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An Analysis and Commentary on Federal Health Care Issues
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CMS Releases FY 2017 Medicare IPPS and LTCH Update

The Centers for Medicare and Medicaid Services (CMS) have released a final rule to update both the Hospital Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System for fiscal year (FY) 2017.

The rule is some 2,434 pages. The proposed rule was only 1,579 pages, and the rule doesn't include tables that are on the CMS website.

The document is currently on public display at the ***Federal Register*** office and is scheduled for publication August 22nd. A copy is available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-18476.pdf. This link will change upon publication.

The IPPS tables at: http://www.cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html. Click on the link on the left side of the screen titled, "FY 2017 IPPS Final Rule Home Page" or "Acute Inpatient—Files for Download".

The LTCH PPS tables are at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/index.html under the list item for Regulation Number CMS-1655-F.

Comment

The sheer size of this rule is unbelievable. It was published the very last day open to CMS to promulgate. By statute, the agency must release rules 60 days prior to implementation.

Something is very wrong that CMS finds it so necessary to repeat so much history which clouds the issues at hand from being more easily identified, digested and understood.

The table of contents is 40 pages alone, and CMS still has not adapted to the concept of page numbering.

Most sections do NOT contain *clearly* marked final action/ decision areas. CMS does say throughout the document that it is "finalizing our proposal," but these actions are not bolded or necessarily in separate sections. You have to search.

CMS says the changes it is making will increase Medicare payments by $746 million in FY 2017.

CMS is backing off plans to begin using hospital S-10 data for purposes of the disproportionate share hospital adjustment. It is delaying these efforts from FY 2018 to FY 2021.

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The following material is from CMS' fact sheet which is based on material in the rule's executive summary of its major provisions ***(pages 63-75)*** ***(see notes below regarding page numbers)****.*

Changes to Payment Rates under IPPS

The final increase in operating payment rates for hospitals that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful electronic health record (EHR) users is 0.95 percent. This reflects a projected hospital market basket update of 2.7 percent adjusted by -0.3 percentage point for multi-factor productivity and an additional adjustment of -0.75 percentage point in accordance with the ***Affordable Care Act*** (ACA). The update also reflects a 1.5 percentage point reduction for documentation and coding required by the ***American Taxpayer Relief Act of 2012*** (ATRA) and an increase of approximately 0.8 percentage points to remove the adjustment to offset the estimated costs of the **Two Midnight** policy and address its effects in FYs 2014, 2015, and 2016.

Hospitals that do not successfully participate in the Hospital IQR Program and do not submit the required quality data will be subject to a one-fourth reduction of the market basket update. Also, the law requires that any hospital that is not a meaningful EHR user will be subject to a three-fourths reduction of the market basket update in FY 2017.

CMS projects that the rate increase, together with other final changes to IPPS payment policies, will increase IPPS operating payments by approximately 1.0 percent and that changes in uncompensated care payments will decrease IPPS operating payments by 0.4 percent. Other continued additional payment adjustments will include: a 1.0 percent reduction for hospitals in the lowest performing quartile under the Hospital Acquired Condition Reduction Program; payment adjustments for excess readmissions under the Hospital Readmissions Reduction Program (up to 3.0 percent); and incentive payments and reductions under the Hospital-Value Based Purchasing Program that will initially remove $1.8 billion in payments.

IPPS Rate Adjustments for Documentation and Coding and Two Midnight Policy

CMS is finalizing the last year of recoupment adjustments required by ATRA Section 631. This provision requires CMS to recover $11 billion by FY 2017 to fully recoup documentation and coding overpayments related to the transition to the MS-DRGs that began in FY 2008.

For FYs 2014, 2015, and 2016, CMS implemented a series of cumulative -0.8 percent adjustments. For FY 2017, CMS calculates that $5.05 billion of the $11 billion requirement remains to be addressed. Therefore, CMS is finalizing a -1.5 percent adjustment to complete the statutorily-specified recoupment.

CMS is also taking action regarding the -0.2 percent adjustment it implemented in the FY 2014 IPPS/LTCH PPS final rule to account for an estimated increase in Medicare expenditures due to the Two Midnight Policy. Specifically, in the FY 2014 IPPS/LTCH PPS final rule, CMS estimated that this policy would increase expenditures and accordingly made an adjustment of -0.2 percent to the payment rates. CMS believes the assumptions underlying the -0.2 percent adjustment were reasonable at the time they were made. Additionally, CMS does not generally believe it is appropriate in a prospective payment system to retrospectively adjust rates. CMS is permanently removing this adjustment and also its effects for FYs 2014, 2015, and 2016 by adjusting the FY 2017 payment rates. This will increase FY 2017 payments by approximately 0.8 percent.

Medicare Uncompensated Care Payments **(page 758)**

CMS distributes a prospectively determined payment amount to Medicare disproportionate share hospitals based on their relative share of uncompensated care nationally. As required by the ACA, this amount is equal to an estimate of 75 percent of what otherwise would have been paid as Medicare disproportionate share hospital payments prior to the ACA, adjusted for decreases in the rate of uninsured individuals and other factors. In this rule, CMS will distribute almost $6 billion in

uncompensated care payments in FY 2017, a decrease of approximately $400 million from the FY 2016 amount.

For FY 2017, CMS is finalizing a policy of continuing to distribute these funds using a proxy for uncompensated care based on insured low income days, which include inpatient days for patients eligible for Medicaid and inpatient days for patients entitled to Medicare and Supplemental Security Income (SSI). CMS is also finalizing two changes to this methodology. First, CMS will use data from three cost reporting periods instead of one cost reporting period to limit major fluctuations in uncompensated care payments from year-to-year. Second, CMS will apply a proxy to estimate Medicare SSI inpatient days for Puerto Rico hospitals since residents of Puerto Rico are not eligible for SSI benefits.

S-10 Development

CMS proposed to begin incorporating uncompensated care cost data from Worksheet S-10 of the Medicare cost report for distributing Medicare Uncompensated Care Payments funds starting in FY 2018. CMS says it is not finalizing this proposal. Instead, the agency is intent to engage in future rulemaking and begin to incorporate Worksheet S-10 data into the computation of the Medicare DSH Factor 3 no later than FY 2021. CMS intends to make certain modifications and clarifications to the cost report instructions for Worksheet S-10, as well as implement review protocol for the Medicare Administrative Contractors (MACs) to use in reviewing Worksheet S-10.

***CMS-1632-F & IFC –Finalization of the Extension of the MDH Program and Low-Volume Hospital Adjustment Provided by the MACRA* (page 1219)**

On August 17, 2015, CMS issued an interim final rule with comment period (IFC) implementing the extension of the temporary changes to the criteria and payment adjustment for low-volume hospitals and the Medicare-dependent hospital (MDH) program for discharges occurring from April 1, 2015 through September 30, 2017, as provided by sections 204 and 205 of the ***Medicare Access and CHIP Reauthorization Act of 2015*** (MACRA). Under these extensions, a hospital can qualify as a low-volume hospital if it is located more than 15 road miles from another hospital and has fewer than 1,600 Medicare discharges. CMS is finalizing this IFC in the FY 2017 IPPS/LTCH PPS final rule.

***Notification Procedures for Outpatients Receiving Observation Services* (page 1148)**

The ***Notice of Observation Treatment and Implication for Care Eligibility Act*** (NOTICE Act) requires hospitals and Critical Access Hospitals (CAH) to provide notification to individuals receiving observation services as outpatients for more than 24 hours explaining the status of the individual as an outpatient, not an inpatient, and the implications of such status.

- Hospitals and CAHs are required to furnish a new CMS-developed standardized notice, the Medicare Outpatient Observation Notice (MOON), to a Medicare beneficiary who has been receiving observation services as an outpatient for more than 24 hours. Under the final rule, hospitals and CAHs may deliver the MOON to individuals receiving observation services as an outpatient before such individuals have received more than 24 hours of observation services. The notice must be provided no later than 36 hours after observation services are initiated or, if sooner, upon release;

- The MOON will inform beneficiaries annually of the reason(s) they are an outpatient receiving observation services and the implications of such status with regard to Medicare cost sharing and coverage for post-hospitalization skilled nursing facility (SNF) services; and

- An oral explanation of the MOON must be provided, ideally in conjunction with the delivery of the notice, and a signature must be obtained from the individual, or a person acting on such individual's behalf, to acknowledge receipt. In cases where such individual or person refuses to

sign the MOON, the staff member of the hospital or CAH providing the notice must sign the notice to certify that notification was presented.

The standardized notice, the MOON, is undergoing the Paperwork Reduction Act process, thus affording the public an opportunity to comment on the MOON. The 30-day public comment period begins when the final rule is published.

Hospital-Acquired Condition (HAC) Reduction Program **(page 1038)**

The HAC Reduction Program creates an incentive for hospitals to reduce the incidence of hospital-acquired conditions by requiring the Secretary to make an adjustment to payments to hospitals that are in the worst performing quartile for hospital-acquired conditions. CMS is making five changes to existing HAC Reduction Program policies:

1. Establishing National Healthcare Safety Network (NHSN) CDC Healthcare Associated Infections (HAI) data submission for newly opened hospitals;
2. Clarifying data requirements for Domain 1 scoring;
3. Establishing performance periods for the FY 2018 and FY 2019 HAC Reduction Program;
4. Adopting a refined PSI 90: Patient Safety for Selected Indicators Composite Measure (NQF # 0531); and
5. Changing the Program scoring methodology from the current decile-based scoring to a continuous scoring methodology.

Hospital Readmissions Reduction Program (HRRP) ***(page 885)***

The Hospital Readmission Reduction Program (HRRP) requires a reduction to a hospital's base operating DRG payment to account for excess readmissions associated with selected applicable conditions. For FY 2017 and subsequent years, the reduction is based on a hospital's risk-adjusted readmission rate during a three-year period for acute myocardial infarction (AMI), heart failure (HF), pneumonia, chronic obstructive pulmonary disease (COPD), total hip arthroplasty/total knee arthroplasty (THA/TKA), and coronary artery bypass graft (CABG). To align with other quality reporting programs and allow the posting of data as soon as possible, CMS is updating the public reporting policy so that excess readmission rates will be posted to the *Hospital Compare* website as soon as feasible following the hospitals' preview period.

Medicare and Medicaid EHR Incentive Programs **(page 1455)**

This rule also includes the requirements for eligible hospitals and CAHs reporting clinical quality measures (CQMs) for the Medicare and Medicaid EHR Incentive Programs. CMS has finalized modifications to some of the CQM reporting and submission requirements, including the proposed removal of certain CQMs to align with the Hospital IQR Program.

Hospital Inpatient Quality Reporting (IQR) Program **(page 1455)**

The Hospital IQR Program is a program established by the ***Medicare Prescription Drug, Improvement, and Modernization Act*** (MMA). CMS is finalizing the addition of four new claims-based measures for the FY 2019 payment determination and subsequent years (three clinical episode-based payment measures and one communication and coordination-of-care measure). CMS is also finalizing the removal of 15 measures for the FY 2019 payment determination and subsequent years. Of these 15 measures, 13 are electronic clinical quality measures (eCQMs), two of which CMS is also removing in their chart-abstracted form, and two others are structural measures. CMS is also finalizing the refinement of two previously adopted measures beginning with the FY 2018 payment determination.

