

Medicare Inpatient Prospective Payment System Final Rule Impact Analysis Federal Fiscal Year 2017

-Version 1, August 2016-

Analysis Description

The federal fiscal year (FFY) 2017 Medicare Inpatient Prospective Payment System (IPPS) Final Rule Analysis is intended to show providers how Medicare inpatient fee-for-service (FFS) payments will change from FFY 2016 to FFY 2017 based on the policies adopted in the FFY 2017 IPPS final rule. The analysis compares the year-over-year change in operating, capital, and uncompensated care IPPS payments and includes breakout sections that provide detailed insight into specific policies that influence IPPS payment changes, including:

- potential payment penalties under the Inpatient Quality Reporting (IQR) and electronic health record (EHR) Incentive Programs;
- value of the Medicare Dependent Hospital (MDH) and Low Volume Hospital Adjustment (LVA) programs;
- quality-based payment adjustments, in addition to the adopted change in HAC scoring;
- Disproportionate Share Hospital (DSH) uncompensated care (UCC) payments; and
- CMS' adoption of three year averaging of Factor 3s for distribution of UCC payments.

Dollar impacts in this analysis may differ from those provided by other organizations due to differences in source data and analytic methods.

This analysis does not include estimates for outlier payments, payments for services provided to Medicare Advantage (MA) patients (including Indirect Medical Education (IME) payments for MA patients), electronic health record incentive payments, or modifications in FFS payments as a result of hospital participation in new payment models being tested under Medicare demonstration/pilot programs.

FFY 2017 IPPS Final Rule Changes Modeled in this Analysis:

- **Marketbasket Update:** 2.7% operating marketbasket increase and 1.2% capital marketbasket increase; plus additional adjustments for budget neutrality.
- **ACA Mandated Marketbasket Reductions:** Combined 0.3 percentage point (PPT) productivity reduction and 0.75 PPT pre-determined reduction to the marketbasket authorized by the Affordable Care Act (ACA) of 2010.
- **Forecast Error Adjustment:** 0.3 PPT reduction to the inpatient capital rate in order to address unanticipated price fluctuations that may result in differences between actual price increases and those forecasted to calculate the capital update factor.
- **ATRA Mandated Coding Adjustment Reduction:** 1.5% retrospective reduction to the federal operating rate authorized by the American Taxpayer Relief Act (ATRA) of 2012 to recoup/adjust for what CMS claims to be over-payments due to coding improvements.
- **2-Midnight Rule Adjustment:** In response to the outcome of Shands Jacksonville Medical Center, Inc. v. Burwell, CMS is applying a permanent 0.2% prospective increase combined with a temporary 0.6% increase to the federal operating and capital rates.
- **Wage Index/GAF:** Updated wage index and capital geographic adjustment factor (GAF) values, including any remaining impact of the transitional wage indexes (if applicable) due to the new CBSA delineations, new wage data; reclassifications; and other adjustments to the wage indexes.

- **DSH–Traditional DSH Payment Changes:** Changes to traditional, rate-based DSH payments for hospitals that change special status and/or geographic location.
- **DSH–UCC Payment Changes:** Changes to UCC payments under the ACA-mandated DSH payment formula. In this analysis, DSH and UCC payment eligibility are held constant at the eligibility status predicted by CMS in its FFY 2017 final rule DSH Supplemental File. As a result, changes in hospital UCC payments that result from changes in the national UCC pool dollars are isolated to the list of DSH-eligible hospitals in the FFY 2017 DSH supplemental file. The impacts also consider year-to-year changes in hospital-specific UCC payment factors (factor 3) for these hospitals.

Impacts of the adopted methodology change for the calculation of Factor 3 values for distribution of the uncompensated care pool are provided on page 5 of the report. For FFY 2017 and subsequent years, Factor 3 will be determined utilizing the average of three years of data in order to reduce year-to-year fluctuations in payment.

- **Change in Hospital Specific Rate:** Reflects the impact to special status hospitals (SCHs, MDHs, or EACHs) where there is a change in provider type, payment status (hospital-specific vs federal), or where the value of the hospital-specific/federal blend for MDHs is changed due to a variation in uncompensated care payments.
- **MS-DRG Updates:** Changes due to updates to the DRG groupings and weights. The impact shown is the case-mix change resulting from running the FFY 2015 Medicare claims data through the two DRG Grouper software programs (Grouper Version 33.0 for FFY 2016 and Grouper Version 34.0 for FFY 2017) and assigning the respective MS-DRG weights for each year.

- **Quality-Based Payment Adjustments:** Year-to-year change in hospital-specific quality performance and subsequent adjustments under the VBP, Readmissions Reduction, and HAC Reduction programs.

The adopted scoring methodology change for the HAC Reduction program utilizing z-scores in place of deciles for FFY 2018 and subsequent years is provided on page 5 of the report. Estimates utilize the data and measures used to calculate FFY 2017 performance as a proxy.

