# Medicare Inpatient Prospective Payment System

## Payment Rule Brief — PROPOSED RULE

Program Year: FFY 2018

## Overview and Resources

On April 14, 2017, the Centers for Medicare and Medicaid Services (CMS) released the proposed federal fiscal year (FFY) 2018 payment rule for the Medicare Inpatient Prospective Payment System (IPPS). The proposed 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 proposed rule includes:

- The proposed rate increase amount (+0.4588%) for the Coding Offset adjustment;
- Expiration of the Medicare Dependent Hospital and expanded Low-Volume Hospital programs at the end of FFY 2017;
- 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 Hospital IQR and Electronic Health Record (EHR) Incentive Programs; and
- Updates to the Medicare Disproportionate Share Hospital (DSH) payment policies.

Program changes would be effective for discharges on or after October 1, 2017 unless otherwise noted.

A copy of the proposed rule 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/FY2018-IPPS-Proposed-Rule-Home-Page.html. Comments on all aspects of the proposed rule are due to CMS by June 13 and can be submitted electronically at http://www.regulations.gov/ by using the website's search feature to search for file code "1677-P".

On April 28, 2017, an online version of the rule will be available at https://federalregister.gov/d/2017-07800.

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

## IPPS Payment Rates

***Display Copy pages 104-109, 567-575, 839-843, 848-854, 1,530-1,557 and 1,572-1,607***

The table below lists the federal operating and capital rates proposed for FFY 2018 compared to the rates currently in effect for FFY 2017. 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 2017 | Proposed FFY 2018 | Percent Change |
|---|---|---|---|
| **Federal Operating Rate** | **$5,516.14** | **$5,596.00** | **+1.45%** |
| **Federal Capital Rate** | **$446.79** | **$451.37** | **+1.03%** |

The table below provides details for the proposed annual updates to the inpatient federal operating, hospital-specific, and federal capital rates for FFY 2018.

| | Federal Operating Rate | Hospital-Specific Rates | Federal Capital Rate |
|---|---|---|---|
| Marketbasket (MB) Update/Capital Input Price Index | **+2.9%** | **+2.9%** | **+1.2%** |
| ACA-Mandated Reductions<br>0.4 percentage point (PPT) productivity reduction and 0.75 PPT pre-determined reduction | **-1.15 PPT** | **-1.15 PPT** | **—** |
| Forecast Error Adjustment | **—** | **—** | **0.0 PPT** |
| 21st Century Cures Act-Mandated Retrospective Documentation and Coding Adjustment | **+0.4588%** | **—** | **—** |
| 2-Midnight Rule Temporary Retrospective Adjustment | **-0.60%** | **-0.60%** | **-0.60%** |
| Annual Budget Neutrality Adjustment | **-0.16%** | **-0.16%** | **+0.43%** |
| ***Net Rate Update*** | ***+1.45%*** | ***+0.98%*** | ***+1.03%*** |

- **Effects of the Inpatient Quality Reporting (IQR) and EHR Incentive Programs** ***(Display Copy pages 567-575)***: 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. Beginning FFY 2017, the EHR MU penalty is capped at 75% of the MB; hence the full MB update will be at risk between these two penalty programs. A table displaying the various update scenarios for FFY 2018 is below:

| | Neither Penalty | IQR Penalty | EHR MU Penalty | Both Penalties |
|---|---|---|---|---|
| Net Rate Federal Rate Update (2.9% MB less 0.4 PPT productivity and 0.75 PPT predetermined) | **+1.75%** | | | |
| Penalty for Failure to Submit IQR Quality Data (25% of the base MB Update of 2.9%) | **—** | **-0.725 PPT** | **—** | **-0.725 PPT** |
| Penalty for Failure to be a Meaningful User of EHR (75% of the base MB Update of 2.9%) | **—** | **—** | **-2.175 PPT** | **-2.175 PPT** |
| ***Adjusted Net Rate Update (prior to ATRA and 2-Midnight)*** | ***+1.75%*** | ***+1.025%*** | ***-0.425%*** | ***-1.15%*** |

- **Retrospective Coding Adjustment** ***(Display Copy pages 1,530-1,557)*****:** CMS is proposing to apply a retrospective coding adjustment of +0.4588% to the federal operating rate in FFY 2018. The coding offset rate increase 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 recoupment requirement of $11 billion, CMS applied -0.8% coding adjustments in FFYs 2014 through 2016 and a -1.5% adjustment in FFY 2017. Under ATRA, once the full recoupment had been accomplished, the base amount was to be restored.
- **2-Midnight Policy Adjustment** ***(FR pages 839-843)*****:** 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 single-year increase of 0.6%. For FFY 2018 CMS will end the single-year component of the adjustment by applying a reduction of 0.6% to the IPPS rates.

