Executive Summary: CMS 2017 IPPS Proposed Rule

Key Financial and Operational Impacts from the Proposed 2017 Inpatient Prospective Payment System (IPPS) Rule:

The 2017 IPPS Proposed Rule was made available on April 18, 2016. A detailed summary of the rule is will be available shortly.

1) **Base Operating Rate**: The IPPS base operating rate increased by .85% for hospitals that successfully reported quality measures and are "meaningful users" of certified electronic health records (EHRs). The table below lists the proposed operating rates for hospitals under a variety of circumstances.

FY17 PROPOSED RULE TABLES 1A-1D

	Standardized Operating Amounts Wage Index > 1		**Standardized Operating Amounts Wage Index < 1**	
	Labor	Non-Labor	Labor	Non-Labor
Submitted Quality Data and Is a Meaningful User	$3,836.20	$1,675.59	$3,417.31	$2,094.48
Did Not Submit Quality Data and Is a Meaningful User	$3,756.87	$1,640.94	$3,346.64	$2,051.17
Submitted Quality Data and Is Not a Meaningful User	$3,809.76	$1,664.04	$3,393.76	$2,080.04
Did Not Submit Quality Data and Is a Not Meaningful User	$3,730.43	$1,629.39	$3,323.09	$2,036.73
Puerto Rico	N/A	N/A	$3,417.31	$2,094.48

Note that the standardized amounts do not include the 2% Medicare sequester reduction that began in 2013, and will continue until 2024, absent new legislation.

2) **National Capital Rate**: The proposed national capital rate for FY17 is $466.35.

3) **Outlier Threshold**: The proposed fixed loss outlier threshold increases to $23,681, which will decrease outlier payments.

4) **Documentation and Coding**: CMS proposes to complete the $11 billion recoupment mandated by the American Taxpayer Relief Act (ATRA) of 2012 by making an estimated -1.5% adjustment to the FY17 standardized amounts and leaving in place the cumulative the -2.4% adjustments made for FY14 through FY16. The final adjustment could differ from the current -1.5% estimate.

For FY18 through FY23 the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) replaces the one-time FY18 increase to reverse the cumulative effects of the documentation and coding adjustments on base rates with rate increases equal to 0.5% per year. Section 414 of MACRA also removes the HHS Secretary's authority to make an additional prospective adjustment to IPPS rates to offset payment increases resulting from documentation and coding changes for discharges occurring during FY10.

5) **Reversal of RAC Related Payment Reduction**: CMS proposes to reverse the unsubstantiated .2% reduction in inpatient MS-DRG payments as a result of the implementation of the two-midnight rule that began in FY14. This results in a .8% increase in IPPS payment for 2017.

6) **Overall impact of Other Policy Changes**: The proposed rule impact analysis shows average per case operating payments increasing 0.7%. However this only includes policy changes related to productivity adjustments as mandated by the Affordable Care Act (ACA), documentation and coding, the .2% two-midnight "give-back," wage index frontier adjustment, and the increase of fixed loss outlier threshold. The policy changes discussed below are not included in the .7% total operating payment impact analysis. Please see Table I in the attached appendix for specific impacts by type of hospital and region.

7) **Readmissions Penalty**: The penalty for excess readmissions for select conditions remains at 3% of operating payments for FY17. CMS analysis shows payments to an estimated 2,603 hospitals will be reduced by $523 million, an increase of $100 million over the estimated FY16 reduction. The proxy payment adjustment factors are available here.

   For FY17, CMS will add a readmissions measure for Coronary artery bypass graft.