- **Low Volume Adjustment Changes:** Reflects the change in overall payments made as a result of the Low Volume Hospital (LVH) Adjustment program. Eligibility due to distance is held constant between FFYs 2016 and 2017 while the LVH adjustment factors are from each respective year. Distance eligibility was determined using the most recent 3 years of cost report data (2012, 2013, 2014). If a hospital reported low volume payments in their most recent cost report, or had reported in its most recent year that the distance requirement had been met on Worksheet S-2, it is assumed that the hospital currently meets the distance requirement of the low volume adjustment.

Data Sources

Estimated FFYs 2016 and 2017 IPPS payments are calculated using individual hospital characteristics provided by CMS in its FFY 2017 IPPS final rule Impact File and data from CMS' DSH Supplemental files. These files are available on CMS' website at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Final-Rule-Home-Page.html>.

The inpatient federal operating and capital rates are from the FFYs 2016 and 2017 final rules, as published in the *Federal Register*.

Medicare cases and case-mix indices are from the CMS FFY 2017 final rule Impact File and include cases, case-mix indices, and transfer-adjusted cases resulting from running the FFY 2015 Medicare claims data through the two DRG Grouper software programs (Grouper Version 33.0 for FFY 2016 and Grouper Version 34.0 for FFY 2017).

Wage indexes are based upon information about hospitals' permanent and reclassified wage areas from CMS' FFYs 2016 and 2017 final rule Impact Files and the wage index tables in the *Federal Register*.

The DSH impact estimates are based on the Impact and DSH Supplemental files published with the FFYs 2016 and 2017 IPPS final rules. The DSH Supplemental file includes the following data points critical to the DSH payment methodology: an indicator of DSH-eligible hospitals for FFY 2017 (CMS is projecting that 2,432 hospitals will be eligible for DSH payments and paid as such in FFY 2017); national UCC pool dollars; and hospital-specific UCC factors/payment amounts.

The list of adjustment factors released by CMS appears to have been constructed incorrectly due to two reasons:

- Values assigned to the FFYs 2012 and 2013 Medicare SSI Days columns in the FFY 2017 Final Rule DSH Supplemental file are each assigned to the wrong year (2012 in 2013 and 2013 in 2012) when compared to DSH SSI data previously released by CMS (<https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/dsh.html>); and
- Values assigned to Factor 3 overstate the distribution of the full UCC pool amount by \$11,324,718.54 (0.19%).

It is expected that a correction notice will be released regarding these two issues sometime in the future. For this analysis, in order to offset the overstated distributions, hospital Factor 3 values were adjusted by a ratio (0.9981) to remove these excess distributions. The issue affecting DSH SSI data for FFYs 2012 and 2013 was not accounted for, as it is unknown (due to the over distribution of funds, and averaging of three years) if CMS had calculated Factor 3 using the correct data assignments internally, but then posted a file with the years reversed.

The impact of the quality-based payment adjustments are based on the following: The readmissions adjustment factors used to calculate impacts for FFY 2017 are from IPPS final rule Table 15, and were calculated by applying the FFY 2017 excess readmission ratios to claims data for the period July 1, 2012 to June 30, 2015. The list of hospitals that could potentially be subject to the HAC Reduction Program penalty used to calculate impacts for FFY 2017 is estimated based on hospital quality data available from Hospital Compare as CMS did not release penalty flags with the final rule. Although CMS has stated that no more than 25% of hospitals will be penalized under the HAC program, this analysis assumes that all hospitals at-or-over the 75th percentile breakpoint will receive a penalty. As a result, HAC penalties may be overstated. The VBP adjustment factor for FFY 2017 is estimated based on hospital quality data available from Hospital Compare as CMS' VBP proxy adjustment factors from final rule Table 16 are not considered reliable. The quality adjustment factors used to calculate FFY 2016 impacts are from the FFY 2016 IPPS final rule. Please note that quality adjustments that have been estimated are based on CMS' 2nd Quarter 2016 update of the data available on the Hospital Compare website.

Note: This analysis was developed to measure the impact of IPPS policy changes only. Hospitals' provider types, volume, patient mix, DSH eligibility, factors used to calculate DSH and IME adjustments and other factors used to estimate IPPS payments are held constant at the status/value published in the FFY 2017 final rule Impact File and DSH Supplemental File. For example, this analysis will not measure the impact to IME payments for a hospital that has increased the number of interns and residents from the previous year.

Methods

Calculating Impacts by Component Change

The dollar impact of each component change has been calculated by first estimating 2016 payments. Estimated 2016 payments reflect the wage index, labor-share, DSH, IME and quality-adjusted federal payment amount (or hospital-specific for SCHs or blended payment amount for MDHs) multiplied by each hospital's appropriate cases, case-mix index, and low volume adjustment. Using estimated 2016 payments, the adopted policy changes to the IPPS payment rates are applied. Then, the effect of the updated wage index values, MS-DRG groupings and weights, performance under the quality-based payment policies, and DSH policy changes are calculated by substituting 2016 values with 2017 values and calculating the incremental differences in payments. Percent changes by each component change are derived from the resulting changes in payment.

