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FINAL RULE: MEDICARE INPATIENT HOSPITAL OPERATING AND CAPITAL PAYMENT FOR FISCAL YEAR 2018

SUMMARY

On August 2, 2017, the Centers for Medicare & Medicaid Services (CMS) released its final rule describing federal fiscal year (FY) 2018 policies and rates for Medicare's prospective payment systems for acute care inpatient hospitals (IPPS) and the long-term care hospital prospective payment system (LTCH PPS). The final rule will be published in the *Federal Register* on August 14, 2017. Policies in the final rule will generally take effect on October 1, 2017.

CMS makes many data files available to support analysis of the final rule. These data files are generally available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page-Items/FY2018-IPPS-Final-Rule-Data-Files.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending

Numbered tables that were historically included in the IPPS but are now only available on the CMS website can be found at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page-Items/FY2018-IPPS-Final-Rule-Tables.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending

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

CMS estimates that policies and rates in the final rule will increase combined operating and capital payments to approximately 3,300 acute care hospitals paid under the IPPS of approximately $2.4 billion in FY 2018 compared to FY 2017. This results from an increase of $1.7 billion in IPPS operating payments; an increase of $0.8 billion in uncompensated care payments; an increase of $0.2 billion in IPPS capital payments; and a decrease of $0.3 billion in low volume hospital payments. CMS estimated the increase in the proposed rule would be $3.1 billion. However, the $3.1 billion did not include the estimated decrease of $0.3 billion in low volume hospital payments. The remainder of the reduction is explained by a lower hospital annual update and also by a change in CMS' estimate of uncompensated care payments. The change to uncompensated care payments is explained in detail in section V.G below.

A. Inpatient Hospital Operating Update for FY 2018

The final rule will increase IPPS operating payment *rates* by 1.3 percent on average across all hospitals. The increase reflects an average hospital "applicable percentage increase" of 1.2 percent. Miscellaneous other factors result in CMS estimating that operating payment rates will increase by 1.3 percent.

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

Factor	Percent Change
FY 2018 inflation (market basket) update	2.7
Multifactor productivity adjustment	-0.6
Additional -0.75 percentage point update adjustment required by ACA	-0.75
Documentation and coding adjustment required by 21st Century Cures Act	+0.4588
"2 Midnight" adjustment	-0.6
Net increase in national standardized amounts (before application of budget neutrality factors)	*1.2*

B. Payment Impacts

While the FY 2018 "applicable percentage increase" to the standardized amounts is 1.2 percent (0.75 percent for hospitals that receive payment based on hospital-specific rates), the CMS payment impact analysis shows average per case operating payments increasing 1.3 percent. Importantly, as discussed below, not all policy changes are reflected in this total. For example, increases due to the effects of policy changes related to uncompensated care payments are not included in the 1.3 percent total. The factors that are included in the impact table of the FY 2018 final rule are:

Contributing Factor	**National Percent Change**
FY 2018 increase in final rule payment rates	+1.2
Frontier hospital wage index floor and out-migration wage adjustment	+0.1*
Expiration of MDH Status	-0.1**
Residual	+0.1
Total	*+1.3***

*The frontier hospital wage index floor increases payments about $65 million to 49 hospitals and the out-migration adjustment increases payments about $42 million to 267 providers.
**The MDH program will expire on September 30, 2017. There are currently 159 MDHs, of which CMS estimate 96 would have been paid based on a blend of the hospital-specific rate and the federal rate were the MDH to be continued in FY 2018. CMS estimates expiration of the MDH program will reduce spending $119 million. The MDH program has expired or been scheduled to expire several times previously and has been extended by an Act of Congress either prospectively or retroactive to its expiration date.
*** CMS indicates that there are "interactive effects among the various factors comprising the payment system that [it is] not able to isolate which contribute to [the] estimate of the changes in payments per discharge from FY 2017 and FY 2018."

Table I Impact Analysis

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

Hospital Type	**All Final Rule Changes**
All Hospitals	1.3%
Large Urban	1.4%
Other Urban	1.5%
Rural	0.2%
Major Teaching	1.4%

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

DSH and Uncompensated Care. Payments for DSH and uncompensated care from the final rule policies are estimated to be $1.1 billion higher in FY 2018 than FY 2017, an 11.2 percent

increase. (For the proposed rule, CMS estimated this increase would be $1.4 billion or 14.4 percent). CMS estimates that $800 million of the $1.1 billion increase can be attributed to uncompensated care payments while just under $300 million can be attributed to DSH payments. CMS is also transitioning to a different data source to distribute uncompensated care payments. In the final rule Addendum, an analysis of the DSH/UCP changes are shown for 2,427 hospitals that are projected to be eligible for DSH in FY 2018. See section V.G below for more details as to the components of the change in payment.