8) **Value Based Purchasing Program**: The hospital Value-Based Purchasing Program (VBP) will reduce payments by 2% in FY17. The program is budget neutral but will redistribute about $1.7 billion from low performing hospitals to high performing hospitals based on their historical performance scores. Table 16 on the proposed rule webpage includes a file of proxy hospital-specific VBP adjustment factors for FY17 based on hospitals' Total Performance Scores from the FY16 Hospital VBP Program that hospitals can use to understand the payment impact of their historical performance on FY17 payments. An updated Table 16, *Proposed Proxy Hospital Inpatient Value-Based Purchasing (VBP) Program Adjustment Factors for FY 2017*, was posted to *CMS.gov* with the publication of the FY17 IPPS proposed rule on April 18th. These proxies therefore reflect the performance periods, measures, and domain weights in effect for the relevant measurement periods. In the final rule, CMS will publish Table 16A which reflects changes based on the March 2016 update to the FY15 MedPAR file.

   The proposed rule adds measures and makes technical changes to existing measures that providers need to be aware of.

In the appendix, tables II – IV provides domain weighting, case minimums, and domain scoring minimums for FY19. Table V includes measures for the years FY17 – FY22.

Proposed Domain Weights for FY 2019	
Domain	**Weight**
Safety	25%
Clinical Care	25%
Efficiency and Cost Reduction	25%
Person and Community Engagement (Patient and Caregiver Centered Experience of Care/Care Coordination)	25%

Case Minimums for FY 2019	
Type of Measure	**Cases**
NHSN measures	1 predicted infection
AHRQ PSI 90 composite measure	3 cases for any underlying Indicator**
PC-01 measure	10 cases
Mortality	25 cases
Medicare Spending per Beneficiary*	25 cases
HCAHPS	100 surveys
*The 25 case minimum would also apply to the AMI and HF payment measures proposed for FY 2021 and later years **CMS proposes in this rule that beginning with FY 2017 payment, hospitals must also have 12 months or more of PSI-90 data to receive a Domain 1 score	

Measure Minimums for Domain Score FY 2019	
Domain	**Minimum Measures**
Safety (includes NSHN, AHRQ PSI 90, PC-01)	3
Clinical Care (mortality)	2
Efficiency and Cost Reduction	MSPB score
Person and Community Engagement Patient and Caregiver Centered Experience of Care/Care Coordination	HCAHPS score

Summary Table VBP-1: Measures and Domains for selected payment years					
Measure	**2017**	**2018**	**2019/ 2020**	**2021**	**2022**
Clinical Care–Process (*removed beginning 2018)*					
AMI-7a Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	X	Removed			
IMM-2 Influenza Immunization	X	Removed			
Perinatal Care: elective delivery < 39 completed weeks gestation	X	Moved to Safety domain			
Clinical Care–Outcomes *(labeled as 'Clinical Care' beginning 2018)*					
Acute Myocardial Infarction (AMI) 30-day mortality rate	X	X	X	X	X
Heart Failure (HF) 30-day mortality rate	X	X	X	X	X
Pneumonia (PN) 30- day mortality rate	X	X	X	X	X
Complication rate for elective primary total hip arthroplasty/total knee arthroplasty			X	X	X
Chronic Obstructive Pulmonary Disease (COPD) 30-day mortality rate				X	X
CABG 30-day mortality rate					*Proposed*
Safety					
AHRQ PSI–90 patient safety composite	X	X	X	X	X
Central Line Associated Blood Stream Infection (CLABSI)	X	X	X	X	X
Catheter Associated Urinary Tract Infection (CAUTI)	X	X	X	X	X
Surgical Site Infection: Colon Abdominal hysterectomy	X	X	X	X	X
Methicillin-Resistant Staphylococcus Aureus (MRSA) Bacteremia	X	X	X	X	X
Clostridium Difficile infection (CDI)	X	X	X	X	X
Perinatal Care: elective delivery < 39 completed weeks gestation (oved from Clinical Care – Process)	In Clinical Care – Process domain	X	X	X	X