In addition, CMS is finalizing a number of changes in relation to eCQMs:

1. Requiring hospitals to report four quarters of data on an annual basis for eight of the available eCQMs included in the Hospital IQR Program measure set for the FY 2019 and FY 2020 payment determinations in order to align with the Medicare and Medicaid EHR Incentive Programs. This is a modification from the proposal, which proposed to require hospitals to submit on all available eCQMs (15 eCQMs) in the Hospital IQR Program;
2. Requiring several related technical eCQM submission requirements beginning with the FY 2019 payment determination; and
3. Expanding the current validation process to include the validation of eCQM data beginning in the spring of CY 2018 for the FY 2020 payment determination.

Lastly, CMS is finalizing an update to its Extraordinary Circumstances Extensions/Exemptions (ECE) policy by:

1. Extending the ECE request deadline for non-eCQM circumstances from 30 to 90 calendar days following an extraordinary circumstance; and
2. Establishing a separate submission deadline of April 1 following the end of the reporting calendar year for ECEs related to eCQMs.

***Hospital Value-Based Purchasing (VBP) Program* (page 910)**

Established by the ACA, the Hospital VBP Program adjusts payments to hospitals for inpatient services based on their performance on an announced set of measures. CMS is finalizing updates to the Hospital VBP Program requirements and the expansion of the Hospital VBP Program measure set. Specifically, the rule finalizes expanding the number of hospital units to which two National Healthcare Safety Network measures apply beginning with the FY 2019 program year. In addition, CMS is finalizing expansion of the cohort used to calculate the 30-day pneumonia mortality measure beginning with the FY 2021 program year. CMS is also finalizing the addition of two condition-specific payment measures (one for acute myocardial infarction and one for heart failure) beginning with the FY 2021 program year and a 30-day mortality measure following CABG surgery beginning with the FY 2022 program year. The rule also finalizes changes to the policy that governs whether a hospital will be excluded from the program if it is cited for deficiencies that pose immediate jeopardy to the health and safety of patients.

***Inpatient Psychiatric Facility Quality Reporting Quality Reporting (IPFQR) Program* (page 1975)**

The IPFQR Program was established by the ACA. CMS is finalizing a technical update to the previously finalized measure, Screening for Metabolic Disorder. CMS is also finalizing the addition of two new measures to the program beginning with the FY 2019 payment determination: (1) Thirty-day All-Cause Readmission Following Psychiatric Hospitalization in an IPF, which is a measure calculated from administrative claims data; and (2) SUB-3: Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and the subset measure SUB-3a: Alcohol & Other Drug Use Disorder Treatment at Discharge (NQF #1664). SUB-3/3a is a chart-abstracted measure that complements the previously adopted substance abuse measures in the IPFQR Program.

In addition, CMS is finalizing a policy to include the SUB-3/SUB-3a measure in the list of measures covered by the global sample for the FY 2019 payment determination and subsequent years. The agency is also finalizing that it will make the data for the IPFQR Program available as soon as possible and announce both the date of public display of the program's data and the 30-day preview period via sub regulatory methods. CMS is also finalizing that it will no longer specify how long before public display the preview period will be; this timeframe was previously finalized as 12 weeks. CMS is finalizing that, if it is technically feasible to display the data in December 2016, the Agency would provide data to IPFs for a two-week preview period that would start on October 1, 2016. Moreover, CMS is finalizing that, for the FY 2017 payment determination only, if CMS is able to display the data in December 2016, the Agency would ensure that IPFs have approximately 30 days for review by providing IPFs with their data as early as mid-September.

Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) Changes **(page 1267)**

CMS is updating the LTCH PPS standard Federal payment rate by 1.75 percent for FY 2017 for LTCHs that successfully participate in the LTCH Quality Reporting Program (LTCH QRP). This update is based on the most recent estimate of the revised and rebased LTCH PPS market basket (which is being adopted in this final rule) of 2.8 percent adjusted by -0.3 percentage point for multi-factor productivity and an additional adjustment of -0.75 percentage point in accordance with the ACA. CMS is also continuing to implement the changes required by ***The Pathway for SGR Reform Act of 2013*** that establish two different types of LTCH PPS payment rates depending on whether the patient meets certain clinical criteria. As a result of the continued phase-in of these changes, CMS projects that LTCH PPS payments will decrease by 7.1 percent, or approximately $363 million in FY 2017. Cases that qualify for the higher standard LTCH PPS payment rate under the revised system will see an increase in payments of 0.7 percent in FY 2017. In addition, CMS is streamlining its regulations regarding the 25 percent threshold policy, which is a payment adjustment made when the number of cases an LTCH admits from a single hospital exceeds a specified threshold (generally 25 percent).

Along with the FY 2017 IPPS/LTCH PPS final rule, CMS finalized an IFC to implement section 231 of the ***Consolidated Appropriations Act*** that established a temporary exception from the site neutral payment rate for certain severe wound care discharges from certain LTCHs.

Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) **(page 1799)**

Beginning in FY 2014, the applicable annual update for any LTCH that did not submit the required data to CMS is reduced by two percentage points. The IMPACT Act requires the continued specification of quality measures for the LTCH QRP, as well as resource use and other measures.

In order to satisfy the requirements of the IMPACT Act, CMS is finalizing one new assessment-based quality measure, and three claims-based measures for inclusion in the LTCH QRP:

1. Discharge to Community – Post-Acute Care (PAC) LTCH QRP (claims-based);
2. Medicare Spending Per Beneficiary (MSPB) – PAC LTCH QRP (claims-based);
3. Potentially Preventable 30 Day Post-Discharge Readmission Measure for LTCHs (claims-based); and
4. Drug Regimen Review Conducted with Follow-Up for Identified Issues (assessment-based).

CMS is finalizing the addition of four new measures to LTCH QRP public reporting for fall 2017. CMS is clarifying the previously finalized procedures for provider review and correction of performance data in advance of LTCH QRP public reporting, in order to ensure the agency is aligned with the Hospital IQR Program's policies and practices.

Comment

To assist those with a particular subject interest page numbers corresponding to the material in the **display copy** are provided. Note, these numbers will change upon the rule's publication in the ***Federal Register***. It is highly recommended that you download the display version before it is removed on August 22nd. Also, there are instances in which a particular item can be discussed in more than one area. Not all such area page listings are identified.

For many payment issues, the rule's Addendum **(beginning on page 2130)** contains much concise and helpful information.

The material that follows is a section-by-section analysis of major components based on the final rule. The material does not follow the order in the regulation.

I. STANDARDIZED PAYMENT RATES (pages 2130)

For FY 2016, CMS made two corrections to the standardized payment amounts. One occurred in the October 5th ***Federal Register*** effective as of October 1, 2015. The other occurred via Change Request/Transmittal R3449CP in February 2016 retroactive to payments on and after January 1, 2016.

The following are the current FY 2016 standardized payment amounts as shown in CR/Transmittal R3449CP.The total labor/nonlabor amount for the full update (2 left columns) is **$5,467.53**.

Hospital Submitted Quality Data and is a Meaningful EHR User		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User		Hospital Submitted Quality Data and is NOT a Meaningful EHR User		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User	
Wage Index Greater Than 1.0000							
Labor	**Nonlabor**	**Labor**	**Nonlabor**	**Labor**	**Nonlabor**	**Labor**	**Nonlabor**
$3,805.40	$1,662.13	$3,782.95	$1,652.32	$3,760.50	$1,642.52	$3,738.05	$1,632.71
Wage Index Equal to or Lower Than 1.0000							
Labor	**Nonlabor**	**Labor**	**Nonlabor**	**Labor**	**Nonlabor**	**Labor**	**Nonlabor**
$3,389.87	$2,077.66	$3,369.87	$2,065.40	$3,349.87	$2,053.15	$3,329.87	$2,040.89

The FY 2017 standardized amounts for operating and capital costs appear in Tables 1A, 1B, and 1C that are listed and published in section VI of the Addendum to this rule.

There are four possible applicable percentage increases that can be applied to the national standardized amount. The table below reflects these four options:

FY 2017	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
Market Basket Rate-of-Increase	2.7	2.7	2.7	2.7
Adjustment for Failure to Submit Quality Data under Section 1886(b)(3)(B)(viii) of the Act	0.0	0.0	-0.675	-0.675
Adjustment for Failure to be a Meaningful EHR User under Section 1886(b)(3)(B)(ix) of the Act	0.0	-2.025	0.0	-2.025
MFP Adjustment under Section 1886(b)(3)(B)(xi) of the Act	-0.3	-0.3	-0.3	-0.3
Statutory Adjustment under Section 1886(b)(3)(B)(xii) of the Act	-0.75	-0.75	-0.75	-0.75
Applicable Percentage Increase Applied to Standardized Amount	**1.65**	**-0.375**	**0.975**	**-1.05**

The **labor-related** portion for areas with wage indexes greater than 1.0000 will remain at **69.6 percent.** Areas with wage index values equal to or less than 1.000 will also remain at **62.0** percent.

The following table **(pages 2191-2193)** illustrates the changes from the FY 2016 national standardized amount. The unadjusted FY 2017 total rates are $6,313.35 for all columns. Multiplying this amount by the adjustments in red in the left column (items 1 through 5 and dividing the result by item 6) yields $5,467.53, the FY 2016 payment rates.

	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
FY 2016 Base Rate after removing	If Wage Index is Greater Than 1.0000:	If Wage Index is Greater Than 1.0000:	If Wage Index is Greater Than 1.0000:	If Wage Index is Greater Than 1.0000:
1. FY 2016 Geographic Reclassification Budget Neutrality **(0.988169)**	Labor (69.6%): $4,394.09	Labor (69.6%): $4,394.09	Labor (69.6%): $4,394.09	Labor (69.6%): $4,394.09
2. FY 2016 Rural Community Hospital Demonstration Program Budget Neutrality **(0.999837)**	Nonlabor (30.4%): $1,919.26	Nonlabor (30.4%): $1,919.26	Nonlabor (30.4%): $1,919.26	Nonlabor (30.4%): $1,919.26
3. Cumulative FY 2008, FY 2009, FY 2012, FY 2013, FY 2014, FY 2015 and FY 2016 Documentation and Coding Adjustment as Required under Sections 7(b)(1)(A) and 7(b)(1)(B) of Pub. L. 110-90 and Documentation and Coding Recoupment Adjustment as required under Section 631 of the American Taxpayer Relief Act of 2012 **(09255)**	*(Combined labor and nonlabor = $6,313.35)*	*(Combined labor and nonlabor = $6,313.35)*	*(Combined labor and nonlabor = $6,313.35)*	*(Combined labor and nonlabor = $6,313.35)*
4. FY 2016 Operating Outlier Offset **(0.948998)**	If Wage Index is less Than or Equal to 1.0000:	If Wage Index is less Than or Equal to 1.0000:	If Wage Index is less Than or Equal to 1.0000:	If Wage Index is less Than or Equal to 1.0000:
5. FY 2016 New Labor Market Delineation Wage Index Transition Budget Neutrality Factor **(0.999998)**	Labor (62%): $3,914.28	Labor (62%): $3,914.28	Labor (62%): $3,914.28	Labor (62%): $3,914.28
	Nonlabor (38%): $2,399.07	Nonlabor (38%): $2,399.07	Nonlabor (38%): $2,399.07	Nonlabor (38%): $2,399.07
	(Combined labor and nonlabor = $6,313.35)	*(Combined labor and nonlabor = $6,313.35)*	*(Combined labor and nonlabor = $6,313.35)*	*(Combined labor and nonlabor = $6,313.35)*
6. FY2017 Proposed 2-Midnight Rule Permanent Adjustment **(1/0.998)**				
FY 2017 Update Factor (refer table above)	1.0165	0.99625	1.00975	0.9895
FY 2017 MS-DRG Recalibration Budget Neutrality Factor	0.999079	0.999079	0.999079	0.999079
FY 2017 Wage Index Budget Neutrality Factor	1.000209	1.000209	1.000209	1.000209
FY 2017 Reclassification Budget Neutrality Factor	0.988224	0.988224	0.988224	0.988224
FY 2017 Operating Outlier Factor	0.948999	0.948999	0.948999	0.948999
Cumulative Factor: FY 2008, FY 2009, FY 2012, FY 2013, FY 2014, FY 2015, FY 2016 and FY 2017 Documentation and Coding Adjustment as Required under Sections 7(b)(1)(A) and 7(b)(1)(B) of Pub. L. 110-90 and Documentation and Coding Recoupment Adjustment as required under Section 631 of the ***American Taxpayer Relief Act of 2012***	0.9118	0.9118	0.9118	0.9118