Capital. CMS estimates that hospitals will experience a 2.5 percent increase in capital payments per case or about a $220 million in FY 2018 compared to FY 2017.

Hospital Readmissions Reduction Program (HRRP). HRRP will reduce FY 2018 payments to an estimated 2,577 hospitals by $556 million, an increase of $24 million over the estimated FY 2017 savings. The final rule impact section shows the number of hospital affected, the magnitude of the penalty and share of the penalty accounted for by hospital category. The share of the penalty accounted by hospital category is also shown using the current methodology and using the finalized FY 2019 methodology that stratifies hospitals into quintiles based on the proportion of dual eligible beneficiaries.

Hospital Acquired Conditions (HAC). The impact section of the final rule shows the estimated cumulative effect of the measures and scoring system for the HAC by hospital category. CMS does not provide a specific number for the level of savings achieved by the HAC program although it is reasonable to assume that the savings from year-to-year are relatively stable and will not increase in FY 2018 relative to FY 2017 as the payment penalty will always apply to 25 percent of hospitals on an annual basis.

Value Based Purchasing (VBP). The VBP program is budget neutral and will redistribute about $1.9 billion based on hospitals' performance scores. The impact section of the final rule shows how the VBP program redistributes payments by hospital category.

New Technology Add-On Payment (NTAP). CMS estimates that continuing NTAP for four technologies already approved will be approximately $29 million while the three technologies newly approved for NTAP will be $18 million.

Post-Acute Care (PAC) Transfer Policy. CMS is not changing its PAC policy but an additional 3 MS-DRGs will be paid using the special payment transfer policy in FY 2018. CMS does not provide any additional cost or savings in FY 2018 relative to FY 2017.

Volume Decrease Adjustment. CMS estimates that its revised methodology for calculating the volume decrease adjustment will increase spending by $15 million (20 hospitals qualifying receiving $750,000 per hospital)

Low Volume Hospital Adjustment. CMS estimates that expiration of statutory provisions for the low volume hospital adjustment will result in a net reduction of $312 million ($315 million in spending reductions from expiration of the statutory methodology and a $3 million increase due to hospitals receiving the previously established methodology).

Rural Community Hospital Demonstration Program. Implementation of the additional 5-year extension of the Rural Community Hospital Demonstration Program is budget neutral. CMS sets forth the budget neutrality offset methodology but does not provide the specific budget neutrality offset amount.

Indian Health Service and Tribal Facilities and Organizations. CMS indicates the policy in the FY 2018 final rule will have no payment impact because the policy is consistent with CMS' current guidance).

Hospital-within-hospital. As with the above item, CMS indicates there will be no payment impact of its hospital-within-hospital policy in the final rule because the policy is consistent with current CMS guidance.

Frontier Community Health Integration Project (FCIP). FCIP is budget neutral. A budget neutrality adjustment will be made at a later date among all CAHs if later payments are found to exceed payments that would otherwise have been made.

C. IPPS Standardized Amounts for FY 2018

The four rate categories continue in FY 2018:

- Hospital Submitted Quality Data and is a Meaningful EHR User (applicable percentage increase [i.e., before adjustments] = **1.35 percent**
- Hospital did NOT submit quality data and is a meaningful EHR user (applicable percentage increase = **0.675 percent**)
- Hospital submitted quality data and is NOT a meaningful EHR user (applicable percentage increase = **-0.675 percent**)
- Hospital did NOT submit quality data and is NOT a meaningful EHR user (applicable percentage increase = **-1.35 percent**)

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

The updated standardized amounts for the final rule were calculated applying the additional -0.6 percentage point adjustment for the 2-midnight rule (1/1.006) and the 21st Century Cures Act mandated documentation and coding adjustment of +0.4588 percentage points for FY 2018.

Additional budget neutrality adjustments to the standardized amounts are as follows:

- MS-DRG recalibration, 0.997432 (a decrease of 0.026 percent);
- Wage index, 1.001148 (an increase of 0.11 percent);
- Geographic reclassification, 0.988008, a reduction of 1.2 percent; and
- Rural and imputed floor budget neutrality, 0.993348, a reduction of 0.67 percent applied to

hospital wage indices (68.3 percent of total payments for hospitals with a wage index of 1.0 or greater and 62 percent of total payments for hospitals with a wage index of less than 1.0).

- The outlier offset factor is 0.948999, the same as in prior years.

The net increase in the operating standardized amounts from FY 2017 to FY 2018 is 1.1 percent including the IPPS update of 1.35 percent. The increase for documentation and coding (0.4588 percent) is more than offset by the removal of the adjustment for 2-midnight rule (-0.6 percent) taking the net update of 1.35 percent down to about 1.1 percent. The additional 0.15 percent residual in the change to the standardized amount is accounted for by modest differences in budget neutrality adjustments for the change to the labor share and geographic reclassification. The capital rate is increased from $446.79 to $453.97, or 1.6 percent. Taken together the operating plus capital standardized amounts will increase by 1.1 percent from FY 2011 to FY 2017.