Each component change is applied sequentially in order to capture the compounded dollar impacts. For example, the change due to the marketbasket update is applied to estimated 2016 payments. Then, the change in the ACA-mandated marketbasket reductions are applied to the dollar result of the first change. This method continues for the remaining changes; creating a compounded effect. The difference between the results after each layered component is the impact of that component. Due to the influence of the DSH uncompensated care pool, which is not tied to the inpatient rate, percentage impacts may not tie to the values listed for component updates (i.e. marketbasket, ACA, etc.).

Note: Individual percentages and dollars shown in this analysis may not add to total due to compounding and rounding. Dollar amounts less than \$50 and percentages less than 0.05% will appear as zeroes due to rounding.

Hospitals with Special Status

SCH status and federal/hospital-specific payment determinations for SCHs are based on the status predicted by CMS in its FFY 2017 final rule DSH Supplemental File. MDHs eligible for special IPPS payment rates during FFY 2017 are also identified based upon their provider status in the CMS 2017 final rule Impact Files (unless the FFY 2017 DSH Supplemental file identifies the hospital as having SCH status). If the hospital-specific payment rate is more beneficial than the adjusted federal rate (after wage index, DSH, IME, and transfer adjustments), payments based on the hospital-specific rate are used in this analysis.

This analysis does not factor in the impact of outlier payments (facilities paid at the hospital-specific rate are not eligible for outlier payments). In some cases, the inclusion of outlier payments may make the difference as to whether the federal or the hospital-specific rate is more beneficial.

For SCHs, if the hospital-specific rate is more beneficial, these hospitals are paid at 100% of the hospital-specific rate. For MDHs, if the hospital-specific rate is more beneficial, these hospitals are paid at a blend of 75% of the hospital-specific rate and 25% of the federal rate.

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Medicare Inpatient Prospective Payment System

Payment Rule Brief — FINAL RULE

Program Year: FFY 2017

Overview and Resources

On August 2, 2016, the Centers for Medicare and Medicaid Services (CMS) released the final federal fiscal year (FFY) 2017 payment rule for the Medicare Inpatient Prospective Payment System (IPPS). The final rule reflects the annual updates to the Medicare fee-for-service (FFS) inpatient payment rates and policies. In addition to the regular updates to wage indexes and market basket, this final rule includes:

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

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

A copy of the final rule *Federal Register* (FR) and other resources related to the IPPS are available on the CMS website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Final-Rule-Home-Page.html>.

An online version of the rule is available at <https://federalregister.gov/a/2016-18476>.

A brief summary of the major hospital provisions of the IPPS final rule is provided below.

IPPS Payment Rates

FR pages 56,782-56,785, 56,938-56,940, 57,058-57,063, 57,274-57,281, and 57,291-57,295

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

	Final FFY 2016	Final FFY 2017	Percent Change
Federal Operating Rate	\$5,467.53	\$5,516.63 (proposed at \$5,511.79)	+0.90% (proposed at 0.81%)
Federal Capital Rate	\$438.75	\$446.81 (proposed at \$466.35)	+1.84% (proposed at 1.7%)

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

	Federal Operating Rate	Hospital-Specific Rates	Federal Capital Rate
Marketbasket (MB) Update/Capital Input Price Index	+2.7% (proposed at 2.8%)	+2.7% (proposed at 2.8%)	+1.2%
ACA-Mandated Reductions 0.3 percentage point (PPT) productivity reduction (proposed at -0.5 PPT) and 0.75 PPT pre-determined reduction	-1.05 PPT	-1.05 PPT	—
Forecast Error Adjustment	—	—	-0.3 PPT
American Taxpayer Relief Act (ATRA)-Mandated Retrospective Documentation and Coding Adjustment	-1.5%	—	—
2-Midnight Rule Prospective Adjustment	+0.2%	+0.2%	+0.2%
2-Midnight Rule Temporary Retrospective Adjustment	+0.6%	+0.6%	+0.6%
Annual Budget Neutrality Adjustment	-0.03% (proposed at -0.02%)	-0.03% (proposed at -0.02%)	+0.13% (proposed at +0.02%)
Net Rate Update	+0.90% (proposed at 0.81%)	+2.43% (proposed at 2.34%)	+1.84% (proposed at 1.73%)

- **Effects of the Inpatient Quality Reporting (IQR) and EHR Incentive Programs (FR pages 56,938-56,939):** Beginning in FFY 2015, the IQR MB penalty changed from -2.0 percentage points to a 25% reduction to the full MB, and the EHR Meaningful Use (MU) penalty began its phase-in over three years, starting at 25% of the full MB. In FFY 2017, the EHR MU penalty will be capped at 75% of the MB; hence, beginning FFY 2017, the full MB update will be at risk between these two penalty programs. A table displaying the various update scenarios for FFY 2017 is below:

	Neither Penalty	IQR Penalty	EHR MU Penalty	Both Penalties
Net Rate Federal Rate Update (2.7% MB less 0.3 PPT productivity and 0.75 PPT predetermined)	+1.65%	+1.65%	+1.65%	+1.65%
Penalty for Failure to Submit IQR Quality Data (25% of the base MB Update of 2.7%)	—	-0.675 PPT	—	-0.675 PPT
Penalty for Failure to be a Meaningful User of EHR (75% of the base MB Update of 2.7%)	—	—	-2.025 PPT	-2.025 PPT
Adjusted Net Rate Update (prior to ATRA and 2-Midnight)	+1.65%	+0.975%	-0.375%	-1.05%

CMS has released a list of 130 non-compliant hospitals that will be penalized under the IQR for FFY 2017, while 187 hospitals will be penalized for non-compliance under EHR MU for FFY 2017. In FFY 2016, 178 hospitals were penalized under the EHR MU Program, while 55 were non-compliant under IQR. Generally, successful participation in both programs is based on data collection two years prior to the payment adjustment year.

- **Retrospective Coding Adjustment (FR pages 56,782-56,785):** CMS will apply a retrospective coding adjustment of -1.5% to the federal operating rate in FFY 2017. The coding offset rate reduction was authorized as part of the American Taxpayer Relief Act of 2012 (ATRA), which required inpatient payments to be reduced by \$11 billion (or -9.3%) over a 4-year period. To meet the ATRA requirements, CMS applied -0.8% coding adjustments in FFYs 2014 through 2016 and while originally it was expected that CMS would to apply a similar reduction in FFY 2017, CMS has determined that the existing reductions have only recovered \$5.95 billion of the \$11 billion called for in ATRA, due to decreasing inpatient volumes. CMS estimated that a reduction of 1.5% will be necessary in FFY 2017 in order to reach the \$11 billion target by the end of the fourth year. Each of these four annual reductions has been layered on top of the prior year's, thereby compounding the reductions in order to achieve the full recoupment over four years. Under ATRA, once the full recoupment had been

accomplished, the base amount was to be restored.

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

- **2-Midnight Policy Adjustment (FR pages 57,058-57,060):** In the FFY 2014 IPPS final rule, CMS adopted its 2-midnight policy for inpatient admissions and implemented a 0.2% prospective reduction to the IPPS rate to offset a predicted increase in expenditures resulting from this policy. The industry challenged the validity of CMS' reasoning for the reduction and in *Shands Jacksonville Medical Center, Inc. v. Burwell*, the Court ordered that the policy be remanded back to the Secretary "to correct certain procedural deficiencies in the promulgation of the 0.2 percent reduction and reconsider the adjustment." In response to the Court's decision, CMS will rescind the prospective adjustment - increasing the IPPS rates by 0.2% - and will restore the money previously recouped in FFYs 2014, 2015 and 2016 by applying a one-year adjustment of 0.6%. The 0.6% adjustment will drop off at the end of FFY 2017.

Wage Index

FR pages 56,912-56,937

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

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

- **Core-Based Statistical Area Revisions (FR pages 56,913-56,913):** On July 15, 2015, the Office of Management and Budget (OMB) issued revisions to three CBSAs that will be in effect for FFY 2017 rulemaking:
 1. Garfield County, OK previously classified as rural is now part of the new Enid, OK - CBSA 21420.
 2. The county of Bedford City, VA (SSA code 49088) has changed to town status and is now part of Bedford County (SSA code 49090). It remains a part of CBSA 31340- Lynchburg, VA.
 3. The name of CBSA 31420 - Macon, GA has been renamed as Macon-Bibb County, GA.
- **Imputed Rural Floor (FR pages 56,921-56,922):** CMS extended the imputed rural floor policy by one additional year, through September 30, 2017 while potential wage index reforms are explored.
- **"Lock-In" Date for Urban to Rural Reclassifications (FR pages 56,930-56,932):** In order to process all rural redesignation requests in a timely fashion for the IPPS final rule, CMS is implementing a "lock-in" date (i.e. deadline) for the second Monday in June of each year. In order to meet this deadline, CMS states that a hospital would need to file its application with the CMS Regional Office no later than 70 days prior to the second Monday in June of each year in order to provide the required 60 days for the CMS Regional Office to notify the hospital of the application's approval/disapproval; and to allow processing and administrative time for the CMS Central Office to be notified of the reclassification. Approved applications received after this date would not be classified as rural until the following fiscal year.
- **Labor-Related Share (FR pages 56,933-56,934):** The wage index adjustment is applied to the portion of the IPPS rate that CMS considers to be labor-related. For FFY 2017, CMS will continue to apply a labor-related share of 69.6% for hospitals with a wage index of 1.0 or more. By law, the labor-related share for hospitals with a wage index less than 1.0 will remain at 62%.
- **Treatment of Overhead and Home Office Costs (FR pages 56,934-56,937):** In the proposed rule, CMS sought comment on two issues related to the calculation of the wage index:

1. What future rulemaking or cost reporting changes should be implemented in order to remove the overhead wage-related costs for areas excluded from the wage index calculation i.e. applying a single allocation methodology between Worksheet S-3 Part IV and Worksheet S-3 Part II, lines 17 through 25.
2. What can be done about the inconsistent reporting of home office salaries and wage-related costs? CMS is considering an end to the reporting of home office costs on line 14 of Worksheet S-3, Part II, and is considering requiring that home office costs be reported as part of the lines representing overhead; possibly by adding lines, columns, or by subscribing lines 27 and 28.