	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
FY 2017 New Labor Market Delineation Wage Index Three Year Hold Harmless Transition Budget Neutrality Factor	0.999994	0.999994	0.999994	0.999994
FY 2017 2-Midnight Rule One-Time Prospective Increase	1.006	1.006	1.006	1.006
National Standardized Amount for FY 2017 if Wage Index is Greater Than 1.0000; Labor/Non-Labor Share Percentage (69.6/30.4)	**Labor: $3,839.57 Nonlabor: $1,677.06**	**Labor: $3,763.08 Nonlabor: $1,643.65**	**Labor: $3,814.07 Nonlabor: $1,665.92**	**Labor: $3,737.58 Nonlabor: $1,632.51**
National Standardized Amount for FY 2017 if Wage Index is less Than or Equal to 1.0000; Labor/Non-Labor Share Percentage (62/38)	**Labor: $3,420.31 Nonlabor: $2,096.32**	**Labor: $3,352.17 Nonlabor: $2,054.56**	**Labor: $3,397.59 Nonlabor: $2,082.40**	**Labor: $3,329.46 Nonlabor: $2,040.63**

The FY 2017 rates above are the same as those cited in the rule's Section IV tables. Also, as reflected above are CMS' adjustments for budget neutrality factors. **(most are addressed in the Addendum section)**

The combined FY 2017 labor and nonlabor amounts for a full update is $5,516.63. The current amount is $5,467.53 for a net increase of $49.10.

These amounts are before other adjustments such as the hospital value-based purchasing program, readmission program, and hospital acquired conditions program.

Changes to Payment Rates for Acute Care Hospital Inpatient Capital-Related Costs for FY 2016 (pages 1246 and 2203)

The FY 2017 capital rate will be at **$446.81**. The current amount is $438.75.

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

	FY 2016	FY 2017	Change	Percent Change
Update Factor[1]	1.0130	1.009	1.009	0.90
GAF/DRG Adjustment Factor[1]	0.9976	0.9991	0.9991	-0.09
Outlier Adjustment Factor[2]	0.9365	0.9386	1.0022	0.22
Permanent 2-midnight Policy Adjustment Factor	N/A	1.002	1.002	0.20
One-Time 2-midnight Policy Adjustment Factor	N/A	1.006	1.006	0.60
Capital Federal Rate	$438.75	**$446.81**	1.0184	1.84

1 The update factor and the GAF/DRG budget neutrality adjustment factors are built permanently into the capital Federal rates. Thus, for example, the incremental change from FY 2016 to FY 2017 resulting from the application of the 0.9991 GAF/DRG budget neutrality adjustment factor for FY 2017 is a net change of 0.9991 (or -0.09 percent).
2 The outlier reduction factor is not built permanently into the capital Federal rate; that is, the factor is not applied cumulatively in determining the capital Federal rate. Thus, for example, the net change resulting from the application of the FY 2017 outlier adjustment factor is 0.9386/0.9365, or 1.0022 (or 0.22 percent).

Outlier Payments (page 2165)

CMS is establishing an outlier fixed-loss cost threshold for FY 2017 equal to the prospective payment rate for the MS-DRG, plus any IME, empirically justified Medicare DSH payments, estimated uncompensated care payment, and any add-on payments for new technology, plus **$23,570**.

The current amount is $22,538.

CMS' current estimate, using available FY 2015 claims data, is that actual outlier payments for FY 2015 were approximately 4.68 percent of actual total MS-DRG payments. Therefore, the data indicate that, for FY 2015, the percentage of actual outlier payments relative to actual total payments is lower than projected for FY 2015.

CMS notes that because the MedPAR claims data for the entire FY 2016 will not be available until after September 30, 2016, CMS is unable to provide an estimate of actual outlier payments for FY 2016 based on FY 2016 claims data in this final rule. CMS says it will provide an estimate of actual FY 2016 outlier payments in the FY 2018 IPPS/LTCH PPS proposed rule.

Comment

Again, CMS does not make any corrections to this highly visible factor and consistently under estimated adjustment factor. CMS tries to explain its rationale for not making corrections to its poor estimating process, but it appears weak and inexcusable. Also, if CMS does not have data to estimate current year outlier payments, why is it increasing the threshold by over $100?

Sole Community and Medicare Dependent *Hospitals* (page 742)

The prospective payment rate for SCHs for FY 2017 equals the higher of the applicable Federal rate, or the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; the updated hospital-specific rate based on FY 1996 costs per discharge; or the updated hospital-specific rate based on FY 2006 costs per discharge.

The prospective payment rate for MDHs for FY 2017 equals the higher of the Federal rate, or the Federal rate plus 75 percent of the difference between the Federal rate and the hospital-specific rate. For MDHs, the updated hospital-specific rate is based on FY 1982, FY 1987 or FY 2002 costs per discharge, whichever yields the greatest aggregate payment.

Changes to Payment Rates for Excluded Hospitals: Rate-of-Increase Percentages for FY 2017 (page 1257)

Payments for services furnished in children's hospitals, 11 cancer hospitals, and hospitals located outside the 50 States, the District of Columbia and Puerto Rico (that is, short-term acute care hospitals located in the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa) that are excluded from the IPPS are made on the basis of reasonable costs based on the hospital's own historical cost experience, subject to a rate-of-increase ceiling.

The rate of increase update will be **2.7 percent.**

II. CHANGES TO THE HOSPITAL WAGE INDEX FOR ACUTE CARE HOSPITALS (page 628)

Core-Based Statistical Areas (CBSAs) **(page 629)**

The current statistical areas (which were implemented beginning with FY 2015) are based on revised OMB delineations issued on February 28, 2013, in OMB Bulletin No. 13-01.

CMS notes that OMB has issued a revised bulletin – OMB Bulletin 15-01 that makes the following adjustments to CBSAs:

- Garfield County, OK, with principal city Enid, OK, which was a Micropolitan (geographically rural) area, now qualifies as an urban new CBSA 21420 called Enid, OK.
- The county of Bedford City, VA, a component of the Lynchburg, VA CBSA 31340, changed to town status and is added to Bedford County. Therefore, the county of Bedford City (SSA State county code 49088, FIPS State County Code 51515) is now part of the county of Bedford, VA (SSA State county code 49090, FIPS State County Code 51019). However, the CBSA remains Lynchburg, VA, 31340.
- The name of Macon, GA, CBSA 31420, as well as a principal city of the Macon-Warner Robins, GA combined statistical area, is now Macon-Bibb County, GA. The CBSA code remains as 31420.

Occupational Mix Adjustment to the FY 2017 Wage Index **(page 642)**

For the FY 2017 wage index, CMS used the occupational mix data collected using the 2013 survey.

Using the occupational mix survey data and applying the occupational mix adjustment to 100 percent of the FY 2017 wage index results in a national average hourly wage of **$41.1615.**

The FY 2017 national average hourly wages for each occupational mix nursing subcategory are as follows:

Occupational Mix Nursing Subcategory	Average Hourly Wage
National RN	$38.83416971
National LPN and Surgical Technician	$22.73766832
National Nurse Aide, Orderly, and Attendant	$15.95353295
National Medical Assistant	$18.04809696
National Nurse Category	$32.8589243

Transitional Wage Indexes **(page 650)**

FY 2017, will be the third and final year of two 3-year transition periods for wage index for (1) hospitals that, for FY 2014, were located in an urban county that became rural under the revised OMB delineations, and had no form of wage index reclassification or redesignation in place for FY 2015 (that is, MGCRB reclassifications under section 1886(d)(10) of the Act, redesignations under section 1886(d)(8)(B) of the Act, or rural reclassifications under section 1886(d)(8)(E) of the Act); and (2) for hospitals deemed urban under section 1886(d)(8)(B) of the Act where the urban area became rural under the new OMB delineations.

Beginning in FY 2018, these formerly urban hospitals will receive their statewide rural wage index, absent any reclassification or redesignation.

Rural Floor Section **(page 657 and 2321)**

The area wage index applicable to any hospital that is located in an urban area of a State may not be less than the area wage index applicable to hospitals located in rural areas in that State. CMS estimates that 397 hospitals will receive an increase in their FY 2017 wage index due to the application of the rural floor.

The Medicare statute also requires a budget neutrality adjustment be made on a Federal and not a state basis to account for urban area increases to statewide rural amounts. There has been and still is much controversy over the Federal versus state adjustment.

CMS notes that "many commenters expressed concern about the decline in the proposed Massachusetts rural wage index, due partially to preliminary audit adjustments made by the MAC to Nantucket Cottage Hospital's FY 2017 wage data, and certain errors identified by Nantucket Cottage Hospital in the FY 2017 wage data it submitted." Further, CMS says that the corrections requested by Nantucket Cottage Hospital fall outside the applicable deadline set forth in the FY 2017 Wage Index Development Timetable finalized in the FY 2015 IPPS/LTCH PPS final rule." Therefore, CMS is not incorporating the adjustments requested by Nantucket Cottage Hospital for the FY 2017 final rule wage index.

Imputed Floor for FY 2016 **(page 663)**

Currently, there are three all-urban States: Delaware, New Jersey, and Rhode Island.

New Jersey, Rhode Island and Delaware hospitals will be able to receive an imputed floor through September 30, 2017. In New Jersey, 18 out of 64 hospitals will receive the imputed floor for FY 2017, 10 out of 11 hospitals in Rhode Island and 2 out of 6 hospitals in Delaware.

State Frontier Floor **(page 669)**

Fifty hospitals, as proposed, will continue to receive the frontier floor value of 1.0000 for their FY 2017 wage index. These hospitals are located in Montana, North Dakota, South Dakota, and Wyoming.

FY 2017 Reclassification Requirements and Approvals **(page 670)**

In compliance with recent litigation (Geisinger Community Medical Center v. Burwell and others), CMS will, effective for reclassification applications due to the MGCRB by September 1, 2016, for reclassification first effective for FY 2018, permit a hospital to apply for a reclassification under the MGCRB while still being redesignated from urban to rural under § 412.103. Such hospitals are eligible to use distance and average hourly wage criteria designated for rural hospitals at § 412.230(b)(1) and (d)(1).

CMS is clarifying that a hospital redesignated as rural under § 412.103 can use that rural status to reclassify via the MGCRB to another rural or urban area, provided it meets the distance and average hourly wage criteria under § 412.230(b)(1), (d)(1)(iii)(C), and (d)(1)(iv)(E).