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

Effective January 1, 2016, separate standardized amounts for Puerto Rico no longer apply. The separate labor-related share of 62 percent continues for Puerto Rico hospitals and other hospitals with a wage index of less than 1.0. As all CBSAs in Puerto Rico have a wage index that is less than 1.0, the standardized amounts in Table 1C are the same as those in Table 1B for hospitals that submit quality data and are meaningful EHR users. Puerto Rico hospitals are not required to submit quality data and, therefore, are not subject to the penalties for not submitting quality data. However, section 602 of Public Law 114–113 specifies that Puerto Rico hospitals are eligible for incentive payments for the meaningful use of certified EHR technology, effective beginning with FY 2016, and also applies the adjustments to the applicable percentage increase under the statute for Puerto Rico hospitals that are not meaningful EHR users, effective FY 2022. Thus, until FY 2022, the standardized amounts for Puerto Rico hospitals will always be the same as those for hospitals with a wage index of less than 1.0 that have submitted quality data and are meaningful EHR users.

FY 2018 FINAL RULE TABLES 1A-1D

TABLE 1A. NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS; LABOR/NONLABOR (68.3 PERCENT LABOR SHARE/31.7 PERCENT NONLABOR SHARE IF WAGE INDEX IS GREATER THAN 1.0)—FY 2018							
Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 1.35 Percent)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = -0.675 Percent)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 0.675 Percent)		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = - 1.35 Percent)	
Labor	**Nonlabor**	**Labor**	**Nonlabor**	**Labor**	**Nonlabor**	**Labor**	**Nonlabor**
$3,806.04	$1,766.49	$3,729.99	$1,731.20	$3,780.69	$1,754.73	$3,704.65	$1,719.43

TABLE 1B. NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE IF WAGE INDEX LESS THAN OR EQUAL TO 1.0)—FY 2018							
Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 1.35 Percent)		Hospital Submitted Quality Data and is a NOT a Meaningful EHR User (Update = -0.675 Percent)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 0.675 Percent)		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = - 1.35 Percent)	
Labor	**Nonlabor**	**Labor**	**Nonlabor**	**Labor**	**Nonlabor**	**Labor**	**Nonlabor**
$3,454.97	$2,117.56	$3,385.94	$2,075.25	$3,431.96	$2,103.46	$3,362.93	$2,061.15

TABLE 1C. ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR PUERTO RICO, LABOR/NONLABOR (NATIONAL: 62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE BECAUSEWAGE INDEX IS LESS THAN OR EQUAL TO 1)—FY 2018				
	Rates if Wage Index Greater Than 1		Rates if Wage Index Less Than or Equal to 1	
	Labor	Nonlabor	Labor	Nonlabor
National[1]	Not Applicable	Not Applicable	$3,454.97	$2,117.56
[1]For FY 2017, there are no CBSAs in Puerto Rico with a national wage index greater than 1.				

TABLE 1D. CAPITAL STANDARD FEDERAL PAYMENT RATE	
	Rate
National	$453.95

D. Outlier Payments and Threshold

FY 2018 outlier threshold. The FY 2018 fixed-loss threshold will be $26,601, slightly lower than $26,713 for the proposed rule compared to $23,573 in FY 2017.

CMS projects that the final outlier threshold for FY 2018 will result in outlier payments equal to 5.1 percent of operating DRG payments and 5.16 percent of capital payments based on the respective federal rates, and it adjusts the respective operating and capital standardized amounts using the different percentages.

II. Changes to MS-DRG Classifications and Relative Weights

A. FY 2018 Documentation and Coding Adjustment

In FY 2018, CMS is beginning a six-year process required by statute to restore prior payment adjustments removed from the IPPS rates to recoup $11 billion in additional IPPS payments attributable to documentation and coding. As required by the 21st Century Cures Act, CMS proposed and is finalizing an adjustment of +0.4588 percentage points as the FY 2018 installment in the six-year process to restore prior payment adjustments to the IPPS standardized amounts.

B. Recalibration of the FY 2018 MS-DRG Weights

Please see Appendix I for a list of MS-DRGs whose payment increased or decreased by 10% or more.