- **Rebasing and Revision of the Acute Care Hospital Marketbasket** ***(Display Copy pages 512-548)*****:** CMS rebases the IPPS marketbasket every four years by updating the costs and input price indexes used in the calculation. In addition, CMS may revise the marketbasket by changing the data sources for price proxies used in the input price index. The last update to the marketbasket was implemented in FFY 2014 using 2010 data as the base period for the construction of the marketbasket costs.

  For FFY 2018, CMS is proposing to rebase the hospital marketbasket cost weights using FFY 2014 Medicare cost report data and the 2007 Benchmark Input-Output (I-O) "Use Tables/Before Redefinitions/Purchaser Value" tables published by the Bureau of Economic Analysis (BEA) which are available publicly at https://www.bea.gov/industry/io_annual.htm. Data taken from the BEA file are derived from the 2007 Economic Census, and will be inflated to 2014 values by CMS. In addition, CMS will revise several of the price proxies using Bureau of Labor Statistics (BLS) data.

  As a result, CMS proposes to apply a marketbasket update of 2.9% for FFY 2018 which CMS states would be the same if rebasing were not done.

- **Rebasing and Revision of the Capital Input Price Index (CIPI)** ***(Display Copy pages 548-561)*****:** As with the IPPS marketbasket, CMS also rebases the CIPI in a similar fashion every four years.

  For FFY 2018, CMS is proposing to rebase the CIPI cost weights using FFY 2014 Medicare cost report data, BEA, and BLS data.

  As a result, CMS proposes to apply a capital update of 1.2% for FFY 2018 which CMS states would be 0.1 percentage points less than if rebasing was not done.

- **Eliminating Inappropriate Payment Differentials for Similar Services in IPPS and OPPS** ***(Display Copy page 843)*****:** As part of the June 2015 "Medicare and Health Care Delivery System Report to Congress," MedPAC noted that *"The high profitability of one-day stays under the inpatient prospective payment system (IPPS) and the generally lower payment rates for similar care under the outpatient prospective payment system (OPPS) have heightened concern about the appropriateness of inpatient one-day stays."* As CMS believes that both hospitals and CMS have had the opportunity to gain experience with various policy changes regarding short inpatient stays, CMS is seeking public comment on ways to identify and eliminate inappropriate Medicare payment differences for similar services provided in the inpatient and outpatient settings.

## Wage Index

***Display Copy pages 435-511***

For FFY 2018, CMS is proposing several changes that will affect the wage index and wage index-related policies, including:

- **County Code Revisions** ***(FR pages 438-440)*****:** CMS states that it has learned that Social Security Administration (SSA) county codes are no longer being updated, and proposes for FFY 2018 to transition to the use of the Federal Information Processing Standard (FIPS) county codes for crosswalking to CBSAs. Coinciding with this, the Census Bureau has made the following updates to the FIPS codes:
  1. Petersburg Borough, AK (FIPS 02195) created from part of former Petersburg Census Area (FIPS 02195) and part of the Hoonah-Angoon Census Area (FIPS 02105).
  2. The name of La Salle Parish, LA (FIPS 22059) is renamed to LaSalle Parish, LA (FIPS 22059).
  3. The name of Shannon County, SD (FIPS 46113) is renamed to Oglala Lakota County, SD (FIPS 46102).

- **Imputed Rural Floor** ***(Display Copy pages 461-466)*****:** The imputed rural floor policy is set to expire on September 30, 2017. CMS states in the proposed rule that it is not proposing an additional extension to this policy, in part because it disadvantages those states whose urban areas are unaffected by the rural floor due to the budget

neutral aspect of the policy. As a result, the imputed rural floor would no longer be considered a factor in the national budget neutrality adjustment.