There are 265 hospitals approved for wage index reclassifications by the MGCRB starting in FY 2017. Because MGCRB wage index reclassifications are effective for 3 years, hospitals reclassified beginning in FY 2015 or FY 2016 are eligible to continue to be reclassified to a particular labor market area based on such prior reclassifications for the remainder of their 3-year period. There were 294 hospitals approved for wage index reclassifications in FY 2015 that continue for FY 2017, and 258 hospitals approved for wage index reclassifications in FY 2016 that continue for FY 2017. Of all the hospitals approved for reclassification for FY 2015, FY 2016, and FY 2017, based upon the review at the time of this rule, 817 hospitals are in a reclassification status for FY 2017.

Applications for FY 2018 reclassifications are due to the MGCRB by September 1, 2016 (the first working day of September 2016). Applications and other information about MGCRB reclassifications may be obtained via the Internet on the CMS Web site at: http://www.cms.gov/Regulations-and-Guidance/Review-Boards/MGCRB/index.html, or by calling the MGCRB at (410) 786-1174. The mailing address of the MGCRB is: 2520 Lord Baltimore Drive, Suite L, Baltimore, MD 21244.

Lugar Counties **(page 698)**

Section 1886(d)(8)(B)(i) of the Act requires the Secretary to treat a hospital located in a rural county adjacent to one or more urban areas as being located in the urban metropolitan statistical area to which the greatest number of workers in the county commute if certain adjacency and commuting criteria are met.

Hospitals located in these counties are referred to as "Lugar" hospitals and the counties themselves are often referred to as "Lugar" counties. The chart with the listing of the rural counties containing the hospitals designated as urban under section 1886(d)(8)(B) of the Act is available on the CMS Web site.

Out-Migration Adjustment Based on Commuting Patterns of Hospital Employees **(page 702)**

Table 2 associated with this proposed rule (on the CMS Web site) lists the out-migration adjustments for the FY 2017 wage index.

Notification Regarding CMS "Lock-In" Date for Urban to Rural Reclassifications under § 412.103 **(page 704)**

CMS is finalizing, without modification, its proposal that, in order for a hospital that applies for reclassification under § 412.103 to be treated as rural in the wage index and budget neutrality calculations under §§ 412.64(e)(1)(ii), (e)(2), (e)(4), and (h) for payment rates for the next Federal fiscal year, the hospital's filing date must be no later than 70 days prior to the second Monday in June of the current Federal fiscal year and the application must be approved by the CMS Regional Office in accordance with the requirements of § 412.103.

Public Comments on Treatment of Overhead and Home Office Costs in the Wage Index Calculation as a Result of Our Solicitation **(page 721)**

In this section, CMS responds to it solicitation comments regarding the allocation of certain overhead salaries.

Comment

Here is another example of "overkill" narrative. CMS spends some dozen pages responding to solicited comments to say, "Because we did not make specific proposals in the proposed rule regarding treatment of overhead and home office costs in the wage index calculation, that is, we only solicited comments to gain a better understanding of hospitals' reporting practices, we are not making any changes at this time. However, we will take the comments into consideration for future cost reporting changes and/or rulemaking as appropriate."

Guess this material could have been said in a single paragraph and not spread over 12 pages.

III. CHANGES TO MEDICARE SEVERITY DIAGNOSIS-RELATED GROUP (MS-DRG) CLASSIFICATIONS AND RELATIVE WEIGHTS (pages beginning on 101)

***FY 2017 MS-DRG Documentation and Coding Adjustment* (page 102)**

Comment

This subject matter is discussed in other sections of this document as well as in several of sections of the rule.

***Positive Documentation and coding adjustment* (page 122)**

With the end of payment reductions for documentation and coding beginning in FY 2018, CMS says it planned on making a full positive adjustment to return IPPS rates to their appropriate payment amounts.

CMS notes that section 414 of MACRA replaced the single positive adjustment the agency intended to make in 2018 with a 0.5 percent positive adjustment for each of FYs 2018 through 2023. The provision under section 414 of the MACRA does not impact the FY 2017 adjustment.

Comment

CMS is required by statute to reinstate the IPPS rates to the amounts that would be have been made had no reduction offsets been made. In other words, if CMS was paying hospitals $1,100 but reduced payment to recapture previous over payments to say $1,000 by $100, CMS needs to reset the amounts back to $1,100. It cannot go forward using the $1,000 rate.

As noted above, MACRA is going to limit the return to "proper/normal" amounts. In fact, MACRA appears to never allow the full recapture. CMS has withheld 0.8 percent for 3 years (2.4 in aggregate) plus 1.5 percent this year (2.4 + 1.5 =3.9). Yet, MACRA will only permit 3.0 percent (6 X 0.5) to be returned.

Changes to the MS-DRGs for FY 2017

The following items are MS-DRG changes for FY 2017.

***Total Artificial Heart Replacement* (page 147)**

CMS, as proposed, will assign ICD-10-PCS procedure codes 02RK0JZ and 02RL0JZ as a code cluster to ICD-10 Version 34 MS-DRGs 001 and 002 (Heart Transplant or Implant of Heart Assist System with and without MCC, respectively) to accurately replicate the Version 32 ICD-9-CM based MS-DRG logic of procedure code 37.52.

***Endovascular Embolization (Coiling) or Occlusion of Head and Neck Procedures* (page 149)**

In the proposed IPPS rule, CMS spent 14 pages on a commenter's request for this item with a no change result. The commenter requested again, to have CMS investigate this item. CMS has spent another 14 pages explaining that no actions are being taken once again.

One must applaud CMS for its in-depth analysis of the material, but if no action is being taken, would it not be more effective to simply state the action without all the reasons for not adopting any proposals.

Comment

Items discussed by CMS without any actions are not addressed in this analysis.

Mechanical Complication Codes **(page 163)**

CMS will reassign ICD-10-CM diagnosis codes T85.610A, T85.620A, T85.630A, and T85.690A from MDC 21 under MS-DRGs 919, 920, and 921 to MDC 1 under MS-DRGs 091, 092, and 093.

In addition, CMS will reassign 18 other codes from MDC 21 to MDC 1. They are shown on page 166 of the rule.

Reassignment of Diagnosis Code R22.2 (Localized Swelling, Mass and Lump, Trunk) **(page 168)**

CMS will reassign ICD-10-CM diagnosis code R22.2 from MDC 4 to MDC 9 under MS-DRGs 606 and 607 (Minor Skin Disorders with and without MCC, respectively).

Implant of Loop Recorder **(page 177)**

CMS will designate the following four ICD-10-PCS codes as O.R. procedures within Appendix E of the Version 34 ICD-10 MS-DRG Definitions Manual:

- 0JH602Z (Insertion of monitoring device into chest subcutaneous tissue and fascia, open approach);
- 0JH632Z (Insertion of monitoring device into chest subcutaneous tissue and fascia, percutaneous approach);
- 0JWT02Z (Revision of monitoring device in trunk subcutaneous tissue and fascia, open approach); and
- 0JWT32Z (Revision of monitoring device in trunk subcutaneous tissue and fascia, percutaneous approach).

The ICD-10 MS-DRG assignment for these four ICD-10-PCS codes replicate the ICD-9-CM based MS-DRG assignment for procedure code 37.79; that is, MS-DRGs 040, 041, 042, 260, 261, 262, 579,580, 581, 907, 908, 909, 957, 958, and 959.

Endovascular Thrombectomy of the Lower Limbs **(page 185)**

For implementation October 1, 2016, CMS proposed to restructure the ICD-10-PCS MS-DRG configuration and add the ICD-10-PCS code translations listed in the proposed rule's chart on page 272 (which would capture procedures describing endovascular thrombectomy of the lower limbs) to ICD-10-PCS Version 34 MS-DRGs 270, 271, and 272.

CMS is finalizing its proposal with modifications. CMS is finalizing the assignment of the ICD-10-PCS procedure codes describing endovascular thrombectomy of the lower limbs listed in the final rule's table on page 191.

Pacemaker Procedures Code Combinations **(page 191)**

CMS is finalizing its proposal to modify the MS-DRG logic for MS-DRGs 242, 243, and 244 to establish that cases reporting one ICD-10-PCS code from the list of procedure codes describing procedures involving pacemaker devices and one ICD-10-PCS code from the list of procedure codes describing procedures involving pacemaker leads in combination with one another will qualify the case for assignment to MS-DRGs 242, 243, and 244.

CMS is also finalizing its proposal to modify the MS-DRG logic for MS-DRGs 258 and 259 (Cardiac Pacemaker Device Replacement with and without MCC, respectively) to establish that a case reporting one ICD-10-PCS procedure code describing procedures involving pacemaker device insertions without any other procedure codes describing procedures involving pacemaker leads reported is assigned to MS-

DRGs 258 and 259 for FY 2017. Refer to the table on page 200 (which was included in the proposed rule) that lists the ICD-10-PCS procedure codes describing procedures involving pacemaker device insertions without any other procedure codes describing procedures involving pacemaker leads reported that are assigned to MS-DRGs 258 and 259 for FY 2017.

Transcatheter Mitral Valve Repair with Implant **(page 208)**

CMS will collapse MS-DRGs 228, 229, and 230 from three severity levels to two severity levels by deleting MS-DRG 230 and revising MS-DRG 229. CMS will also reassign ICD-9-CM procedure code 35.97 and the cases reporting ICD-10-PCS procedure code 02UG3JZ (Supplement mitral valve with synthetic substitute, percutaneous approach) from MS-DRGs 273 and 274 to MS-DRG 228 and revised MS-DRG 229. The title of the revised MS-DRG 229 will be "Other Cardiothoracic Procedures without MCC". The title for MS-DRG 228 will remain the same: MS-DRG 228 (Other Cardiothoracic Procedures with MCC).

CMS is also removing ICD-10-PCS procedure code 02UG3JZ and ICD-9-CM procedure code 35.97 from the PTCA list in MS-DRGs 231 and 232 (Coronary Bypass with PTCA with MCC and without MCC, respectively) for FY 2017.

MDC 6 (Diseases and Disorders of the Digestive System): Excision of Ileum **(page 191)**

CMS is reassigning ICD-10-PCS procedure codes 0DBB0ZZ (Excision of ileum, open approach) and 0DBA0ZZ (Excision of jejunum, open approach) from MS-DRGs 347, 348, and 349 (Anal and Stomal Procedures with MCC, with CC, and without CC/MCC, respectively) to MS-DRGs 329, 330, and 331 (Major Small and Large Bowel Procedures with MCC, with CC, and without CC/MCC, respectively) effective with the ICD-10 MS-DRGs Version 34.

MDC 7 (Diseases and Disorders of the Hepatobiliary System and Pancreas): Bypass Procedures of the Veins **(page 225)**

CMS will assign ICD-10-PCS code 06183DY (Bypass portal vein to lower vein with intraluminal device, percutaneous approach) to MDC 7 (Diseases and Disorders of the Hepatobiliary System and Pancreas) under MS-DRGs 405, 406, and 407 (Pancreas Liver and Shunt Procedures with MCC, with CC, and without CC/MCC, respectively).

Combination Codes for Removal and Replacement of Knee Joints **(page 250)**

CMS will add 58 new code combinations that capture the joint revisions to the Version 34 MS DRG structure for MS-DRGs 466, 467, and 468, effective October 1, 2016. The list of codes begins on page 252.