C. Add-On Payments for New Services and Technologies for FY 2018

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

For FY 2018, CMS finalizes its proposal to discontinue new technology add-on payments for:

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

For FY 2018, CMS finalizes its proposal to continue new technology add-on payments for:

- Defitelio® (Defibrotide) with the maximum new technology add-on payments remaining at $75,900. CMS estimates the FY 2018 add-on payments as approximately $5,161,200 (based on 68 patients).
- GORE®EXCLUDER® Iliac Branch Endoprosthesis (IBE) with the maximum new technology add-on payments remaining at $5,250. CMS estimates the FY 2018 add-on payments as approximately $5,685,750 (based on 1,083 patients).
- Praxbind® (Idarucizumab) with the maximum new technology add-on payments remaining at $1,750. CMS estimates the FY 2018 add-on payments as approximately $14,766,500 (based on 8,438 patients).
- Vistogard™ (Uridine Triacetate) with the maximum new technology payment add-on payment of $40,130, which incorporates the increased pricing provided by the manufacturer. CMS estimates the FY 2018 add-on payments as approximately $3,009,750 (based on 75 patients).

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

For FY 2018, CMS approves the applications for new technology add-on payments for FY 2018:

- *Bezlotozumab (ZINPLAVA™)*: Cases involving ZINPLAVA™ will be identified by ICD-10-PCS codes XW033A3 and XW043A3. The maximum new technology add-on payment amount for a case involving ZINPLAVA™ is $1,900 for FY 2018. Given the FDA's prescribing information about heart failure, CMS expects that ZINPLAVA™ will be reserved for use when the benefit outweighs the risks. CMS estimates the FY 2018 add-on payments as approximately $2,857,600 (based on 1,504 patients).

- *EDWARDS INTUITY Elite™ Valve System (INTUITY) and LivaNova Perceval Valve (Perceval)*: Cases involving the valves will be identified by ICD-10-PCS code X2RF032. CMS calculated a case-weighted average cost of $12,220.46 for the valves. The maximum new technology add-on payment amount for a case involving the INTUITY or Perceval valve is $6.110.23 for FY 2018. CMS estimates the FY 2018 add-on payments as approximately $14,841,749 (based on 2,429 patients).

- *Ustekinumb (Stelara®)*: Cases involving Stelara® will be identified by ICD-10-PCS code XW033F3. The maximum new technology add-on payment amount for a case involving Stelara® is $2,400 for FY 2018. CMS estimates the FY 2018 add-on payments as approximately $400,800 (based on 167 patients).

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

A. Background

CMS finalizes its proposal to transition to using only FIPS codes beginning October 1, 2017, and to use the Census Bureau update changes listed below to calculate area wage indexes consistent with the CBSA-based methodologies finalized in the FY 2015 IPPS/LTCH PPS final rule:

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

CMS states that hospitals located in these counties will not be impacted by these changes; they will continue to be considered rural for the hospital wage index. For FY 2018, tables 2 and 3 of the final rule and the County to CBSA Crosswalk File and Urban CBSAs and Constituent Counties for Acute Care Hospitals file on the CMS Web site reflect the county changes.

B. Worksheet S-3 Wage Data for the FY 2018 Wage Index

The FY 2018 wage index values are based on data from hospital cost reports for cost reporting periods beginning in FY 2014.

C. Method for Computing the FY 2018 Unadjusted Wage Index

The FY 2018 national average hourly wage, unadjusted for occupational mix, is $42.1027. CMS no longer computes a separate unadjusted wage index for Puerto Rico because section 601 of the Consolidated Appropriations Act, 2016 (Public Law 114–113) provided for 100 percent payment based on the national standardized amount for Puerto Rico hospitals.

<u>Clarification of Other Wage-Related Costs in the Wage Index</u>

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

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

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

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

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

CMS notes that wage-related costs reported as salaries on Line 1 (e.g., loan forgiveness or sick pay accruals) should not be included as other wage-related costs on line 18.

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

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

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

The final FY 2018 occupational mix-adjusted national average hourly wage is $42.056. The FY 2018 national average hourly wages for each occupational mix nursing subcategory are as follows:

Occupational Mix Nursing Subcategory	Average Hourly Wage
National RN	$38.86637039
National LPN and Surgical Technician	$22.73227683
National Nurse Aide, Orderly, and Attendant	$15.95002569

Occupational Mix Nursing Subcategory	Average Hourly Wage
National Medical Assistant	$17.96799473
National Nurse Category	$32.856948

CMS observes that, based on its analysis of the occupational mix data, the national percentage of hospital employees in the nurse category is again approximately 43 percent (42.6 percent). The wage index values for FY 2018 increase for a larger percentage of urban areas (54.4 percent) than rural areas (48.9 percent) and decrease for a larger percentage of rural areas (51.1 percent) than urban areas (45.1 percent).