Patient and Caregiver Centered Experience of Care/Care Coordination *(Person and Community Engagement)*					
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)					
8 dimensions: Communication with Nurses Communication with Doctors Responsiveness of Hospital Staff Pain Management Communication About Medicines Cleanliness and Quietness of Hospital Environment Discharge Information Overall Rating of Hospital	X	X	X	X	X
9th dimension: 3-Item Care Transition measure		X	X	X	X
Efficiency and Cost Reduction					
Medicare Spending per Beneficiary	X	X	X	X	X
AMI payment per 30-day episode				*Proposed*	
HF payment per 30-day episode				*Proposed*	

9) **Hospital-Acquired Conditions (HACs):** An estimated 774 hospitals will have their total IPPS payments reduced by 1% in FY17 for the HAC penalty. Table VI in the appendix shows the percent of hospitals, by type, estimated to be subject to the 1% payment reduction. It shows that hospitals with 300 or more beds, teaching hospitals, hospitals with a disproportionate share hospital percent of 50% or more, and hospitals with fewer than 25 beds are disproportionately penalized. CMS staff notes that the table data is a projection based on past performance. The actuals are not in yet, and hospitals have not been informed if they will be subject to the payment penalty. The payment reduction will go into effect on October 1, 2016.

ESTIMATED PROPORTION OF HOSPITALS IN THE WORST-PERFORMING QUARTILE (75TH PERCENTILE) OF THE TOTAL HAC SCORE FOR THE FY 2017 HAC REDUCTION PROGRAM

[By hospital characteristic]

Hospital characteristic	Number of hospitals [a]	Number of hospitals in the worst-performing quartile [b]	Percent of hospitals in the worst-performing quartile [c]
Total [d]	3,225	774	24.0
By Geographic Location:			
All hospitals:			
Urban	2,403	656	27.3
Rural	808	108	13.4
Urban hospitals:			
1–99 beds	593	90	15.2
100–199 beds	737	164	22.3
200–299 beds	436	128	29.4
300–399 beds	273	103	37.7
400–499	151	62	41.1
500 or more beds	213	109	51.2
Rural hospitals:			
1–49 beds	306	44	14.4
50–99 beds	294	32	10.9
100–149 beds	120	11	9.2
150–199 beds	47	11	23.4
200 or more beds	41	10	24.4
By Region:			
New England	134	46	34.3
Mid-Atlantic	367	130	35.4
South Atlantic	520	131	25.2
East North Central	499	105	21.0
East South Central	299	58	19.4
West North Central	262	39	14.9
West South Central	510	79	15.5
Mountain	225	64	28.4
Pacific	395	112	28.4
By DSH Percent: [e]			
0–24	1,512	336	22.2
25–49	1,370	329	24.0
50–64	170	48	28.2
65 and over	159	51	32.1
By Teaching Status: [f]			
Non-teaching	2,189	398	18.2
Fewer than 100 residents	1,022	366	35.8
100 or more residents	777	230	29.6
By Type of Ownership:			
Voluntary	1,874	480	25.6
Proprietary	834	160	19.2
Government	489	122	24.9
By MCR Percent:			
0–24	480	143	29.8
25–49	2,096	498	23.8
50–64	533	104	19.5
65 and over	82	14	17.1

Source: FY 2017 HAC Reduction Program Proposed Rule Preliminary Results. Scores are based on AHRQ PSI 90 data from July 2013 through June 2015 and CDC CLABSI, CAUTI, Colon and Abdominal Hysterectomy SSI, MRSA Bacteremia and CDI data from January 2013 to December 2014. Hospital Characteristics are based on the FY 2016 Final Rule Impact File updated on October 8, 2015.

[a] The total number of non-Maryland hospitals with a Total HAC Score with hospital characteristic data (3,211 for geographic location, region, bed size, DSH percent, and teaching status; 3,197 for type of ownership; and 3,191 for MCR) does not add up to the total number of non-Maryland hospitals with a Total HAC Score for the FY 2017 HAC Reduction Program (3,225) because 14 hospitals are not included in the FY 2016 Final Rule Impact File and not all hospitals have data for all characteristics.