Decompression Laminectomy **(page 259)**

CMS proposed to reassign the selected ICD-10-PCS procedure codes from MS-DRGs 515 through 517 to MS-DRGs 028 through 030 and MS-DRGs 518 through 520 under the ICD-10 MS-DRGs Version 34. CMS is *not* making any of its proposed changes.

Lordosis **(page 264)**

CMS will remove the following four diagnosis codes from the secondary diagnosis list.

- M40.50 (Lordosis, unspecified, site unspecified);
- M40.55 (Lordosis, unspecified, thoracolumbar region);
- M40.56 (Lordosis, unspecified, lumbar region); and
- M40.57 (Lordosis, unspecified, lumbosacral region).

MDC 13 (Diseases and Disorders of the Female Reproductive System): Pelvic Evisceration **(page 265)**

CMS will remove the procedure code cluster for pelvic evisceration procedures from MDC 6 under the ICD-10 MS-DRGs Version 34. The cluster would remain in ICD-10 MDC 13 under MS-DRGs 734 and 735 only.

MDC 19 (Mental Diseases and Disorders): Proposed Modification of Title of MS-DRG 884 (Organic Disturbances and Mental Retardation) **(page 269)**

CMS will change the title of MS-DRG 884 from "Organic Disturbances and Mental Retardation" to "Organic Disturbances and Intellectual Disability."

Medicare Code Editor **(page 286)**

The Medicare Code Editor (MCE) is a software program that detects and reports errors in the coding of Medicare claims data, Patient diagnoses, procedure(s), and demographic information entered into the Medicare claims processing systems and are subjected to a series of automated screens. The MCE screens are designed to identify cases that require further review before classification into an MS-DRG.

Comment

This is not an insignificant topic. CMS spends nearly 50 pages addressing edits and issues.

Changes to the MS-DRG Diagnosis Codes for FY 2017 **(page 338)**

CMS (page 347) is making available on the CMS Web site at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html the following final tables:

- Table 6A.--New Diagnosis Codes–FY 2017;
- Table 6B.--New Procedure Codes–FY 2017;
- Table 6C.--Invalid Diagnosis Codes–FY 2017;
- Table 6D.--Invalid Procedure Codes–FY 2017;
- Table 6E.--Revised Diagnosis Code Titles–FY 2017;
- Table 6F.--Revised Procedure Code Titles–FY 2017;
- Table 6G.1.--Secondary Diagnosis Order Additions to the CC Exclusions List--FY 2017;
- Table 6G.2.--Principal Diagnosis Order Additions to the CC Exclusions List--FY 2017;
- Table 6H.1.--Secondary Diagnosis Order Deletions to the CC Exclusions List--FY 2017;
- Table 6H.2.--Principal Diagnosis Order Deletions to the CC Exclusions List--FY 2017;
- Table 6I.--Complete MCC List--FY 2017;
- Table 6I.1.--Additions to the MCC List–FY 2017;
- Table 6I.2.–Deletions to the MCC List--FY 2017;
- Table 6J.--Complete CC List--FY 2017;
- Table 6J.1.--Additions to the CC List–FY 2017;
- Table 6J.2.--Deletions to the CC List –FY 2017;
- Table 6K.--Complete List of CC Exclusions–FY 2017;
- Table 6L.--Principal Diagnosis Is Its Own MCC List–FY 2017;
- Table 6M.--Principal Diagnosis Is Its Own CC List–FY 2017; and
- Table 6M.1.--Additions to the Principal Diagnosis Is Its Own CC List—FY 2017

Replaced Devices Offered without Cost or with a Credit **(page 392)**

For FY 2017 CMS did not propose to add any MS-DRGs to the policy for replaced devices offered without cost or with a credit.

Add-On Payments for New Services and Technologies for FY 2017 **(page 481)**

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

- Kcentra™ - Discontinued
- Argus® II Retinal Prosthesis System – Discontinued
- MitraClip® System – Discontinued
- Responsive Neurostimulator (RNS®) System – Discontinued

- Blinatumomab (BLINCYTO™Trade Brand) - continue new technology add-on payments for this technology. The maximum payment for a case involving BLINCYTO™ will remain at $27,017.85 for FY 2017.
- CardioMEMS™ HF (Heart Failure) Monitoring System - 2017), will be continued as new technology add-on for FY 2017. The maximum payment for a case involving the CardioMEMS™ HF Monitoring System will remain at $8,875 for FY 2017.
- Lutonix® Drug Coated Balloon PTA Catheter and In.PACT™ Admiral™ Paclitaxel Coated Percutaneous Transluminal Angioplasty (PTA) Balloon Catheter - continue new technology add-on payments for both the LUTONIX® and IN.PACT™ Admiral™ technologies for FY 2017. The maximum add-on payment for a case involving LUTONIX® and IN.PACT™ Admiral™ will remain at $1,035.72 for FY 2017.

The following items are being approved as new technology status for FY 2017 and beyond.

- MAGEC® Spinal Bracing and Distraction System (MAGEC® Spine). The maximum new technology add-on payment for a case involving the use of the MAGEC® Spinal Bracing Distraction system is $15,750 for FY 2017.

- Idarucizumab. The maximum new technology add-on payment for a case involving the use of Idarucizumab is $1,750 for FY 2017.

- Defitelio® (Defibrotide). The maximum new technology add-on payment amount for a case involving the use of Defitelio® is $75,900 for FY 2017.

- GORE® EXCLUDER® Iliac Branch Endoprosthesis (IBE). The maximum new technology add-on payment for a case involving the use of the GORE IBE device is $5,250 for FY 2017.

- Vistogard™ (Uridine Triacetate). the maximum new technology add-on payment amount for a case involving the use of Vistogard™ is $37,500 for FY 2017.

Comment

In the past, we have observed the length and discussion of new technologies. This year's material is nearly 150 pages. It would help if the discussion on these items were placed in a separate appendix. One must assume that most readers are only interested in actions being taken by the agency and not the ongoing discussions and rational positions between CMS and the manufacturers.

Better yet, maybe put new technology in its own rulemaking system.

IV. OTHER DECISIONS AND CHANGES TO THE IPPS FOR OPERATING COSTS AND GRADUATE MEDICAL EDUCATION (GME) COSTS (page 734)

Rural Referral Centers (RRCs) (page 744)

A rural hospital with less than 275 beds may be classified as an RRC if—

- The hospital's case-mix index (CMI) is at least equal to the lower of the median CMI for urban hospitals in its census region, excluding hospitals with approved teaching programs, or the median CMI for all urban hospitals nationally; and

- The hospital's number of discharges is at least 5,000 per year, or, if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located. (The number of discharges criterion for an osteopathic hospital is at least 3,000 discharges.)

In addition to meeting other criteria, if rural hospitals with fewer than 275 beds are to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2016, they must have a CMI value for FY 2015 that is at least—

- 1.6111; or
- The median CMI value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs as identified in § 413.75) calculated by CMS for the census region in which the hospital is located.

The CMI values by region are set forth in the following table:

Region		Case Mix Index Value
1	New England (CT, ME, MA, NH, RI, VT)	1.3633
2	Middle Atlantic (PA, NJ, NY)	1.4409
3	South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.5079
4	East North Central (IL, IN, MI, OH, WI)	1.5331
5	East South Central (AL, KY, MS, TN)	1.4472
6	West North Central (IA, KS, MN, MO, NE, ND, SD)	1.5946
7	West South Central (AR, LA, OK, TX)	1.64525
8	Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.6944
9	Pacific (AK, CA, HI, OR, WA)	1.6165

A hospital, if it is to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2016, must also have the number of discharges for its cost reporting period that began during FY 2015 a figure that is at least—

- 5,000 (3,000 for an osteopathic hospital); or

- The median number of discharges for urban hospitals in the census region in which the hospital is located.

All census proposed regional discharge numbers are greater than 5,000.

Payment Adjustment for Low-Volume Hospitals (§ 412.101) (page 755)

Table 14 listed at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html lists the "subsection (d)" hospitals with fewer than 1,600 Medicare discharges based on the claims data from the March 2016 update of the FY 2015 MedPAR file and their potential low-volume hospital payment adjustment for FY 2017.

***IME Adjustment Factor for FY 2016* (page 757)**

For discharges occurring during FY 2016, the formula multiplier is 1.35.

Payment Adjustment Methodology for Medicare Disproportionate Share Hospitals (DSHs) under Section 3133 of the Affordable Care Act (page 758)

The 3 factors to distribute DSH payments for FY 2017 are the same as the ones used for the current fiscal year.

Beginning with discharges in FY 2014, hospitals that qualify for Medicare DSH payments under section 1886(d)(5)(F) of the Act receive 25 percent of the amount they previously would have received under the statutory formula for Medicare DSH payments.

The remaining amount, equal to an estimate of 75 percent of what otherwise would have been paid as Medicare DSH payments, reduced to reflect changes in the percentage of individuals under age 65 who are uninsured, is available to make additional payments to each hospital that qualifies for Medicare DSH payments and that has uncompensated care.

Calculation of Factor 1 for FY 2017 (page 770)

Factor 1 is the difference between CMS' estimates of: (1) the amount that would have been paid in Medicare DSH payments for the fiscal year, in the absence of the new payment provision; and (2) the amount of empirically justified Medicare DSH payments that are made for the fiscal year, which takes into account the requirement to pay 25 percent of what would have otherwise been paid under section 1886(d)(5)(F) of the Act. In other words, this factor represents CMS' estimate of 75 percent (100 percent minus 25 percent) of its estimate of Medicare DSH payments that would otherwise be made, in the absence of section 1886(r) of the Act, for the fiscal year.

The June 2016 Office of the Actuary estimate for Medicare DSH payments for FY 2017, without regard to the application of section 1886(r)(1) of the Act, $14,396,635,710.16 billion.

Therefore, based on the June 2016 estimate, the estimate for empirically justified Medicare DSH payments for FY 2017, with the application of section 1886(r)(1) of the Act, is $3,599,158,927.54 billion (or 25 percent of the total amount of estimated Medicare DSH payments for FY 2017).

Therefore, Factor 1 for FY 2017 is **$10,797,476,782.62**, which is equal to 75 percent of the total amount of estimated Medicare DSH payments for FY 2017 ($14,396,635,710.16 minus $3,599,158,927.54).

Calculation of Factor 2 for FY 2015 (page 788)

Section 1886(r)(2)(B) of the Act establishes Factor 2 in the calculation of the uncompensated care payment. Specifically, section 1886(r)(2)(B)(i) of the Act provides that for each of FYs 2014, 2015, 2016, and 2017, a factor equal to 1 minus the percent change in the percent of individuals under the age of 65 who are uninsured, as determined by comparing the percent of such individuals who are uninsured in 2013, the last year before coverage expansion under the ***Affordable Care Act***.

The calculation of Factor 2 for FY 2017, employing a weighted average of the CBO projections for CY 2015 and CY 2016, is as follows:

- CY 2016 rate of insurance coverage (March 2016 CBO estimate): 90 percent.
- CY 2017 rate of insurance coverage (March 2016 CBO estimate): 90 percent.
- FY 2016 rate of insurance coverage: (90 percent * .25) + (90 percent * .75) = 90 percent.
- Percent of individuals without insurance for 2013 (March 2010 CBO estimate): 18 percent.
- Percent of individuals without insurance for FY 2017 (weighted average): 10 percent.