Public responses to these issues may be found on pages 56,935-56,937 of the final rule.

- **Changes to the Three-Year Average Pension Policy (no FR page reference):** Prior to FFY 2017, CMS calculated the pension cost component of the wage index as the three-year average of pension contributions using cost report data for the base wage index year and the each year immediately before and after the base . As adopted in the FFY 2016 IPPS final rule, beginning in FFY 2017, CMS will calculate the three-year average pension contribution using the base cost report year and the two preceding years. Hence, for FFY 2017 (the first year of this change) the pension component of the wage index will use the same three years of data that have been used for FFY 2016.
- **Wage Index Development Timetable for FFY 2018 (FR pages 56,927-56928):** Applications for FFY 2018 wage index reclassifications are due to the Medicare Geographic Classification Review Board (MGCRB) by September 1, 2016. CMS has revised the MBCRB submission policy such that, for FFYs 2018 and beyond, hospitals would be required to send a copy of the reclassification application to CMS electronically, not on paper. CMS is also clarifying that in cases of hospital mergers, if the acquired hospital had been receiving an MGCRB reclassification, it will continue to receive that reclassification until the end of the 3-year reclassification period.
- **Criteria for an Individual Hospital Seeking Redesignation to Another Area (FR pages 56,922-56,927 and 56,929-56,929):** Based on the outcome of *Geisinger Community Medical Center v. Secretary, United States Department of Health and Human Services* on July 23, 2015, CMS is revising the regulations regarding hospitals redesignated as rural that are seeking MGCRB reclassification to a different CBSA. Effective with reclassification applications for FFY 2018, a hospital may apply for MGCRB reclassification while retaining a rural redesignation. This allows these hospitals to use the distance and average hourly wage criteria applicable for rural hospitals for their reclassification application.

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

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

A complete list of the final wage indexes for payment in FFY 2017 is available on Table 2 on the CMS Web site at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2017-CMS-1655-FR-Table-2-3.zip>.

Quality-Based Payment Adjustments

FR pages 56,973-57,026

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

- **VBP Adjustment (FR pages 56,979-57,011):** The FFY 2017 program will include hospital quality data for 21 measures in 5 domains: safety of care; clinical care - process; clinical care - outcomes; patient experience of care; and efficiency. By law, the VBP Program must be budget neutral and the FFY 2017 program will be funded by a 2.0% reduction in IPPS payments for hospitals that meet the program eligibility criteria (estimated at \$1.8 billion) compared to 1.75% in FFY 2016. Because the program is budget neutral, hospitals can earn back some, all, or more than their 2.0% reduction.

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

The proxy factors published with the final rule are available in Table 16A on the CMS website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2017-CMS-1655-FR-Table-16.zip>.

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

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

- **Readmissions Reduction Program (RRP) (FR pages 56,973-56,979):** The FFY 2017 RRP will evaluate hospitals on 6 conditions/procedures: acute myocardial infarction (AMI), heart failure (HF), pneumonia (PN) (expanded to include diagnoses of sepsis with a secondary diagnosis of pneumonia, and aspiration pneumonia), chronic obstructive pulmonary disease (COPD), elective total hip arthroplasty (THA) and total knee arthroplasty (TKA), and coronary artery bypass graft (CABG). The RRP is not budget neutral; hospitals can either maintain full payment levels or be subject to a penalty of up to 3.0%.

The adopted FFY 2017 RRP factors are published with the final rule in Table 15 and on the CMS website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2017-CMS-1655-FR-Table-15.zip>.

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

- **HAC Reduction Program (FR pages 57,011-57,026):** The FFY 2017 HAC program will evaluate hospital performance on 6 measures: the AHRQ Patient Safety Indicator (PSI)-90—a composite of 8 individual HAC measures, Central Line-Associated Bloodstream Infection (CLABSI) rates, Catheter-Associated Urinary Tract Infection (CAUTI) rates, the Surgical Site Infection (SSI) Pooled Standardized Infection Ratio, Methicillin-resistant Staphylococcus Aurea (MRSA) rates (new in FFY 2017), and Clostridium difficile (C.diff.) rates (new in FFY 2017). The HAC Reduction Program is not budget neutral; hospitals with a total HAC Score that falls within the worst performing quartile for all eligible hospitals will be subject to a 1.0% reduction in IPPS payments. CMS has stated that it expects to release the list of hospitals subject to the HAC penalty for FFY 2017 in October 2016.