- **Submission Deadline for SCH and RRC Classification Status to the MGCRB** ***(Display Copy pages 474-480 and 491-494)*****:** CMS is proposing to establish a deadline of the first business day after January 1 for hospitals to submit documentation for SCH or RRC status approvals to the MGCRB. In addition, CMS is proposing that a hospital would qualify for the RRC exceptions if it was ever approved as a RRC, and must submit this documentation to the MGCRB by the same deadline. If the hospital is such a grandfathered RRC, it would not have to demonstrate that it meets the average hourly wage criterion for wage index reclassification. CMS clarifies that this would not apply to an RRC seeking an urban-to-rural reclassification, and that RRCs may continue to submit these applications at any time. This proposal is in order to allow the MGCRB sufficient time to review SCH and RRC status approvals, and to provide hospitals greater clarity as to when documentation must be submitted.

- **Changes to the 45-Day Notification Rule** ***(Display Copy pages 485-487)*****:** Currently, hospitals have 45 days from publication of the IPPS proposed rule to notify CMS or the MGCRB of changes regarding reclassification/redesignation and outmigration requests, such as withdrawal or termination of an application. CMS is proposing to that written notification must be provided to CMS or the MGCRB (as applicable) within 45 days of the date of public display of the annual IPPS proposed rule.

- **Labor-Related Share** ***(Display Copy pages 508-511)*****:** The wage index adjustment is applied to the portion of the IPPS rate that CMS considers to be labor-related. For FFY 2018, as CMS is proposing to rebase and revise the IPPS market basket from a FFY 2010-baseline to FFY 2014, it is also proposing to update the wage index labor share, in a budget neutral manner. CMS is thus proposing apply a labor-related share of 68.3% 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 or equal to 1.0 will remain at 62%.

- **Inclusion of Other Wage-Related Costs** ***(Display Copy pages 446-455)*****:** As 80 out of 3,320 hospitals reporting "Other wage-related costs" on Line 18 of Cost Report Worksheet S-3 Part II actually meet the 1% test for inclusion on that line (costs must exceed 1% of the total adjusted salaries net of excluded areas), CMS believes that costs reported on this line might not constitute an appropriate part of wage costs in a labor market area. As a result, CMS is clarifying that in order to be included on Line 18 of Cost Report Worksheet S-3 Part II, a cost must match the IRS's description of a fringe benefit, and must be reported to the IRS on employees' or contractors' W-2 or 1099 forms as taxable income. Additionally, CMS is seeking comment on whether "Other wage-related costs" should be removed from wage index calculation.

- **CY 2016 Occupational Mix Survey** ***(Display Copy page 457)*****:** CMS states that the FFY 2019 wage index calculation will utilize the CY 2016 Occupational Mix Survey. Hospitals are required to submit their completed 2016 surveys to their MACs by July 3, 2017. The preliminary, unaudited survey data will be posted to the CMS website in mid-July 2017 for review and verification. The survey form may be found at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/2016-hospital-form-cms-10079-om-survey-instructions.zip.

- **Wage Index Development Timetable for FFY 2019** ***(Display Copy pages 400-473 and 494-507)*****:** Applications for FFY 2019 wage index reclassifications are due to the Medicare Geographic Classification Review Board (MGCRB) by September 1, 2017. CMS is proposing that, beginning with wage index revision requests due to the MACs in April 2018, a hospital seeking to challenge the MAC's handling of wage data would be required to request (via mail or email) that CMS intervene by the date in April specified as the deadline for hospitals to appeal MAC determinations in cases where the hospital disagrees with the MAC's determination. CMS is also proposing to use existing appeal deadlines for hospitals to dispute CMS corrections made after the posting of the January wage index public use file (PUF) that do not arise from a hospital data revision request. Starting with the April 2018 appeal deadline, hospitals would use the earliest available appeal deadline to dispute any adjustments made by CMS unless the hospital were notified of said adjustment within 14 days of an appeal deadline. In such cases, the hospital would have until the following deadline to dispute any adjustments.