Using the statute's formula results in the following:

1-|((0.10-0.18)/0.18)| = 1- 0.4444 = 0.5555 (55.56 percent)
0.5556 (55.56 percent) - .002 (0.2 percentage points for FY 2017 under section 1886(r)(2)(B)(i) of the Act) = 0.5536 or 55.36 percent

Factor 2= 0.5536

The FY 2017 Final Uncompensated Care Amount is: $10,797,476,782.62 x 0.5536 = **$5,977,483,146.86.**

Calculation of Factor 3 for FY 2017 (page 798)

Factor 3 is equal to the percent, for each subsection (d) hospital, that represents the quotient of (1) the amount of uncompensated care for such hospital for a period selected by the Secretary (as estimated by the Secretary, based on appropriate data (including, in the case where the Secretary determines alternative data are available that are a better proxy for the costs of subsection (d) hospitals for treating the uninsured, the use of such alternative data)); and (2) the aggregate amount of uncompensated care for all subsection (d) hospitals that receive a payment under section 1886(r) of the Act for such period (as so estimated, based on such data).

Factor 3 is applied to the product of Factor 1 and Factor 2 to determine the amount of the uncompensated care payment that each eligible hospital will receive for FY 2017 and subsequent fiscal years; i.e., the pool amount of $5.977 billion.

S-10 (page 827)

CMS is *NOT* finalizing its proposal to begin to incorporate Worksheet S-10 data into the computation of Factor 3 for FY 2018, and CMS is *NOT* finalizing the proposed regulations text changes at § 412.106(g)(C)(4) through (7) regarding FY 2018 and subsequent fiscal years. In light of the significant concerns expressed by commenters, CMS is postponing the decision regarding when to begin incorporating data from Worksheet S-10 and proceeding with revisions to the cost report instructions to address the commenters' concerns in an appropriate manner.

***Hospital Readmissions Reduction Program:* (page 885)**

The Hospital Readmissions Reduction Program currently includes the following five applicable conditions: acute myocardial infarction (AMI), heart failure (HF), pneumonia (PN), total hip arthroplasty/total knee arthroplasty (THA/TKA), and chronic obstructive pulmonary disease (COPD), and Hospital-Level, 30-Day, All-Cause, Unplanned Readmission Following Coronary Artery Bypass Graft (CABG) Surgery.

CMS estimates that the Hospital Readmissions Reduction Program will save approximately $528 million in FY 2017, an increase of $108 million over the estimated FY 2016 savings.

ACA Section added a new section 1886(q) to the Act. Section 1886(q) of the Act establishes the "Hospital Readmissions Reduction Program," effective for discharges from an "applicable hospital" beginning on or after October 1, 2012, under which payments to those applicable hospitals may be reduced to account for certain excess readmissions.

For FY 2017, consistent with the definition specified at § 412.152, CMS says that the "applicable period" for the Hospital Readmissions Reduction Program will be the 3-year period from July 1, 2012 through June 30, 2015.

For FY 2017, a hospital subject to the Hospital Readmissions Reduction Program will have an adjustment factor that is between 1.0 (no reduction) and 0.9700 (greatest possible reduction)

Formulas to Calculate the Readmissions Adjustment Factor for FY 2017

Aggregate payments for excess readmissions = [sum of base operating DRG payments for AMI x (Excess Readmissions Ratio for AMI-1)] + [sum of base operating DRG payments for HF x (Excess Readmissions Ratio for HF-1)] + [sum of base operating DRG payments for PN x (Excess Readmissions Ratio for PN-1)] + [sum of base operating DRG payments for COPD) x (Excess Readmissions Ratio for COPD-1)] + [sum of base operating DRG payments for THA/TKA x (Excess Readmissions Ratio for THA/TKA-1)] + [sum of base operating DRG payments for CABG x (Excess Readmissions Ratio for CABG-1)].

*CMS notes that if a hospital's excess readmissions ratio for a condition is less than/equal to 1, there are no aggregate payments for excess readmissions for that condition included in this calculation.

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

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

Readmissions Adjustment Factor for FY 2017 is the higher of the ratio or 0.9700.
*Based on claims data from July 1, 2012 to June 30, 2015 for FY 2017.

***Hospital Value-Based Purchasing (VBP) Program:* (page 910)**

Section 1886(o) of the Act, as added by ACA section 3001(a)(1), requires the Secretary to establish a hospital value-based purchasing program (the Hospital VBP Program) under which value-based incentive payments are made in a fiscal year to hospitals that meet performance standards established for a performance period for such fiscal year. Both the performance standards and the performance period for a fiscal year are to be established by the Secretary.

Section 1886(o)(7)(B) of the Act instructs the Secretary to reduce the base operating DRG payment amount for a hospital for each discharge in a fiscal year by an applicable percent. The FY 2017 program year is 2.00 percent.

CMS estimates that the total amount available for value-based incentive payments for FY 2017 is approximately $1.8 billion.

CMS will change the domain name of Patient- and Caregiver-Centered Experience of Care/Care Coordination to, more simply, Person and Community Engagement beginning with the FY 2019 program year.

Based on public comments received in prior rulemaking, CMS will include selected ward (non-ICU) locations in the CAUTI and CLABSI measures for the Hospital VBP Program beginning with the FY 2019 program year, with a baseline period of January 1, 2015 through December 31, 2015 and a performance period of January 1, 2017 through December 31, 2017. This expansion of the CAUTI and CLABSI measures aligns with the Hospital IQR Program.

In summary, for the FY 2019 program, CMS has finalized the following measure set **(page 936)**:

Previously Adopted and Newly Finalized Measure Refinement for the FY 2019 Program Year		
Short Name	**Domain/Measure Name**	**NQF #**
Person and Community Engagement Domain*		
HCAHPS	HCAHPS + 3-Item Care Transitions Measure	0166 0228
Clinical Care Domain		
MORT-30-AMI	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction Hospitalization	0230
MORT-30-HF	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure (HF) Hospitalization	0229
MORT-30-PN	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization	0468
THA/ TKA	Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	1550
Safety Domain		
CAUTI**	National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure	0138
CLABSI**	National Healthcare Safety Network Central Line-Associated Bloodstream Infection Outcome Measure	0139
Colon and Abdominal Hysterectomy SSI	American College of Surgeons -- Centers for Disease Control and Prevention Harmonized Procedure Specific Surgical Site Infection Outcome Measure	0753
MRSA Bacteremia	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin- resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure	1716
CDI	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection (CDI) Outcome Measure	1717
PSI 90	Patient Safety for Selected Indicators (Composite Measure)	0531
PC-01	Elective Delivery	0469
Efficiency and Cost Reduction Domain		
MSPB-1	Payment-Standardized Medicare Spending Per Beneficiary	2158

* In section IV.H.3.b. of the preamble of this final rule, CMS finalized changing the name of this domain from Patient- and Caregiver-Centered Experience of Care/Care Coordination domain to Person and Community Engagement domain beginning with the FY 2019 program year.

** As discussed in section IV.H.3.c. of the preamble of this final rule, CMS is finalizing inclusion of selected ward (non-ICU) locations in the measure.

Finalized Measures and Measure Refinements for the FY 2021 Program Year and Subsequent Years **(page 937)**

CMS will add, as proposed, two condition-specific payment measures in the Hospital VBP Program that can be directly paired with existing clinical outcome measures in the program.

- Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Acute Myocardial Infarction (AMI) (NQF #2431) (page 943)

- Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Heart Failure (HF) (NQF #2436) (page 958)

Scoring Methodology for the AMI Payment and HF Payment Measures **(page 963)**

CMS is finalizing the scoring of the new AMI Payment and HF Payment measures using the same scoring methodology as the MSPB measure.

Finalized Update to an Existing Measure for the FY 2021 Program Year: Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Pneumonia Hospitalization (NQF #0468) (Updated Cohort) **(page 972)**

The Hospital 30-Day, All-Cause, RSMR Following Pneumonia Hospitalization (NQF #0468) (MORT-30-PN (updated cohort)) measure is a risk-adjusted, NQF-endorsed mortality measure monitoring mortality rates following pneumonia hospitalizations.

CMS will adopt it proposal regarding the measure refinement in the Hospital IQR Program, and its posting of measure data on Hospital Compare for at least 1 year prior to the start of the measure performance period. In addition, the MORT-30-PN (updated cohort) measure addresses a high volume, high cost condition.

Comment

There is much to understand in all this material and subject matter that necessitates extreme review and analysis.

Summary of Previously Adopted and Newly Proposed Baseline and Performance Periods for the FY 2018, FY 2019, FY 2020, FY 2021, and FY 2022 Program Years **(page 1000)**

The tables below summarize the baseline and performance periods that CMS is adopting in this final rule (and include previously adopted baseline and performance periods for the Clinical Care domain).

Newly Finalized Baseline and Performance Periods for the FY 2018 Program Year		
Domain	Baseline Period	Performance Period
Safety • PSI 90*	July 1, 2010 – June 30, 2012	July 1, 2014 – September 30, 2015

* CMS is shortening the performance period for the PSI 90 measure for the FY 2018 program year.

Previously Adopted and Newly Finalized Baseline and Performance Periods for the FY 2019 Program Year		
Domain	Baseline Period	Performance Period
Person and Community Engagement • HCAHPS + 3-Item Care Transition	January 1, 2015 – December 31, 2015	January 1, 2017 – December 31, 2017
Clinical Care • Mortality (MORT-30-AMI, MORT-30-HF, MORT-30-PN)* • THA/TKA*	July 1, 2009 – June 30,2012 July 1, 2010 – June 30, 2013	July 1, 2014 – June 30, 2017 January 1, 2015 – June 30, 2017
Safety • PC-01 and NHSN measures (CAUTI, CLABSI, SSI, CDI, MRSA) • PSI 90	January 1, 2015 – December 31, 2015 July 1, 2011 – June 30, 2013	January 1, 2017 – December 31, 2017 July 1, 2015 – June 30, 2017
Efficiency and Cost Reduction • MSPB	January 1, 2015 – December 31, 2015	January 1, 2017 – December 31, 2017

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

Previously Adopted Baseline and Performance Periods for the FY 2020 Program Year		
Domain	**Baseline Period**	**Performance Period**
Clinical Care • Mortality (MORT-30-AMI, MORT-30-HF, MORT-30-PN)* • THA/TKA*	July 1, 2010 – June 30, 2013 July 1, 2010 – June 30, 2013	July 1, 2015 – June 30, 2018 January 1, 2015 – June 30, 2018

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

Previously Adopted and Newly Finalized Baseline and Performance Periods for the FY 2021 Program Year		
Domain	**Baseline Period**	**Performance Period**
Clinical Care • Mortality (MORT-30-AMI, MORT-30-HF, MORT-30-COPD)* • THA/TKA* • Mort-30-PN (updated cohort)	July 1, 2011 – June 30, 2014 April 1, 2011 – March 31,2014 July 1, 2012 – June 30, 2015	July 1, 2016 – June 30, 2019 April 1, 2016 – March 31, 2019 September 1, 2017 – June 30, 2019

Previously Adopted and Newly Finalized Baseline and Performance Periods for the FY 2021 Program Year		
Domain	**Baseline Period**	**Performance Period**
Efficiency and Cost Reduction • MSPB • Payment (AMI Payment and HF Payment	January 1,2017 - December 31,2017 July 1, 2012 – June 30, 2015	January 1 -2019 – December 31, 2019 July 1, 2017 to June 30, 2019