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

Rural Floor. CMS notes that the rural floor will increase the FY 2018 wage index for 366 hospitals. The rural floor policy and imputed rural floor policy are budget neutral. CMS calculates a national rural floor and imputed floor budget neutrality adjustment factor of 0.993348 that CMS projects will reduce payments to rural hospitals by 0.67 percent. Hospitals located in urban areas will not experience any change in payments; however, urban hospitals in the New England region can expect a 1.4 percent increase in payments, primarily due to the application of the rural floor in Massachusetts and the imputed floor in Rhode Island. CMS expects that 36 urban providers in Massachusetts will receive a rural floor wage index value which increases payments overall to Massachusetts by $44 million in FY 2018; Massachusetts hospitals will receive approximately a 1.3 percent increase in IPPS payments. Urban Puerto Rico hospitals will receive a 0.2 percent increase in IPPS payments.

One-year Extension of Imputed Floor Policy

In the FY 2018 IPPS/LTCH PPS proposed rule, CMS proposed to let the temporary imputed floor policy expire effective October 1, 2017, and invited comments on the proposal. CMS does not finalize the proposal; instead, it extends the temporary imputed floor policy for one additional year which will expire effective October 1, 2018.

Under the imputed floor program, CMS imputes a “floor” for states with no rural counties; those states are Delaware, New Jersey and Rhode Island.

Frontier Floor Wage Index. CMS did not propose any changes to the frontier floor wage index policies for FY 2018. 49 hospitals in Montana, Nevada, North Dakota, South Dakota, and Wyoming will receive the frontier floor value of 1.0000 for FY 2018. This provision is not budget neutral, and CMS estimates an increase of approximately $65 million in IPPS operating payments in FY 2018 by reason of the frontier floor. In the West North Central region, rural hospitals will experience an increase in payments by 0.3 percent and payments to urban hospitals will increase by 0.7 percent since many hospitals located in the region are frontier state hospitals.

F. FY 2018 Wage Index Tables

The FY2018 wage index tables 2 and 3 are available here:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-

IPPS-Final-Rule-Home-Page-Items/FY2018-IPPS-Final-Rule-Tables.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending

G. Revisions to the Wage Index Based on Hospital Reclassifications

Reclassifications

The MGCRB approved 374 hospitals for wage index reclassifications starting in FY 2018. Because these reclassifications are effective for 3 years, a total of 865 hospitals are in a reclassification status for FY 2018 (including those initially approved by the MGCRB for FY 2016 (257 hospitals) and FY 2017 (274 hospitals)).

Applications for FY 2019 reclassifications are due by September 1, 2017, which is also the deadline for canceling a previous wage index reclassification withdrawal or termination. Applications for FY 2018 and subsequent years, CMS requires that applications and supporting documentation be submitted to the MGCRB by the method that the MGCRB prescribes, with an electronic copy to CMS. Copies to CMS are sent by email to wageindex@cms.hhs.gov.

Deadline for Submittal of Documentation of Sole Community Hospital (SCH) and Rural Referral Center (RRC) Classification Status to the MGCRB

SCHs and RRCs do not have to demonstrate a close proximity to the area to which they seek reclassification pursuant to §412.230(a)(3).
CMS proposed the following changes to provide greater clarity for hospitals and to provide the MGCRB more time to conduct reviews:

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

CMS does finalize its proposal to specify that a hospital's SCH or RRC status must be approved as of the date of MGCRB review without regard to the effective date of that status. Documentation of the status could include the CMS approval letter; the MGCRB could provide that other documentation may serve the purpose or could require documents in addition to the CMS approval letter. Thus, a hospital with approved SCH or RRC status (or both) does not need to demonstrate close proximity to the area to which it seeks redesignation under §412.230(a)(3)(i), and it qualifies for urban redesignation under §412.230(a)(3)(ii).

CMS also finalizes its proposal that a hospital that was ever approved as an RRC does not have to demonstrate that it meets the average hourly wage criterion under §412.230(d)(1)(i) and only is required to demonstrate that the hospital's average hourly wage is equal to at least 82 percent of the average hospital hourly wage in the area to which it seeks redesignation under §412.230(d)(1)(iv) regardless of its actual location in an urban or rural area.

Clarification of Special Rules for SCHs and RRCs Reclassifying to Geographic Home Area

CMS finalizes its proposal to clarify the regulation so that an SCH or RRC under these circumstances may be redesignated to either the hospital's geographic home area or the closest area outside the hospital's geographic home area. Thus, a hospital with SCH or RRC status (or both) that qualifies for urban redesignation is redesignated to the urban area closest to the hospital or to the hospital's geographic home area. If the hospital is closer to another rural area, it may seek redesignation to either the closest rural or the closest urban area.