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

The other clarification pertains to newly opened hospitals. CMS states that "if a hospital files a notice of participation (NOP) with the Hospital IQR Program within 6 months of opening, the hospital would be required

to begin submitting data for the CDC NHSN HAI measures no later than the first day of the quarter following the NOP.” Furthermore, “if a hospital does not file a NOP with the Hospital IQR Program within 6 months of opening, the hospital would be required to begin submitting data for the CDC NHSN HAI measures on the first day of the quarter following the end of the 6-month period to file the NOP.”

Quality-Based Payment Policies—FFYs 2018 and Beyond

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

- **VBP Program—FFYs 2018 through 2022** (*FR pages 56,979-57,011*): CMS has already adopted VBP program rules through FFY 2018 and some program policies and rules beyond FFY 2018. CMS is finalizing further program updates/changes for FFYs 2018-2022, which include:
 - Measure additions/deletions for FFYs 2021 and 2022 (the adopted measure changes would continue the shift of the program’s focus from process measures to patient outcomes/efficiency measures);
 - New data collection time periods (baseline/performance periods) for the FFY 2018-2021 program years;
 - National performance standards for a subset of the FFY 2019, 2021 and 2022 program measures (performance standards for other program measures for future program years will be put forward in future rulemaking);
 - Effective for FFY 2021, an update to the patient cohort comprising the Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization measure to include patients with a principal discharge diagnosis of aspiration pneumonia, and those with a principal discharge diagnosis of sepsis (excluding severe sepsis), with a secondary diagnosis of pneumonia coded as present on admission.
 - Effective for the FFY 2019 program year, the “Patient- and Caregiver-Centered Experience of Care/Care Coordination” domain will be renamed the “Person and Community Engagement” domain.

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

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

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

Public responses to these approaches may be found on pages 56,993-56,994 of the final rule.

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

- **Readmissions Reduction Program** (*FR pages 56,973-56,979*): CMS did not issue any changes for future years of the Readmissions Reduction Program in this rulemaking cycle.

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

- **HAC Reduction Program—FFYs 2017-2019** (*FR pages 57,011-57,026*): For FFY 2018, CMS is adopting a modified version of the PSI-90 composite measure titled “Patient Safety and Adverse Events Composite” comprised of 10 component indicators (up from 8). The changes between this and the current PSI-90 composite measure include:
 - The addition of—
 - PSI 09: Perioperative Hemorrhage or Hematoma Rate;
 - PSI 10: Physiologic and Metabolic Derangement Rate; and
 - PSI 11: Postoperative Respiratory Failure Rate.
 - The removal of—
 - PSI 07: Central Venous Catheter-Related Blood Stream Infection Rate
 - Changes to—
 - PSI 12: Perioperative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT) Rate; and
 - PSI 15: Accidental Puncture or Laceration Rate.
 - Weighting of component indicators based on harms associated with the events, in addition to volume.