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

Newly Finalized Baseline and Performance Periods for the FY 2022 Program Year		
Domain	**Baseline Period**	**Performance Period**
Clinical Care • Mortality (MORT-30-AMI, MORT-30-HF, MORT-30-COPD)* • THA/TKA* • Mort-30-PN (updated cohort)	July 1, 2012 – June 30, 2015 April 1, 2012 – March 31,2015 July 1, 2012 – June 30, 2015	July 1, 2017 – June 30, 2020 April 1, 2017 – March 31, 2020 September 1, 2017 – June 30, 2020
Efficiency and Cost Reduction • MSPB • Payment (AMI Payment and HF Payment	January 1,2018 - December 31,2018 July 1, 2012 – June 30, 2015	January 1 -2020 – December 31, 2020 July 1, 2017 to June 30, 2030

[Note: CMS may have duplicated several of the above tables in the rule (pages 1007-10080]

Performance Standards for the FY 2019 Program Year (page 1020)

Previously Adopted and Newly Proposed Performance Standards for the FY 2019 Program Year: Safety, Clinical Care, and Efficiency and Cost Reduction Measures			
Safety Measures			
Measure ID	**Description**	**Achievement Threshold**	**Benchmark**
CAUTI*	National Healthcare Safety Network Catheter-associated Urinary Tract Infection Outcome Measure	0.464000	0.000000
CLABSI*	National Healthcare Safety Network Central line-associated Bloodstream Infection Outcome Measure	0.427000	0.000000
CDI*	National Healthcare Safety Network Facility-wide Inpatient Hospital- onset *Clostridium difficile* Infection (CDI) Outcome Measure	0.816000	0.012000
MRSA bacteremia*	National Healthcare Safety Network Facility-wide Inpatient Hospital- onset Methicillin-resistant *Staphylococcus aureus* Bacteremia Outcome Measure	0.823000	0.000000
Colon and Abdominal Hysterectomy SSI*	American College of Surgeons – Centers for Disease Control and Prevention Harmonized Procedure Specific Surgical Site Infection Outcome Measure	• 0.832000 • 0.698000	• 0.000000 • 0.000000
PC-01	Elective Delivery	0.010038	0.000000

Previously Adopted and Newly Proposed Performance Standards for the FY 2019 Program Year: Safety, Clinical Care, and Efficiency and Cost Reduction Measures			
PSI-90± *	Patient safety for selected indicators (composite)	0.0840335	0.0589462
Clinical Care Measures			
MORT-30-AMI±	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction Hospitalization	0.850671	0.873263
MORT-30-HF±	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure	0.883472	0.908094
MORT-30-PN±	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization	0.882334	0.907906
THA/ TKA*	Hospital-Level Risk-Standardized Complications Rate (RSMR) Following Elective Primary Total Hip Arthoplasty (THA) and/or Total Knee Arthoplasty (TKA)	0.032229	0.023178
Efficiency and Cost Reduction Measure			
MSPB*	Payment-Standardized Medicare Spending Per Beneficiary	Median Medicare Spending per Beneficiary ratio across all hospitals during the performance period	Mean of the lowest decile Medicare Spending per Beneficiary ratios across all hospitals during the performance period

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

Performance Standards for the FY 2019 Program Year Proposed Person and Community Engagement Domain*			
HCAHPS Survey Dimension	**Floor (Percent)**	**Achievement Threshold (Percent)**	**Benchmark (Percent)**
Communication with Nurses	28.10	78.69	86.97
Communication with Doctors	33.46	80.32	88.62
Responsiveness of Hospital Staff	32.72	65.16	80.15
Pain Management	22.31	70.01	78.53
Communication about Medicines	11.38	63.26	73.53
Hospital Cleanliness & Quietness	22.85	65.58	79.06
Discharge Information	61.96	87.05	91.87
3-Item Care Transition	11.30	51.42	62.77
Overall Rating of Hospital	28.39	70.85	84.63

* CMS is finalizing the re-naming of this domain from Patient- and Caregiver-Centered Experience of Care/Care Coordination domain to Person and Community Engagement domain beginning with the FY 2019 program year, as discussed in section IV.H.3.b. of the preamble of this final rule.

** For more information on the Pain Management dimension, please refer to the Hospital VBP Program proposal in the CY 2017 OPPS/ASC PPS proposed rule (81 FR 45755 through 45757).

Comment

This is another section with extensive and complex material. The document contains additional tables regarding standards beyond FY 2019 as well as much scoring information.

Changes to the Hospital-Acquired Condition (HAC) Reduction Program **(page 1038)**

CMS finalized the following measures for use in the FY 2017 Program: PSI 90 measure for Domain 1 and the CDC NHSN measures CLABSI, CAUTI, Colon and Abdominal Hysterectomy SSI, MRSA Bacteremia, and CDI for Domain 2. CMS is not proposing any changes to this measure set for FY 2017. CMS also is not proposing to make any changes to the measures that were finalized for use in the FY 2016 program (CAUTI, CLABSI, and Colon and Abdominal Hysterectomy SSI) or the FY 2017 program (MRSA Bacteremia and CDI).

CMS is adopting the following HAC Reduction Program policies: (1) clarification data requirements for the term "complete data" for the PSI 90 measure within Domain 1 to require that hospitals have three or more eligible discharges for at least one component indicator and 12 months or more of data to receive a Domain 1 score; and (2) for NHSN CDC HAI data submission requirements for newly opened hospitals.

For FY 2018, CMS will adopt the following HAC Reduction Program policies:

(1) adoption of the modified version of the NQF-endorsed PSI 90: Patient Safety and Adverse Events Composite;
(2) defining the applicable time periods for the FY 2018 HAC Reduction Program and the FY 2019 HAC Reduction Program; and
(3) changes to the scoring methodology.

Comment

Again, this is another complex discussion. While CMS says it is not proposing changes for FY 2017. Changes are being proposed for years beyond 2017.

Payment for Graduate Medical Education (GME) and Indirect Medical Education (IME) Costs (§§ 412.105, 413.75 through 413.83) **(page 1100)**

CMS is revising the direct GME regulations at § 413.79(k) (and which, in turn, would affect IME adjustments under § 412.105(f)(1)(x)) to permit that, effective with rural track training programs started on or after October 1, 2012, in the first 5 program years of the rural track's existence, the rural track FTE limitation for each urban hospital will be the actual number of FTE residents (subject to the rolling average at § 413.79(d)(7) and the IME IRB ratio cap at § 412.105(a)(1)(i), if applicable), training in the rural track training program at the urban hospital, and the rural track FTE limitation would take effect beginning with the urban hospital's cost reporting period that coincides with or follows the start of the sixth program year of the rural track training program's existence.

V. CHANGES TO THE LONG-TERM CARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM (LTCH PPS) FOR FY 2017 (pages 1267 and 2223)

Updates to the Payment Rates for the LTCH PPS for FY 2017 (page 1393)

CMS is establishing an annual update to the LTCH PPS standard Federal payment rate of 1.75 percent, which is based on the full estimated increase in the LTCH PPS market basket of 2.8 percent, less a MFP adjustment of 0.3 percentage point consistent with section 1886(m)(3)(A)(i) of the Act, and less the 0.75 percentage point required by sections 1886(m)(3)(A)(ii) and (m)(4)(F) of the Act.

For LTCHs that fail to submit required quality reporting data for FY 2017, the proposed update is reduced further by 2.0 percentage points, or an (negative) update factor of -0.75 percent.

CMS is establishing a LTCH PPS standard Federal payment rate of **$42,476.41** (calculated as the current FY 2016 rate of $41,762.85 X 1.0175 X 0.999593(budget neutrality adjustment factor)) for FY 2017.

For LTCHs that fail to submit quality reporting data for FY 2017 in accordance with the requirements of the LTCHQRP under section 1886(m)(5) of the Act, CMS is establishing a LTCH PPS standard Federal payment rate of $41,641.49 (calculated as $41,762.85 X 0.9975 X 0.999593) for FY 2017.

The labor-related share under the LTCH PPS for FY 2017 is 66.5 percent. The current amount is 62.0 percent.

The final FY 2017 LTCH PPS standard Federal payment rate wage index values are presented in Table 12A (for urban areas) and Table 12B (for rural areas), available on the CMS Web site.

Adjustment for LTCH PPS High-Cost Outlier (HCO) Cases

CMS is establishing two separate HCO targets—one for LTCH PPS standard Federal payment rate cases and one for site neutral payment rate cases.

CMS is establishing a fixed-loss amount of $21,943 for LTCH PPS standard Federal payment rate cases for FY 2017.

CMS is establishing a fixed-loss amount for site neutral payment rate cases of $23,500.

VI. QUALITY DATA REPORTING REQUIREMENTS FOR SPECIFIC PROVIDERS AND SUPPLIERS (page 1455)

***Hospital IQR* (page 1459)**

CMS will remove the following measures for the FY 2019 payment determination and subsequent years.

Electronic Clinical Measures:

- AMI-2: Aspirin Prescribed at Discharge for AMI (NQF #0142);
- AMI-7a: Fibrinolytic Therapy Received Within 30 minutes of Hospital Arrival;
- AMI-10: Statin Prescribed at Discharge;
- HTN: Healthy Term Newborn (NQF #0716);
- PN-6: Initial Antibiotic Selection for Community-Acquired Pneumonia (CAP) in Immunocompetent Patients (NQF #0147);
- SCIP-Inf-1a: Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision (NQF #0527);
- SCIP-Inf-2a: Prophylactic Antibiotic Selection for Surgical Patients (NQF #0528);
- SCIP-Inf-9: Urinary Catheter Removed on Postoperative Day 1 (POD1) or Postoperative Day 2 (POD2) with Day of Surgery Being Day Zero;
- STK-04 Thrombolytic Therapy (NQF #0437);
- VTE-3: Venous Thromboembolism Patients with Anticoagulation Overlap Therapy (NQF #0373);
- VTE-4: Venous Thromboembolism Patients Receiving Unfractionated Heparin (UFH) with Dosages/Platelet Count Monitoring by Protocol (or Nomogram);
- VTE-5: Venous Thromboembolism Discharge Instructions;
- VTE-6: Incidence of Potentially Preventable Venous Thromboembolism;

Structural Measures:

- Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care; and
- Participation in a Systematic Clinical Database Registry for General Surgery.

Chart Abstracted Measure:

- STK-4: Thrombolytic Therapy (NQF #0437)
- VTE-5: VTE Discharge Instructions

The Hospital IQR Program has previously finalized 65 measures for FY 2018.

CMS is adopting its 2 proposed refinement claims-based measures for FY 2018 -- (1) PN Payment: Hospital-Level, Risk-Standardized 30-Day Episode-of-Care Payment Measure for Pneumonia; and (2) PSI 90: Patient Safety and Adverse Events Composite (previously known as the Patient Safety for Selected Indicators Composite Measure).

For the FY 2019 payment determination and subsequent years, CMS is adopting, as proposed, three clinical episode-based payment measures:

- Aortic Aneurysm Procedure Clinical Episode-Based Payment (AA Payment) Measure;
- Cholecystectomy and Common Duct Exploration Clinical Episode-Based Payment (Chole and CDE Payment) Measure; and
- Spinal Fusion Clinical Episode-Based Payment (SFusion Payment) Measure.

In addition, CMS proposed, and is adopting, one required outcome measure: Excess Days in Acute Care after Hospitalization for Pneumonia.

The table below outlines the Hospital IQR Program measure set for the FY 2019 payment determination and subsequent years and includes both previously adopted and proposed measures (page 1610).