Provisions Relating to Lugar Hospitals

In the FY 2012 IPPS/LTCH PPS final rule, CMS established the policy that an eligible hospital that waives its Lugar status to receive the out-migration adjustment is treated as rural for all purposes (including for the rural DSH adjustment) for each fiscal year for which it receives the out-migration adjustment. CMS permits a Lugar hospital to submit a single notice to automatically waive its deemed urban status for the 3-year period of the out-migration adjustment; however, the hospital before its second or third year of eligibility may notify CMS that it no longer seeks the out-migration adjustment and instead elects to return to its deemed urban status.

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

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

Changes to 45-Day Notification Rules

CMS proposed to change the start date of the 45-day period to the date of the public display copy of the hospital IPPS proposed rule at the *Federal Register* and sought comment.

CMS finalizes most of its proposals as follows:

- Under §§412.64(i)(3)(iii) and 412.211(f)(3)(iii), hospitals may waive application of the out-migration wage index adjustment by notifying CMS within 45 days of the public display of the IPPS proposed rule.
- Lugar hospitals that qualify for and accept the out-migration adjustment (or elect to return to deemed urban status) must notify CMS within 45 days of the public display of the IPPS proposed rule.

CMS does not finalize its proposal with respect to requests to terminate or withdraw MGCRB reclassifications because the proposed 45-day period beginning on the date of public display of the IPPS proposed rule does not take into account the time for CMS to adjudicate appeals of MGCRB decisions. Instead, CMS revises the regulations at §§412.273(c)(1)(ii) and 412.273(c)(2) to clarify current policy that a request for termination or withdrawal of an MGCRB reclassification must be received by the MGCRB within 45 days of the issuance (i.e., publication) in the *Federal Register* of the IPPS proposed rule.

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

Table 2 associated with the final rule lists the out-migration wage index adjustments for FY 2018. CMS finalizes its proposal to use the same policies, procedures and computation that were used for the FY 2012 out-migration adjustment, and estimates increased payments of approximately $42 million in FY 2018 for 267 hospitals receiving the out-migration adjustment.

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

CMS clarifies that a hospital's application for RRC status must be submitted during the last quarter of the cost reporting period before the first quarter of the hospital's cost reporting year. If the application is approved, RRC status takes effect beginning with the hospital's cost reporting period occurring after the last quarter of the cost reporting period in which the hospital submits an application.

CMS also clarifies that while applications for urban-to-rural reclassification under §412.103 may be submitted at any time, a hospital seeking RRC status based on a rural reclassification under §412.103 must still submit the application for RRC status during the last quarter of its cost reporting period before the next cost reporting period.

J. Process for Requests for Wage Index Data Corrections

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

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

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

K. Labor Market Share for the FY 2018 Wage Index

CMS is finalizing its proposal to revise the national labor-related share of the IPPS standardized amounts from 69.6 percent to 68.3 percent. Hospitals with a wage index of 1.0 or less will receive a labor-rated share of 62 percent while hospitals with a wage index of greater than 1.0 will receive the national labor-related share.

The current labor-related share is 69.6 percent using an FY 2010-based IPPS market basket. CMS proposed, and is adopting as final, a policy to rebase and revise the IPPS market basket reflecting 2014 data for discharges occurring on or after October 1, 2017. The 2014-based IPPS market basket has a labor-related share of 68.3 percent. CMS proposed, and is adopting as final, a policy that the revised labor-related share be implemented in a budget neutral manner, but in doing so it assumes all hospitals receive the higher labor-related share of the standardized amount.

IV. Other Decisions and Changes to the IPPS

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

CMS is finalizing its proposal to add MS-DRGs 984, 985 and 986 to the list of MS-DRGs subject to the special payment transfer policy.

These MS-DRGs are being added to the list of special payment transfer policy MS-DRGs as a result of MS-DRGs 984, 985, and 986 (Prostatic O.R. Procedure Unrelated to Principal Diagnosis with MCC, with CC and without CC/MCC, respectively) being deleted. CMS is reassigning the procedure codes currently assigned to these three MS-DRGs to MS-DRGs 987, 988, and 989 (Non-Extensive O.R. Procedure Unrelated to Principal Diagnosis with MCC, with CC and without CC/MCC, respectively). MS-DRGs 987, 988, and 989 are currently subject to the post-acute care transfer policy and will be newly subject to the MS-DRG special payment methodology.

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

For cost reporting periods beginning on or after October 1, 2017, CMS proposed to change how MACs calculate the volume decrease adjustment for SCHs (and for MDHs if Congress extends the MDH program past September 30, 2017, when it is set to expire). CMS finalizes its proposal with a clarifying change to the regulation text. Under the new methodology for calculating the volume decrease, MACs will compare estimated Medicare revenue for fixed costs to the hospital's fixed costs.