[b] This column is the number of non-Maryland hospitals with a Total HAC Score within the corresponding characteristic that are estimated to be in the worst-performing quartile.

[c] This column is the percent of hospitals within each characteristic that are estimated to be in the worst-performing quartile. The percentages are calculated by dividing the number of non-Maryland hospitals with a Total HAC Score in the worst-performing quartile by the total number of non-Maryland hospitals with a Total HAC Score within that characteristic.

[d] Total excludes 47 Maryland hospitals and 64 non-Maryland hospitals without a Total HAC Score for FY 2017.

[e] A hospital is considered to be a DSH hospital if it has a disproportionate patient percentage (DPP) greater than zero.

[f] A hospital is considered to be a teaching hospital if it has an IME adjustment factor for Operation PPS (TCHOP) greater than zero.

Table VII in the appendix includes HAC measures for 2015 – 2019.

Summary Table HAC-1 HAC Reduction Program Measures, Performance Periods, and Domain Weights *(Proposals in Italics)*					
	FY 2015	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**
Domain 1: AHRQ Patient Safety Indicators					
PSI-90 (PSI-90 is a composite of eight PSI measures: PSI-3 (pressure ulcer rate), PSI-6 (iatrogenic pneumothorax), PSI-7 (Central venous catheter related blood stream infections rate), PSI-8 (Postoperative hip fracture rate), PSI-12 (postoperative VE or DVT rate, PSI-13 (Postoperative sepsis rate), PSI-14 (Wound dehiscence rate), and PSI-15 (accidental puncture or Laceration).	X	X	X	*	*
Applicable Time Period/(Performance Period)	7/1/11-6/30/13	7/1/12-6/30/14	7/1/13-6/30/15	*7/1/14-9/30 /15*	*10/1/15-9/30/17*
Domain 1 weight	35%	25%	15%	*	*
Domain 2: CDC HAI Measures					
Central Line-associated Blood Stream Infection (CLABSI)	X	X	X	*	*
Catheter-associated Urinary Tract Infection (CAUTI)	X	X	X	*	*
Surgical Site Infection (SSI): ◦ SSI Following Colon Surgery ◦ SSI Following Abdominal Hysterectomy		X	X	*	*
Methicillin-resistant staphylococcus aureus (MRSA)			X	*	*
Clostridium difficile			X	*	*
Applicable Time Period/(Performance Period)	1/1/12-12/31/13	1/1/13-12/31/14	1/1/14-12/31/15	*1/1/15-12/31/16*	*1/1/16-12/31/17*
Domain 2 weight	65%	75%	85%	*	*
*CMS does not propose weightings for FYs 2018 or 2019. Measures are not proposed either, but continuation of current measures is implied in the discussion of the proposed applicable time periods.					

10) **Notice of Outpatient Observation Status to Medicare Beneficiaries**: The proposed rule includes regulations to implement the Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act[1] which would require hospitals and critical access hospitals (CAHs), as a condition of participation, to provide to individuals receiving outpatient observation services for more than 24 hours both a written notice and an oral explanation that the individual is an

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

outpatient[2] receiving observation services and the implications of that status. *The proposed notice process would be effective August 6, 2016.*

CMS proposes that hospitals and CAHs use a standardized written notice called the Medicare Outpatient Observation Notice (MOON) which would include all the requisite elements specified in the NOTICE Act. Specifically, the MOON would:

- Explain that the individual was an outpatient—not an inpatient
- Explain the reason for outpatient status (i.e., that the physician believes the individual doesn't currently need inpatient services, but requires observation to decide whether the patient should be admitted or discharged)
- Explain the implications of receiving observation services as an outpatient, such as Medicare cost-sharing requirements, and eligibility for skilled nursing facility care
- Provide the explanations in standardized language (using plain language written for beneficiary comprehension)
- Include a blank section that a hospital/CAH may use for additional information
- Include a dedicated signature area to acknowledge receipt and understanding of the notice

CMS will provide guidance for the oral notification in forthcoming Medicare manual provisions.