Hospital IQR Program Measure Set for the FY 2019 Payment Determination and Subsequent Years		
Short Name	**Measure Name**	**NQF #**
NHSN		
CAUTI	National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure	0138
CDI	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection (CDI) Outcome Measure	1717
CLABSI	National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure	0139
Colon and Abdominal Hysterectomy SSI	American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	0753
HCP	Influenza Vaccination Coverage Among Healthcare Personnel	0431
MRSA Bacteremia	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin- resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure	1716
Chart-abstracted		
ED-1*	Median Time from ED Arrival to ED Departure for Admitted ED Patients	0495
ED-2*	Admit Decision Time to ED Departure Time for Admitted Patients	0497
Imm-2	Influenza Immunization	1659
PC-01*	Elective Delivery (Collected in aggregate, submitted via Web-based tool or electronic clinical quality measure)	0469
Sepsis	Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)	0500
VTE-6	Incidence of Potentially Preventable Venous Thromboembolism	+
Claims-based Outcome		
MORT-30-AMI	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (AMI) Hospitalization	0230
MORT-30-CABG	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery	2558
MORT-30-COPD	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	1893
MORT-30-HF	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Heart Failure (HF) Hospitalization	0229
MORT-30-PN	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization	0468
MORT-30-STK	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Ischemic Stroke	N/A
READM-30-AMI	Hospital 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) Following Acute Myocardial Infarction (AMI) Hospitalization	0505
READM-30-CABG	Hospital 30-Day, All-Cause, Unplanned, Risk- Standardized Readmission Rate (RSRR) Following Coronary Artery Bypass Graft (CABG) Surgery	2515
READM-30-COPD	Hospital 30-Day, All-Cause, Unplanned, Risk- Standardized Readmission Rate (RSRR) Following Coronary Artery Bypass Graft (CABG) Surgery	1891
READM-30-HF	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Heart Failure (HF) Hospitalization	0330
READ-30-HWR	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	1789
READM-30-PN	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Pneumonia Hospitalization	0506
READM-30-STK	30-Day Risk Standardized Readmission Rate Following Stroke Hospitalization	N/A
READM-30-THA/TKA	Hospital-Level 30-Day, All-Cause Risk-Standardized Readmission Rate (RSRR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	1551
AMI Excess Days	Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction	N/A
HF Excess Days	Excess Days in Acute Care after Hospitalization for Heart Failure	N/A
PN Excess Days**	Excess Days in Acute Care after Hospitalization for Pneumonia	N/A
Hip/knee complications	Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	1550
PSI 04	Death among Surgical Inpatients with Serious, Treatable Complications	0351

Hospital IQR Program Measure Set for the FY 2019 Payment Determination and Subsequent Years		
Short Name	**Measure Name**	**NQF #**
PSI 90	Patient Safety for Selected Indicators (Composite Measure), Modified PSI 90 (Updated Title: Patient Safety and Adverse Events Composite)	0531
Claims-based Payment		
AMI Payment	Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Acute Myocardial Infarction (AMI)	2431
HF Payment	Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care For Heart Failure (HF)	2436
PN Payment	Hospital-Level, Risk-Standardized Payment Associated with a 30-day Episode-of-Care For Pneumonia	2579
THA/TKA Payment	Hospital-Level, Risk-Standardized Payment Associated with an Episode-of-Care for Primary Elective Total Hip Arthroplasty and/or Total Knee Arthroplasty	N/A
MSPB	Payment-Standardized Medicare Spending Per Beneficiary (MSPB)	2158
Cellulitis Payment	Cellulitis Clinical Episode-Based Payment Measure	N/A
GI Payment	Gastrointestinal Hemorrhage Clinical Episode-Based Payment Measure	N/A
Kidney/UTI Payment	Kidney/Urinary Tract Infection Clinical Episode- Based Payment Measure	N/A
Chole and CDE Payment**	Cholecystectomy and Common Duct Exploration Clinical Episode-Based Payment Measure	N/A
AA Payment**	Aortic Aneurysm Procedure Clinical Episode-Based Payment Measure	N/A
Sfusion Payment**	Spinal Fusion Clinical Episode-Based Payment Measure	N/A
Electronic Clinical Quality Measure (eCQMs)		
AMI-8a	Primary PCI Received Within 90 Minutes of Hospital Arrival	0163
CAC-3	Home Management Plan of Care Document Given to Patient/Caregiver	+
ED-1*	Median Time from ED Arrival to ED Departure for Admitted ED Patients	0495
ED-2*	Admit Decision Time to ED Departure Time for Admitted Patients	0497
EHDI-1a	Hearing Screening Prior to Hospital Discharge	1354
PC-01*	Elective Delivery (Collected in aggregate, submitted via Web-based tool or electronic clinical quality measure)	0469
PC-05	Exclusive Breast Milk Feeding***	0480
STK-02	Discharged on Antithrombotic Therapy	0435
STK-03	Anticoagulation Therapy for Atrial Fibrillation/Flutter	0436
STK-05	Antithrombotic Therapy by the End of Hospital Day Two	0438
STK-06	Discharged on Statin Medication	0439
STK-08	Stroke Education	+
STK-10	Assessed for Rehabilitation	0441
VTE-1	Venous Thromboembolism Prophylaxis	0371
VTE-2	Intensive Care Unit Venous Thromboembolism Prophylaxis	0372
Patient Survey		
HCAHPS	HCAHPS + 3-Item Care Transition Measure (CTM-3)	0166 0228
Structural Measures		
Patient Safety Culture**	Hospital Survey on Patient Safety Culture	N/A
Safe Surgery Checklist	Safe Surgery Checklist Use	N/A

* Measure listed twice, as both chart-abstracted and electronic clinical quality measure.
**Newly finalized measures for the FY 2019 payment determination and for subsequent years.
***Measure name has been shortened. Please refer to annually updated electronically clinical quality measure specifications on the CMS eCQI Resource Center Page for further information: https://www.healthit.gov/newsroom/ecqi-resource-center.
+ NQF endorsement has been removed.

Comment

The section on Inpatient Quality Reporting extends more than 200 pages. The material is very well written. It's easy to follow. It's just long, too long to summarize. This analysis has not discussed issues relating to eCQMs, timing and reporting, and validations, etc.

Those individuals responsible for quality reporting need to pay careful attention to the numerous changes presented. Failure to do so could result in reduced payments for not providing required quality measures.

Final Comment

Over the past few years, there has been both consternation and dismay by many states over an ACA amendment that reversed a CMS rule that would have set area wage index budget neutrality on a statewide basis when urban areas in a state have a lower wage index value than the statewide rural amount. The ACA requirement imposes such budget neutrality on a national basis. The reversal has been extremely beneficial in New England and California.

The following is CMS' FY 2017 estimate of the national budget neutrality statewide calculations.

FY 2017 IPPS Estimated Payments Due to Rural and Imputed Floor with National Budget Neutrality				
State	Number of Hospitals (1)	Number of Hospitals That Will Receive the Rural Floor or Imputed Floor (2)	Percent Change in Payments due to Application of Rural Floor and Imputed Floor with Budget Neutrality (3)	Difference (in millions) (4)
Alabama	83	6	-0.3	-5
Alaska	6	4	-2.1	4
Arizona	57	7	-0.1	-2
Arkansas	44	0	-0.3	-3
California	301	186	1.3	139
Colorado	48	3	0.3	3
Connecticut	31	8	0.3	5
Delaware	6	2	0	0
Washington, D.C.	7	0	-0.4	-2
Florida	171	16	-0.2	-14
Georgia	105	0	-0.3	-8
Hawaii	12	0	-0.3	-1
Idaho	14	0	-0.2	-1
Illinois	126	3	-0.4	-16
Indiana	89	0	-0.4	-9
Iowa	35	0	-0.3	-3
Kansas	53	0	-0.3	-3
Kentucky	65	0	-0.3	-5
Louisiana	95	2	-0.3	-4
Maine	18	0	-0.3	-2
Massachusetts	58	15	0.7	24
Michigan	95	0	-0.4	-15
Minnesota	49	0	-0.3	-5
Mississippi	62	0	-0.3	-3
Missouri	74	2	-0.3	-7
Montana	12	4	0.3	1
Nebraska	26	0	-0.3	-2
Nevada	24	3	-0.2	-1
New Hampshire	13	9	2.3	12
New Jersey	64	18	0.3	10
New Mexico	25	0	-0.2	-1
New York	154	21	-0.2	-15

FY 2017 IPPS Estimated Payments Due to Rural and Imputed Floor with National Budget Neutrality				
State	Number of Hospitals (1)	Number of Hospitals That Will Receive the Rural Floor or Imputed Floor (2)	Percent Change in Payments due to Application of Rural Floor and Imputed Floor with Budget Neutrality (3)	Difference (in millions) (4)
North Carolina	84	1	-0.3	-10
North Dakota	6	1	-0.2	-1
Ohio	130	10	-0.3	-11
Oklahoma	86	2	-0.3	-4
Oregon	34	2	-0.3	-3
Pennsylvania	152	5	-0.3	-17
Puerto Rico	51	12	0.1	0
Rhode Island	11	10	4.5	17
South Carolina	57	5	-0.1	-1
South Dakota	18	0	-0.2	-1
Tennessee	92	20	-0.2	-6
Texas	320	3	-0.3	-22
Utah	33	1	-0.3	-1
Vermont	6	0	-0.2	0
Virginia	76	1	-0.3	-7
Washington	49	6	0	0
West Virginia	29	3	-0.1	-1
Wisconsin	65	6	-0.2	-4
Wyoming	10	0	-0.1	0

The following table identifies those MS-DRGs with 100,000 or more discharges (from tables 5 and 7B).

LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS-DRGS), RELATIVE WEIGHTING FACTORS—FY 2017 Proposed Rule				
MS-DRG	**MS-DRG Title**	**Final FY 2017 Weights**	**Final FY 2016 Weights**	**Percentage Change**
65	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC OR TPA IN 24 HRS	1.0431	1.0593	-1.53
189	PULMONARY EDEMA & RESPIRATORY FAILURE	1.2135	1.2265	-1.06
190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	1.1481	1.1578	-0.84
191	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC	0.9184	0.9321	-1.47
193	SIMPLE PNEUMONIA & PLEURISY W MCC	1.3860	1.4261	-2.81
194	SIMPLE PNEUMONIA & PLEURISY W CC	0.9469	0.9695	-2.33
291	HEART FAILURE & SHOCK W MCC	1.4796	1.4809	-0.09
292	HEART FAILURE & SHOCK W CC	0.9574	0.9707	-1.37
378	G.I. HEMORRHAGE W CC	0.9860	0.9949	-0.89
392	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	0.7402	0.7400	0.03
470	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	2.0671	2.0816	-0.70
603	CELLULITIS W/O MCC	0.8445	0.8429	0.19
641	MISC DISORDERS OF NUTRITION,METABOLISM,FLUIDS/ELECTROLYTES W/O MCC	0.7181	0.7221	-0.55
682	RENAL FAILURE W MCC	1.4989	1.5085	-0.64
683	RENAL FAILURE W CC	0.9191	0.9406	-2.29
690	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	0.7777	0.7828	-0.65
871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	1.7660	1.7926	-1.48
872	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W/O MCC	1.0283	1.0427	-1.38

These 18 MS-DRGs contain 3.3 million discharges or approximately 33.0 percent of the nearly 10 million MS-DRG discharges.

Most are declining and will negatively impact case-mix and therefore payment.