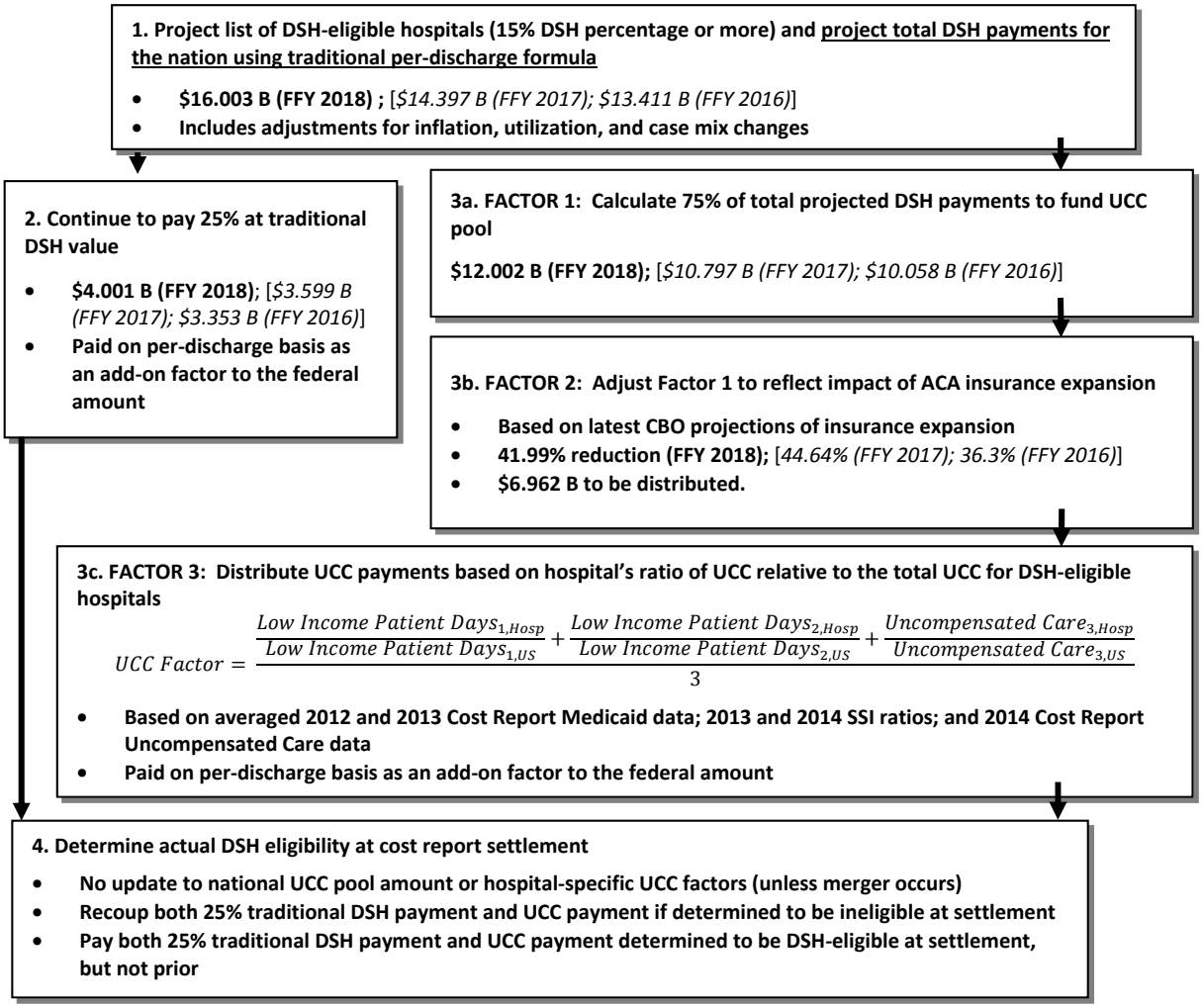
A complete list of the proposed wage indexes for payment in FFY 2018 is available on Table 2 on the CMS Web site at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2018-NPRM-Tables-2-and-3.zip.

## DSH Payments

***Display Copy pages 604-669***

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 2018** ***(FR pages 604-669)*****:**
  The following schematic describes the DSH payment methodology mandated by the ACA along with how the program is proposed to change from FFY 2017 to FFY 2018:




The DSH dollars available to hospitals under the ACA's payment formula are proposed to increase in FFY 2018 due to a proposed change in the data source used by CMS for determination of the reduction factor.

- **Eligibility for FFY 2018 DSH Payments *(Display Copy pages 609-614)*:** CMS is projecting that 2,418 hospitals will be eligible for DSH payments in FFY 2018. Only hospitals identified in the final rule as DSH-eligible will be paid as such during FFY 2018. 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/FY2018-NPRM-Table-18.zip.

  According to the tables provided in this proposed rule, 83 hospitals that were not eligible for DSH in FFY 2017 are projected to receive DSH payments in FFY 2018; while 70 are projected to lose eligibility due to changes in their Medicare and Medicaid days, or likelihood of being paid at their hospital-specific rate.