To calculate the volume decrease adjustment, MACs will multiply (i) the difference between the hospital's fixed Medicare inpatient operating costs and the hospital's total MS-DRG revenue based on MS-DRG-adjusted prospective payment rates for inpatient operating costs (including payments for outlier, DSH, and IME costs) by (ii) the ratio of the hospital's fixed inpatient operating costs to its total inpatient operating costs, in the cost reporting period when the hospital experienced the volume decrease. By taking the ratio derived from the subset of fixed costs to total costs and applying the same ratio to the MS-DRG payment, CMS states that the sum of a hospital's IPPS payment and its volume decrease adjustment payment would never exceed its total Medicare inpatient operating costs. Accordingly, CMS removes the cap calculation from the volume decrease adjustment calculation.

Effective for cost reporting periods beginning on or after October 1, 2017, CMS also finalizes its proposal to no longer require a hospital to explicitly demonstrate that it appropriately adjusted the number of staff in inpatient areas of the hospital based on the decrease in the number of inpatient days. MACs are no longer required to adjust the volume decrease adjustment payment amount for excess staffing.

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

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

- Have a CMI value for FY 2016 that is at least—
  - 1.6638 (national—all urban), or
  - The median CMI value (not transfer adjusted) for urban hospitals (excluding hospitals with approved teaching programs) calculated by CMS for the census region in which the hospital is located.

(The final CMI value is based on the updated MedPAR FY 2016 file which includes bills received through March 2017.)

- Have as the number of discharges for its cost reporting period that began during FY 2015 at least—
  - 5,000 (3,000 for an osteopathic hospital), or
  - The median number of discharges for urban hospitals in the census region in which the hospital is located.

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

As of the date of the final rule, Congress has not extended or made permanent the ACA-revised criteria. Thus, beginning with FY 2018, the preexisting low-volume hospital payment adjustment and qualifying criteria resume. Specifically, for a hospital to qualify for the low-volume payment adjustment, the road mileage qualifying criterion reverts to 25 miles from the nearest subsection (d) hospital, and the discharge qualifying criterion reverts to no more than 200 total discharges—Medicare and non-Medicare.

While section 1886(d)(12)(C)(i) of the Act defines a low-volume hospital as having less than 800 discharges, CMS concluded in the FY 2005 IPPS final rule that a 25-percent low-volume adjustment to discharges of all qualifying hospitals with less than 200 discharges was most consistent with the mandate in section 1886(d)(12)(B)(i) of the Act to provide relief for low-volume hospitals where there is empirical evidence that higher incremental costs are associated with low numbers of discharges. Thus, hospitals with more than 200 discharges will not receive the low-volume adjustment in FY 2018. The number of discharges is determined using a hospital's most recently submitted cost report.

A hospital seeking this adjustment must provide written notice and sufficient documentation to its MAC that it meets the discharge and distance requirements applicable for FY 2018 by not later than September 1, 2017, for the adjustment to apply to discharges occurring during FY 2018. A hospital that qualified as a low-volume hospital for FY 2017 may continue to receive the adjustment in FY 2018 without reapplying if it continues to meet the applicable mileage and discharge criteria (for FY 2018, the pre-ACA criteria). The hospital must send written verification (e.g., using a Web-based mapping tool) to its MAC by September 1, 2017 that it continues to meet the mileage criterion. For requests submitted after September 1, 2017, that are approved, the adjustment will apply prospectively to discharges within 30 days after the MAC approval date.

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

Pursuant to statute[1], for discharges occurring in FY 2018, CMS continues to apply the IME adjustment factor of 5.5 percent for every approximately 10-percent increase in a hospital's resident-to-bed ratio.

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

1. Uncompensated Care Payments

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

The statute provides that the uncompensated care portion of the DSH payment amount for each DSH hospital is the product of three factors:

1. Factor 1 equals 75 percent of the aggregate DSH payments that would be made under section 1886(d)(5)(F) without application of the DSH changes made by the ACA;
2. Factor 2 reduces the amount based on the ratio of the percent of the population who are insured in the most recent period following implementation of the ACA to the percent of the population who were insured in a base year prior to ACA implementation; and

[1] See section 1886(d)(5)(B) of the Act which provides for an IME formula multiplier of 1.35 for discharges occurring on or after October 1, 2007.

3. Factor 3 is determined by a hospital's uncompensated care amount for a given time period relative to the uncompensated care amount for that same time period for all hospitals that receive Medicare DSH payments in that fiscal year, expressed as a percentage.

Factor 1

The June 2017 OACT estimate for Medicare DSH payments for FY 2018, before application of the ACA reduction, is $15.533 billion. The final rule reports that empirically justified Medicare DSH payments for FY 2018 after the ACA reduction is $3.388 billion (25 percent of the total amount estimated for DSH). CMS then states the **FY 2018 Factor 1 amount would be about $11.665 billion ($15.553 billion minus $3.388 billion).**[2] Factor 1 for FY 2018 is about $870 million more than the final Factor 1 for FY 2017. In the FY 2018 proposed rule, CMS estimated that Factor 1 would be $1.2 billion more than the Factor 1 for FY 2017.