[2] CMS defines outpatient to mean a person who has not been admitted as an inpatient but is registered on hospital/CAH records as an outpatient who receives services (versus only supplies) directly from the hospital/CAH.

TABLE I.—IMPACT ANALYSIS OF PROPOSED CHANGES TO THE IPPS FOR OPERATING COSTS FOR FY 2017

	Number of Hospitals [1]	Proposed Hospital Rate Update and Documentation and Coding Adjustment (1) [2]	Proposed FY 2017 Weights and DRG Changes with Application of Recalibration Budget Neutrality	Proposed FY 2016 Wage Data under New CBSA Designations with Application of	FY 2017 MGCRB Reclassifications (4) [5]	Proposed Rural and Imputed Floor with Application of National Rural and Imputed Floor Budget Neutrality	Application of the Proposed Frontier Wage Index and Proposed Out-Migration Adjustment	All Proposed FY 2017 Changes (7) [8]
All Hospitals	3,330	0.9	0	0	0	0	0.1	0.7
By Geographic Location:								
Urban hospitals	2,512	0.8	0	0	-0.1	0	0.1	0.6
Large urban areas	1,378	0.8	0.1	0	-0.3	-0.1	0	0.6
Other urban areas	1,134	0.9	0	0	0.1	0.2	0.2	0.7
Rural hospitals	818	1.5	-0.4	0.1	1.4	-0.2	0.1	0.8
Bed Size (Urban):								
0-99 beds	656	0.8	-0.2	0.2	-0.5	0.1	0.2	0.7
100-199 beds	765	0.9	-0.2	0	0	0.3	0.2	0.5
200-299 beds	449	0.9	-0.1	-0.1	0.1	0	0.1	0.5
300-499 beds	429	0.9	0.1	0.1	-0.2	0	0.2	0.7
500 or more beds	213	0.8	0.2	-0.1	-0.2	-0.1	0	0.8
Bed Size (Rural):								
0-49 beds	320	1.3	-0.5	0.1	0.3	-0.2	0.3	0.6
50-99 beds	292	1.7	-0.6	0.1	0.8	-0.1	0.1	0.8
100-149 beds	119	1.5	-0.4	0	1.5	-0.2	0.2	0.6
150-199 beds	46	1.5	-0.2	0.1	1.7	-0.2	0	1.0
200 or more beds	41	1.5	-0.1	0.2	2.5	-0.2	0	1.2
Urban by Region:								
New England	116	0.7	0	-0.4	1.3	0.8	0	-0.6
Middle Atlantic	315	0.8	0.1	-0.3	0.5	-0.2	0.1	0.2
South Atlantic	406	0.9	0	-0.1	-0.4	-0.2	0.1	0.8
East North Central	390	0.8	0	0.1	-0.2	-0.3	0	1.1
East South Central	147	0.9	0	-0.2	-0.4	-0.3	0	1.0
West North Central	163	1.0	0.1	0	-0.7	-0.3	0.7	0.9
West South Central	384	0.8	0	0.3	-0.4	-0.3	0	1.2
Mountain	163	1.0	0	0.2	-0.4	0	0.2	0.7

