor is 1.000465.

⁵ Shown here are the effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB). The effects demonstrate the FY 2018 payment impact of going from no reclassifications to the reclassifications scheduled to be in effect for FY 2018. Reclassification for prior years has no bearing on the payment impacts shown here. This column reflects the proposed geographic budget neutrality factor of 0.988522.

⁶ This column displays the effects of the proposed rural floor based on the continued implementation of the OMB labor market area delineations. The Affordable Care Act requires the rural floor budget neutrality adjustment to be 100 percent national level adjustment. The proposed rural floor budget neutrality factor applied to the wage index is 0.993672.