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

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

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

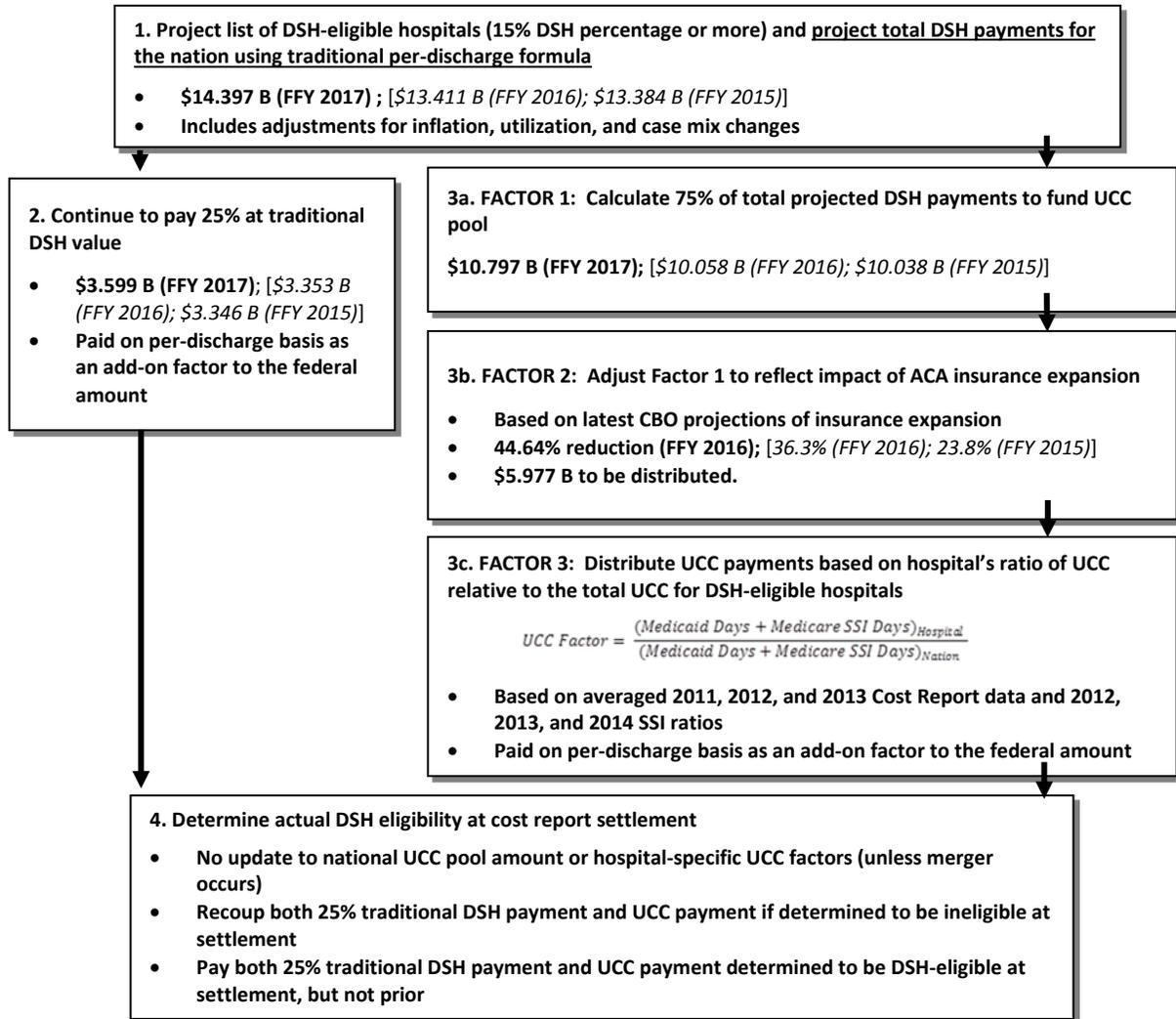
The Z-score represents each hospital’s performance in terms of standard deviation units from the national average (mean); poor performing hospitals would receive a positive z-score (above the national mean) and high performers would receive a negative score (below the national mean). Scoring for domains,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

DSH Payments

FR pages 56,943-56,973

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

- **DSH Payment Methodology for FFY 2017** (*FR pages 56,943-56,959*): The following schematic describes the DSH payment methodology mandated by the ACA along with how the program will change from FFY 2016 to FFY 2017:



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

- **Eligibility for FFY 2017 DSH Payments (FR pages 56,945-56,945):** CMS is projecting that 2,782 hospitals will be eligible for DSH payments in FFY 2017. Only hospitals identified in the final rule as DSH-eligible will be paid as such during FFY 2017. CMS has made a file available that includes DSH eligibility status, UCC factors, payment amounts, and other data elements critical to the DSH payment methodology. The file (Table 18) is available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2017-CMS-1655-FR-Table-18.zip>.

According to the tables provided in this final rule, 150 hospitals that were not eligible for DSH in FFY 2016 are projected to receive DSH payments in FFY 2017; while 37 are projected to lose eligibility due to changes in their Medicare and Medicaid days.

- **Adjustment to Factor 3 Determination (FR pages 56,952-56,959):** CMS has been using the ratio of Medicaid and Medicare SSI days for Factor 3, based on data for the most recent available year. In the proposed rule, CMS had noted that the use of only 1 year’s data has caused large fluctuations from year to year. Beginning in FFY 2017, CMS will calculate the Factor 3 UCC DSH distribution factor based on up to 3 years of data: the most current year and the two prior years. A Factor 3 value would be calculated for each year individually and the final UCC factor would be the average of those three values. If cost report data is missing for any year, that

hospital's final Factor 3 value would be based on the average of the useable cost report data. This change should result in improved stability of individual hospital DSH UCC payments going forward.

For the FFY 2017 UCC pool distribution, CMS will utilize Medicaid data from the 2011, 2012, and 2013 Medicare cost reports and data from the 2012, 2013, and 2014 Medicare SSI files. As residents of Puerto Rico are not eligible for SSI benefits, CMS has adopted a policy to apply a proxy value of 14% of Medicaid days as the Medicare SSI days for hospitals in Puerto Rico. This ratio is based on the average ratio of Medicaid days to Medicare SSI days nationally (excluding Puerto Rico).

- **Future Use of Data from Cost Report Worksheet S-10 for Determining Factor 3 (FR pages 56,959-56,973):** CMS has been using Medicaid and Medicare SSI days as a proxy for uncompensated care in Factor 3 since FFY 2014 and will do so again for FFY 2017, due to concerns regarding data variability and lack of reporting experience with Worksheet S-10. However, CMS had stated in the proposed rule that it had been seeing an improving correlation between Factor 3 values calculated using data on uncompensated care from Worksheet S-10 and those calculated using data from the IRS Form 990. CMS had proposed to phase-in the use of data reported on Line 30 of Worksheet S-10 (Charity Care and Non-Medicare Bad Debt Expense) of the Medicare cost report in order to determine the UCC payment factor (Factor 3), starting with FFY 2014 cost reports for DSH payments in FFY 2018.