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Pacific	377	0.8	0	0.4	-0.4	1.1	0.1	0.4
Puerto Rico	51	0.8	0.1	-0.4	-0.9	0.2	0.1	0.3
Rural by Region:								
New England	21	1.2	-0.2	0.4	1.5	-0.2	0	1.2
Middle Atlantic	55	1.7	-0.4	0.1	0.6	-0.1	0.1	0.9
South Atlantic	127	1.4	-0.4	-0.1	2.5	-0.2	0.1	0.8
East North Central	115	1.6	-0.4	0	1.0	-0.1	0	0.9
East South Central	156	1.0	-0.3	0.4	2.1	-0.3	0.1	0.7
West North Central	99	2.1	-0.4	0	0.3	-0.1	0.3	1.0
West South Central	161	1.6	-0.5	0.2	1.6	-0.2	0.1	0.9
Mountain	60	1.6	-0.4	0.1	0.2	-0.1	0.1	0.7
Pacific	24	1.7	-0.5	-0.2	1.3	-0.1	0	0.8
By Payment Classification:								
Urban hospitals	2,455	0.8	0	0	-0.1	0	0.1	0.6
Large urban areas	1,372	0.8	0.1	0	-0.3	-0.1	0	0.6
Other urban areas	1,083	0.9	0	0	0.2	0.2	0.2	0.7
Rural areas	875	1.6	-0.4	0.1	1.1	-0.1	0.3	0.9
Teaching Status:								
Nonteaching	2,275	1.0	-0.2	0	0.2	0.1	0.1	0.6
Fewer than 100 residents	804	0.9	0	0	-0.1	0	0.2	0.7
100 or more residents	251	0.8	0.2	-0.1	-0.1	-0.2	0	0.8
Urban DSH:								
Non-DSH	597	0.9	0	-0.1	0.1	-0.1	0.1	0.5
100 or more beds	1,608	0.8	0.1	0	-0.1	0	0.1	0.7
Less than 100 beds	330	0.8	-0.3	0.1	-0.6	0.1	0.1	0.5
Rural DSH:								
SCH	266	2	-0.5	-0.1	0.1	-0.1	0.1	0.5
RRC	347	1.5	-0.3	0.1	1.5	-0.2	0.3	0.9
100 or more beds	33	0.8	-0.4	-0.1	2.9	-0.3	0.1	0.5
Less than 100 beds	149	0.7	-0.4	0.1	1.4	-0.3	0.5	0.2
Urban teaching and DSH:								

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Both teaching and DSH	880	0.8	0.1	0	-0.2	-0.1	0.1	0.7
Teaching and no DSH	107	0.8	0	0	0.7	-0.1	0	0.2
No teaching and DSH	1,058	0.8	-0.1	0.1	0	0.2	0.1	0.5
No teaching and no DSH	410	0.8	0	-0.1	-0.3	0	0.1	0.7
Special Hospital Types:								
RRC	193	0.8	-0.1	0.2	2	-0.1	0.4	1.1
SCH	326	2	-0.3	-0.1	0	0	0	1.0
MDH	146	1.6	-0.6	0	0.5	-0.1	0.2	0.8
SCH and RRC	126	2	-0.3	0.1	0.4	-0.1	0	1.2
MDH and RRC	15	1.8	-0.5	-0.1	0.8	-0.1	0	1.3
Type of Ownership:								
Voluntary	1,914	0.9	0	0	0	0	0.1	0.7
Proprietary	858	0.9	0	0.1	0.1	0	0.1	0.8
Government	516	0.9	0	-0.2	-0.2	0.1	0.1	0.5
Medicare Utilization as a Percent of Inpatient Days:								
0-25	517	0.7	0.1	0	-0.4	0.1	0	0.7
25-50	2,128	0.9	0	0	0	0	0.1	0.7
50-65	546	1.1	-0.2	-0.1	0.6	0.1	0.1	0.5
Over 65	94	1.1	-0.3	0.3	-0.5	0.3	0.2	0.9
FY 2017 Reclassifications by the Medicare Geographic Classification Review Board:								
All Reclassified Hospitals	853	0.9	0	0	2.1	-0.1	0	0.6
Non-Reclassified Hospitals	2,477	0.9	0	0	-0.9	0	0.1	0.7
Urban Hospitals Reclassified	576	0.8	0	0	2	-0.1	0	0.5