- **Adjustment to Factor 2 Determination *(Display Copy pages 624-636)*:** For FFYs 2014-2017, CMS used the ratio of "Insured Share of the Nonelderly Population Including All Residents," as reported by the CBO in March of each year, in calculation of Factor 2, the amount by which the UCC pool is reduced each year. For FFY 2018, CMS is proposing to change its source to the uninsured estimates produced by CMS' Office of the Actuary (OACT) as part of the development of the National Health Expenditure Accounts (NHEA), which is used to estimate national levels of healthcare spending.

- **Adjustment to Factor 3 Determination *(Display Copy pages 637-669)*:** CMS has been using Medicaid and Medicare SSI days as a proxy for uncompensated care in Factor 3 since FFY 2014, due to concerns regarding data variability and lack of reporting experience with Worksheet S-10. However, CMS has again stated in that it has 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 is again proposing 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 is proposed to be 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 Medicaid days, 2013 and 2015 Medicare SSI days) and 1 year of S-10 data (2014) for FFY 2018 DSH payments.

  CMS stated that if, in the future, they were to propose to continue this transition using a similar methodology for FFYs 2019 and 2020, the data used would be 1 year of proxy data (2013 Medicaid days, 2015 Medicare SSI days) 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.

  In order to account for hospitals that consistently report very high uncompensated care values on Worksheet S-10, CMS had proposed, a trimming methodology targeting the cost to charge ratio (CCR). The proposed methodology may be found on pages 665-668 of the Display Copy of the proposed rule.

  Additionally, CMS has proposed that it will annualize cost report data used the calculation of Factor 3 so as to not unfairly penalize short-period filers, nor award those with cost reports spanning a period of longer than 12 months. Finally, when calculating the 3-year average factor 3 values, CMS is proposing to add a scaling factor to account for national UCC distributions of other than 100% of the pool amount resulting from hospitals with one or more years excluded from their 3-year average.

  Finally, CMS stated that there will be no additional instructions provided for completion of Worksheet S-10 and that the S-10 data will be subject to a desk review beginning with FFY 2017 cost reports.

## GME Payments

***Display Copy page 603***

CMS did not propose any major changes to the direct GME payment policies for FFY 2018.

The Indirect Medical Education (IME) adjustment factor is proposed to remain at 1.35 for FFY 2018.

## Updates to the MS-DRGs

***Display Copy pages 110-434***

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 proposed for the FFY 2018 MS-DRGs will decrease the number of payable DRGs from 757 to 754. Sixty-eight percent of DRG weights will change by less than +/- 5%. Of those MS-DRGs with weights changing by more than this, the top five are:

| MS-DRG | FFY 2017 Weight | FFY 2018 Weight | Percent Change |
|---|---|---|---|
| MS-DRG 950: Aftercare w/o CC/MCC | 0.5660 | 0.8042 | +42.08% |
| MS-DRG 080: Nontraumatic Stupor & Coma w/ MCC | 1.2566 | 1.7311 | +37.76% |
| MS-DRG 215: Other Heart Assist System Implant | 16.1076 | 10.4983 | -34.82% |
| MS-DRG 941: O.R. Proc w/ Diagnoses of Other Contact w/ Health Services w/o CC/MCC | 1.4341 | 1.8555 | +29.38% |
| MS-DRG 782: Other Antepartum Diagnoses w/o Medical Complications | 0.4711 | 0.6033 | +28.06% |
| MS-DRG 780: False Labor | 0.6099 | 0.4401 | -27.84% |

Of particular note, in response to several recommendations regarding the inclusion of Total Ankle Replacement (TAR) procedures in MS-DRGs 469 and 470, CMS is proposing to move the following ICD-10-CM TAR procedure codes from MS-DRG 470 to the more intensive MS-DRG 469:

- 0SRF0J9: Replacement of Right Ankle Joint with Synthetic Substitute, Cemented, Open Approach;
- 0SRF0JA: Replacement of Right Ankle Joint with Synthetic Substitute, Uncemented, Open Approach;
- 0SRF0JZ: Replacement of Right Ankle Joint with Synthetic Substitute, Open Approach;
- 0SRG0J9: Replacement of Left Ankle Joint with Synthetic Substitute, Cemented, Open Approach;
- 0SRG0JA: Replacement of Left Ankle Joint with Synthetic Substitute, Uncemented, Open Approach; and
- 0SRG0JZ: Replacement of Left Ankle Joint with Synthetic Substitute, Open Approach.