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

Due to comments received, CMS did not adopt these proposals, and will proceed with revisions to the Medicare cost report. CMS expects that the revised Worksheet S-10 data will be available for use no later than FFY 2021, and will again propose to transition to S-10 in future rulemaking, likely using the proposed three-year transition methodology that was initially proposed. CMS also plans to use future rulemaking to determine a new proxy for FFY 2018 and future years that better reflects the uncompensated care provided by hospitals.

In order to account for hospitals that consistently report very high uncompensated care values on Worksheet S-10, CMS had proposed, but did not adopt, a "double trim" methodology targeting the cost to charge ratio (CCR). The methodology that had been proposed may be found on pages 56,971-56,972 of the final rule.

Finally, CMS will revise the instructions for Line 20 of Worksheet S-10 (Total Initial Obligation of Patients Approved for Charity Care) such that charity care will be reported based on the write-off date, not the date of service.

GME Payments

FR pages 56,943-56,943 and 57,026-57,033

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

In this final rule, CMS is also providing public notification of the closure of three teaching hospitals (pages 57,031-57,032 of the Final Rule) for purposes of the established application process for the resident slots attributed to these hospitals. The three facilities are:

CCN	Provider Name	City and State	CBSA Code	Terminating Date	IME Cap (includes all adjustments)	DGME Cap (includes all adjustments)
050277	Pacific Hospital of Long Beach	Long Beach, CA	31084	8/1/2013	20.47	25.92
190009	Huey P. Long Medical Center	Pineville, LA	10780	6/30/2014	11.04	11.04
390132	St. Joseph's Hospital	Philadelphia, PA	37964	3/13/2016	8.35	8.35

Hospitals wishing to apply for these slots must submit applications directly to the CMS Central Office no later than October 31, 2016.

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

Updates to the MS-DRGs

FR pages 56,785-56,912

Each year CMS updates the MS-DRG classifications and relative weights to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. Changes finalized for the FFY 2017 MS-DRGs will decrease the number of payable DRGs from 758 to 757. The majority of the DRG weights (80%) will change by less than +/- 5%.

The full list of FFY 2017 DRGs, DRG weights, and flags for those subject to the post-acute care transfer policy are available in Table 5 on the CMS website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2017-CMS-1655-FR-Table-5.zip>. For comparison purposes, the FFY 2016 DRGs are available in Table 5 on the CMS website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2016-CMS-1632-FR-Table-5.zip>.

Outlier Payments

FR pages 57,281-57,287

To maintain outlier payments at 5.1% of total IPPS payments, CMS finalized an outlier threshold of \$23,570 for FFY 2017. The adopted threshold is 4.55% higher than the current (FFY 2016) outlier threshold of \$22,544. CMS cites an increase in hospital charges as the reason for the threshold increase.

Updates to the IQR Program and Electronic Reporting Under the Program

FR pages 57,110-57,182

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

CMS also finalized two changes to the electronic clinical quality measures (eCQMs). For the calendar year (CY) 2017 reporting period/FFY 2019 payment determination and CY 2018 reporting period/FFY 2020 payment determination, CMS will require that hospitals must report on at least 8 self-selected eCQMs from the list of available eCQMs under IQR. CMS will also require that one year of data be submitted for each of the required eCQMs for the CY 2017 reporting period and thereafter.

A table on pages 57,148-57,150 of the final rule outlines the Hospital IQR Program measure set for the FFY 2019 payment determination and subsequent years and includes both previously adopted and new measures.

New Technology

FR pages 56,877-56,912

CMS states its views on numerous new medical services or technologies that are potentially eligible for add-on payments outside the PPS. In this final rule, CMS:

- discontinued add-on payments for four medical services/technologies;
- continued new technology add-on payments for four technologies; and
- initiated add-on payments for five new medical services/technologies.

Expiration of the More Inclusive Low-Volume Adjustment Criteria

FR pages 56,941-56,943 and 57,054-57,057

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

Medicare Dependent Hospitals (MDH)

FR pages 57,054-57,058

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

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

RRC Status

FR pages 56,940-56,941

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

Medicare Outpatient Observation Notice

FR pages 57,037-57,052

On August 6, 2015, Congress enacted the Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act) requiring hospitals and Critical Access Hospitals (CAHs) to provide written notification to individuals who are receiving observation services for more than 24 hours, effective August 6, 2016. In implementing the NOTICE Act, CMS will require the use of a new CMS-developed standardized notice, the Medicare Outpatient Observation Notice (MOON). CMS believes that by requiring the use of a standardized notice, providers would be assured that they are providing all of the statutorily required elements in a manner that the individuals receiving it will understand.

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

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

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