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Urban Nonreclassified Hospitals	1,879	0.8	0.1	0	-0.9	0.1	0.1	0.7
Rural Hospitals Reclassified Full Year	277	1.6	-0.3	0.1	2.3	-0.2	0	1.0
Rural Nonreclassified Hospitals Full Year	484	1.5	-0.5	0.2	-0.2	-0.1	0.3	0.7
All Section 401 Reclassified Hospitals:	57	1.7	-0.2	0.2	-0.4	0	1.2	1.0
Other Reclassified Hospitals (Section 1886(d)(8)(B))	57	1.2	-0.4	0.1	3	-0.3	0	0.6

[1] Because data necessary to classify some hospitals by category were missing, the total number of hospitals in each category may not equal the national total. Discharge data are from FY 2015, and hospital cost report data are from reporting periods beginning in FY 2012 and FY 2013.

[2] This column displays the payment impact of the proposed hospital rate update and other proposed adjustments including the proposed 1.55 percent adjustment to the national standardized amount and hospital-specific rate (the estimated 2.8 percent market basket update reduced by the 0.5 percentage point for the proposed multifactor productivity adjustment and the 0.75 percentage point reduction under the Affordable Care Act), the -1.5 percent proposed documentation and coding adjustment to the national standardized amount and the proposed adjustment of (1/0.998) to permanently remove the -0.2 percent reduction, and the proposed 1.006 temporary adjustment to address the effects of the 0.2 percent reduction in effect for FYs 2014 through 2016 related to the 2-midnight policy.

[3] This column displays the payment impact of the proposed changes to the Version 34 GROUPER, the proposed changes to the relative weights and the recalibration of the MS-DRG weights based on FY 2015 MedPAR data in accordance with section 1886(d)(4)(C)(iii) of the Act. This column displays the application of the proposed recalibration budget neutrality factor of 0.999006 in accordance with section 1886(d)(4)(C)(iii) of the Act.

[4] This column displays the payment impact of the proposed update to wage index data using FY 2013 cost report data and the OMB labor market area delineations based on 2010 Decennial Census data. This column displays the payment impact of the application of the proposed wage budget neutrality factor, which is calculated separately from the proposed recalibration budget neutrality factor, and is calculated in accordance with section 1886(d)(3)(E)(i) of the Act. The proposed wage budget neutrality factor is 0.999785.

[5] Shown here are the effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB) along with the effects of the continued implementation of the new OMB labor market area delineations on these reclassifications. The effects demonstrate the FY 2017 payment impact of going from no reclassifications to the reclassifications scheduled to be in effect for FY 2017. Reclassification for prior years has no bearing on the payment impacts shown here. This column reflects the proposed geographic budget neutrality factor of 0.988816.

[6] This column displays the effects of the proposed rural and imputed floor based on the continued implementation of the new OMB labor market area delineations. The Affordable Care Act requires the rural floor budget neutrality adjustment to be 100 percent national level adjustment. The proposed rural floor budget neutrality factor (which includes the proposed imputed floor) applied to the wage index is 0.993806. This column also shows the effect of the 3-year transition for hospitals that were located in urban counties that became rural under the new OMB delineations or hospitals deemed urban where the urban area became rural under the new OMB delineations, with a proposed budget neutrality factor of 0.999999.

[7] This column shows the combined impact of the policy required under section 10324 of the Affordable Care Act that hospitals located in frontier States have a wage index no less than 1.0 and of section 1886(d)(13) of the Act, as added by section 505 of Pub. L. 108-173, which provides for an increase in a hospital's wage index if a threshold percentage of residents of the county where the hospital is located commute to work at hospitals in counties with higher wage indexes. These are non-budget neutral policies.

[8] This column shows the proposed changes in payments from FY 2016 to FY 2017. It reflects the impact of the proposed FY 2017 hospital update and the proposed adjustment for documentation and coding. It also reflects proposed changes in hospitals' reclassification status in FY 2017 compared to FY 2016. It incorporates all of the proposed changes displayed in Columns 1 through 6. The sum of these impacts may be different from the proposed percentage changes shown here due to rounding and interactive effects.