The full list of proposed FFY 2018 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/FY2018-NPRM-Table-5.zip.
For comparison purposes, the FFY 2017 DRGs 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.

## New Technology

***Display Copy pages 311-434***

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

- discontinuation of add-on payments for five medical services/technologies; and
- continuation of new technology add-on payments for four technologies.

## Changes to the MS-DRG Postacute Care Transfer and Special Payment Policies

***Display Copy pages 562-567***

When a patient is transferred from an acute care facility to a post-acute care setting, the transferring hospital receives a per diem payment, with a total payment capped at the full MS-DRG amount. For MS-DRGs subject to the post-acute care transfer policy that CMS deems to be high cost, CMS applies a special payment methodology so that the transferring hospital receives 50% of the full MS-DRG payment plus a per diem payment, with total

payment capped at the full MS-DRG amount. Each year CMS, using established criteria, reviews the list of MS-DRGs subject to the post-acute care transfer policy.

Effective FFY 2018, CMS is proposing to add three MS-DRGs to the list of those subject to the special payment transfer policy:

- MS-DRG 987: Non-Extensive O.R. Procedure Unrelated to Principal Diagnosis with MCC
- MS-DRG 988: Non-Extensive O.R. Procedure Unrelated to Principal Diagnosis with CC
- MS-DRG 989: Non-Extensive O.R. Procedure Unrelated to Principal Diagnosis without MCC/CC

## Outlier Payments

***Display Copy pages 1,557-1,572***

To maintain outlier payments at 5.1% of total IPPS payments, CMS is proposing an outlier threshold of $26,713 for FFY 2018. The adopted threshold is 13.33% higher than the current (FFY 2017) outlier threshold of $23,570.

## Expiration of the More Inclusive Low-Volume Adjustment Criteria

***Display Copy pages 590-603***

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 had extended the relaxed low volume adjustment criteria (15-mile/ <1,600 discharges) for an additional 30 months, through the end of FFY 2017. However, as no further legislation has been put into place, beginning October 1, 2017 the criteria for the low-volume hospital adjustment will return to the more restrictive pre-ACA levels. In order to receive a low-volume adjustment, subsection (d) hospitals will need to meet the following criteria:

- Be located more than 25 road miles from another subsection (d) hospital; and
- Have fewer than 200 total discharges (All Payer) during the fiscal year.

In order for a hospital to acquire low-volume status, including for those currently assigned low-volume status, its MAC must receive a written request by September 1 immediately preceding the start of the Federal fiscal year for which the hospital is applying for the 25% add-on beginning the October 1 that immediately follows the request. This written request must include supporting documentation that the hospital meets the updated mileage and discharge criteria. If accepted, the adjustment will be applied prospectively within 30 days of low-volume hospital determination.

Additionally, CMS is proposing an adjustment to the mileage criterion with regards to Indian Health Services (IHS) and Tribal hospitals. Specifically, the mileage criterion would be relaxed such that IHS/Tribal hospitals and non-IHS/Tribal hospitals do not affect the proximity requirement of low-volume eligibility for hospitals belonging to the other group.

## Medicare Dependent Hospitals (MDH)

***Display Copy pages 669-672***

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.

Absent legislation, beginning October 1, 2017, the MDH program will expire, and hospitals that qualified for the MDH program in prior years would be paid based on the IPPS Federal rate. Hospitals that will lose MDH status that intend to apply for SCH status for FFY 2018 must do so by September 1, 2017, and must also request that, if approved, SCH status would be effective with the expiration of the MDH program. Hospitals that do not meet this deadline will have an effective date, if approved, for SCH classification beginning 30 days after the date of CMS' written notification of approval.

## Volume Decrease Adjustment for SCHs and MDHs

***Display Copy pages 575-585***

Payments made to SCHs and MDHs (if the MDH program is extended) are adjusted as necessary to fully compensate the hospital for the fixed costs incurred in providing inpatient services when it experiences a decrease in inpatient discharges of more than 5% due to circumstances beyond its control.

Beginning FFY 2018, in order to ensure that hospitals qualifying for a volume decrease adjustment are fully compensated for fixed costs, CMS is proposing to prospectively estimate the fixed portion of a hospital's Medicare revenue by applying the ratio of the hospital's fixed costs to total costs to the hospital's total Medicare revenue for a given cost report period. As this calculation would never exceed the difference between a hospital's inpatient operating costs and total DRG revenue, CMS is also proposing to eliminate the volume decrease adjustment cap for FFYs 2018 and future years.

In addition, as it is to be expected that a hospital would adjust their staff totals if revenue were to decrease, CMS is proposing to modify the volume decrease process to no longer require that a hospital demonstrate that it adjusted the number of staff in inpatient areas based on the decrease in number of inpatient days, and would no longer require MACs to adjust the volume decrease adjustment payment amount for excess staffing.

## RRC Status

***Display Copy pages 585-590***

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 proposed FFY 2018 minimum case-mix and discharge values are available on the pages listed above.

## Indian Health Services and Tribal Facilities

***Display Copy pages 844-847***

In the April 7, 2000 OPPS final rule, so as to not jeopardize the Medicare participation of IHS and Tribal facilities providing outpatient services, CMS adopted a policy under which IHS or Tribal facilities would be considered as "Departments of hospitals operated by the IHS or Tribes," and thus grandfathered from application of the provider-based rules, if they furnished only services that were billed as if they had been furnished by a department of an IHS or Tribal hospital on or before April 7, 2000 and that they are:

1) Owned and operated by the IHS;
2) Owned by the Tribe, but leased from the Tribe by the IHS under the Indian Self-Determination and Education Assistance Act; or
3) Owned by the IHS but leased and operated by the Tribe under the Indian Self-Determination and Education Assistance Act.

CMS states that as IHS policies and procedures regarding the planning, operation, and funding of such facilities are resulting in appropriate payments, it is proposing to remove the date limitation that restricts the grandfathering provision to IHS or Tribal facilities furnishing services on or prior to April 7, 2000. In addition, CMS is proposing to make a technical change to the billing reference by replacing "were billed" with "are billed using the CCN of the main provider and with the consent of the main provider."

## Changes to Instructions for the Review of the CAH 96-Hour Certification Requirement

***Display Copy pages 870-871***

In an effort to reduce burden on providers, CMS is providing notice that will direct Quality Improvement Organizations, Medicare Administrative Contractors and the Supplemental Medicare Review Contractor, and Recovery Audit Contracts to make the CAH 96-hour physician certification requirement that an individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to a CAH a low priority for medical record reviews conducted on or after October 1, 2017.

## Quality-Based Payment Adjustments

***Display Copy pages 673 -57,026***

For FFY 2018, 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. Detail on the FFY 2018 programs and payment adjustment factors are below (future program year program changes are addressed at the end of this Brief):

- **VBP Adjustment *(Display Copy pages 717-779)*:** The FFY 2018 program will include hospital quality data for 19 measures in 4 domains: safety of care; clinical care; patient experience of care; and efficiency. By law, the VBP Program must be budget neutral and the FFY 2018 program will be funded by a 2.0% reduction in IPPS payments for hospitals that meet the program eligibility criteria (estimated at $1.9 billion). 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 2018 VBP program is still being aggregated, CMS has calculated and published proxy factors based on the current year's (FFY 2017) program. Hospitals should use caution in reviewing these factors as they do not reflect performance on new measures for FFY 2018, 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/FY2018-NPRM-Table-16.zip.

  Effective with the FFY 2018 VBP program, CMS will remove the pain management measure from the patient experience domain.

  CMS anticipates making actual FFY 2018 VBP adjustment factors available in October 2017. Details and information on the program currently in place for FFY 2017 and FFY 2018 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) *(DISPLAY pages 673 - 716)*:** The FFY 2018 RRP will evaluate hospitals on 6 conditions/procedures: acute myocardial infarction (AMI), heart failure (HF), pneumonia (PN) (expanded in FFY 2017 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 proposed proxy FFY 2018 RRP factors are published with the proposed rule in Table 15 and on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2018-NPRM-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 *(Display Copy pages 780 - 797)*:** The FFY 2018 HAC program will evaluate hospital performance on 6 measures: the AHRQ Patient Safety Indicator (PSI)-90 (a composite of 10 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. 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 2018 in October 2017.

  CMS adopted a new continuous program z-score methodology beginning in FFY 2018 for HAC which eliminates ties in the program and enhances the ability to distinguish low performers from top performers.

Details and information on the HAC currently are available on CMS' QualityNet website at https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228774189166 .

## Quality-Based Payment Policies—FFYs 2019 and Beyond

For FFYs 2019 and beyond, CMS is finalizing new policies and measures for its quality-based payment programs as follows:

- **VBP Program–FFYs 2019 through 2023** ***(Display Copy pages 717 -779)*****:** CMS has already adopted VBP program rules through FFY 2019 and some program policies and rules beyond FFY 2019. CMS is proposing further program updates for FFYs 2019-2023, which include:
  - Removing the PSI-90 measure beginning with the FFY 2019 program year;
  - New data collection time periods (baseline/performance periods) for the FFY 2019-2023 program years;
  - National performance standards for a subset of the FFY 2020-FFY 2023 program measures (performance standards for other program measures for future program years will be put forward in future rulemaking);
  - Addition of Hospital-Level Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Pneumonia (PN Payment) measure for the FFY 2022 program year;
  - Addition of modified PSI-90 measure: Patient Safety and Adverse Events (Composite) for the FFY 2023 program year;
  - Changing the minimum number of measure scores a hospital must receive in order to be eligible for the Safety of Care domain from three measures to two measures and addition that a hospital must receive a minimum of one measure within the Efficiency and Cost Reduction domain;
  - New minimum case count criteria for new measures.

  CMS is also proposing that with the additional of new measures for the Efficiency and Cost Reduction domain beginning in FFY 2021, the Medicare Spending Per Beneficiary (MSPB) measure will be weighted at 50% of the Efficiency and Cost Reduction domain, leaving 50% of the domain weight to the other measures.

  Details and tables on the adopted measures, collection time periods, performance standards, and measure weighting are available on the pages listed above.

- **Readmissions Reduction Program** ***(Display Copy pages 673 - 716)*****:** The 21st Century Cures Act requires the development of a transitional methodology for the program that accounts for the percentage of full-benefit dual eligible patients treated by a hospital, as a proxy for social risk factors, to determine a hospital's payment adjustment factor beginning in FFY 2019. In order to do this, hospitals must be assigned into peer groups and compared separately within these groups. The adjustment to the methodology must be budget neutral.

  CMS is proposing to identify full-benefit dual eligible patients using the State Medicare Modernization Act (MMA) file of dual eligibility and to group hospitals based on the ratio of full-benefit dual eligible patients and total Medicare patients into quintiles. CMS is considering two alternative definitions of total number of Medicare patients, using MedPar data:

  1. All Medicare FFS and Medicare Advantage stays
  2. Just Medicare FFS stays

  CMS is also proposing to identify full-dual eligible patients during the same 3-year period as the program performance period (July 1, 2013- June 30, 2016 for FFY 2019).

  CMS has identified 4 potential options for calculating a budget neutral program comparing hospitals to those within their grouping, with the first being the preferred proposal:

- Median excess readmission ratio plus a neutrality modifier
- Mean excess readmission ratio plus a neutrality modifier
- Budget neutralizing excess readmission ratio
- Standardized excess readmission ratio plus a neutrality modifier

CMS is also proposing extraordinary circumstance policy updates.

**HAC Reduction Program–FFY 2020** ***(Display Copy pages 780 - 797)*****:** CMS has already adopted program specifications through FFY 2019. CMS is proposing specifications for the FFY 2020 program such as time periods used to calculate performance scores. CMS also lists measures that they are considering proposing in the future for the HAC program. Lastly, CMS is proposing extraordinary circumstance policy updates.

CMS has also been reviewing how to account for social risk factors in all three programs.

## Updates to the IQR Program and Electronic Reporting Under the Program

***Display Copy pages 969 – 1186***

CMS is proposing to adopt 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 2020. CMS is proposing refinements to two previously adopted measures for the Hospital IQR program beginning in FFY 2020 and one measure refinement beginning in FFY 2023.

CMS is also proposing two changes to the electronic clinical quality measures (eCQMs). For the calendar year (CY) 2017 reporting period/FFY 2019 payment determination, CMS is proposing to decrease the number of eCQMs for which hospitals must report data on from 8 to 6 and decrease the length of submission from a full calendar year to two calendar quarters of CY 2017 data. For CY 2018 reporting period/FFY 2020 payment determination, CMS is proposing to require the submission of three calendar quarters of CY 2018 data.

CMS is also considering potential options to adjust for social factors in the IQR program.

A table on the display copy pages 1016-1022 of the proposed rule outlines previously finalized Hospital IQR Program measure set with proposed refinements to measures for the FFY 2020 payment determination and subsequent years.

####