Factor 2

Factor 2 is based on the percent change in the uninsured since implementation of the ACA. For FYs 2014 through 2017, the statute required Factor 2 to equal the percent change in the number of individuals under the age of 65 who are uninsured from 2013 until the most recent period for which data are available minus 0.1 percentage points for fiscal year 2014 and minus 0.2 percentage points for each of fiscal years 2015, 2016, and 2017. For FYs 2014-2017, the statute required CMS to use CBO's estimate of the uninsured rate in the under 65 population from before enactment of the ACA for FY 2013. At the time, CBO estimated that 18 percent of the under 65 population would be uninsured in FY 2013. CMS consistently used CBO estimates of the rate of uninsured in the under 65 population for the most recent year estimate. For FY 2017, CBO estimated 10 percent of the under 65 population is uninsured.

For FY 2018 and subsequent years, the statute provides greater flexibility in the choice of the data sources to be used in the estimate of the change in the percent of the uninsured. Further, the statute no longer restricts this estimate to the under 65 population. This data source can be based on data from the Census Bureau or other sources the Secretary determines appropriate, and certified by the Chief Actuary of CMS. CMS determined that the source that, on balance, best meets all of these considerations is the uninsured estimates produced by CMS' OACT as part of the development of the National Health Expenditure Accounts (NHEA).
CMS is finalizing without change its proposal to use NHEA in place of CBO data as the source of change in the uninsured population used in Factor 2.

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

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

[2] CMS confirmed that the first figure, $15.533, is a typographical error and should be $15.553 billion as reported later in the same paragraph. The remaining figures for 25 percent of this amount ($3.888 billion) and 75 percent of DSH ($11.665 billion) are consistent with 100% of DSH being $15.553 billion.

Percent of individuals without insurance for CY 2013: 14 percent.
Percent of individuals without insurance for CY 2017: 8.3 percent.
Percent of individuals without insurance for CY 2018: 8.1 percent.
Percent of individuals without insurance for FY 2018 (0.25 times 0.083) +(0.75 times 0.081): 8.15 percent

1-|((0.0815-0.14)/0.14)| = 1- 0.4179 = 0.5821 (58.21 percent)
0.5821 (58.21 percent) - .002 (0.2 percentage points for FY 2018 under section 1886(r)(2)(B)(ii) of the Act) = 0.5801 or 58.01 percent
0.5801= Factor 2

Thus, **CMS calculated Factor 2 for the FY 2018 final rule to be 0.5801, or 58.01 percent, and the final uncompensated care amount for FY 2018 to be $11.664 billion X 0.5801 = $6.767 billion**, which is about $800 million more than the FY 2017 uncompensated care payment total of about $5.977 billion; the percentage increase is 13.2 percent.

Factor 3

a. Data Sources for FY 2018

FY 2018 IPPS/LTCH Rule: CMS is incorporating Worksheet S-10 data from FY 2014 into the calculation of Factor 3 of the uncompensated care payment beginning with FY 2018.

CMS is finalizing its proposed decision with the following changes:

- Aberrant Data. Uncompensated care costs in excess of 50 percent of a hospital's total operating expenses will be considered aberrant. If the hospital's FY 2014 uncompensated costs exceed 50 percent of its total operating expenses, CMS will apply the ratio of the hospital's uncompensated care costs to total operating expenses in FY 2015 to its FY 2014 total operating expenses to determine the hospital's FY 2014 uncompensated care costs. Three hospitals will be affected by this adjustment using FY 2014 cost report data.
- Auditing of Cost Reports. In the proposed rule, CMS indicated that FY 2017 cost reports will be the first cost reports for which the Worksheet S-10 will be subject to a desk review. In the final rule, CMS states, "we expect cost reports beginning in FY 2014, FY 2015 and FY 2016 to be subject to further scrutiny after submission."
- Submission of Cost Reports. CMS has provided hospitals with an opportunity to resubmit FY 2014 and FY 2015 cost reports containing Worksheet S-10 to their local Medicare Administrative Contractor (MAC). The deadline for these resubmissions is September 30, 2017. CMS notes that a resubmitted FY 2014 Worksheet S-10 will not be used in determining a hospital's uncompensated care payments for FY 2018 but may be used in determining future year uncompensated care payments.

b. Time Period for Calculating Factor 3 for FY 2018, Including Methodology for Incorporating Worksheet S-10 Data

CMS proposed to continue to use the methodology finalized in FY 2017 and to compute Factor 3 using an average of data from three cost reporting periods instead of one cost reporting period.

However, rather than using the low-income patient days proxy for all three years, CMS proposed to use to use Worksheet S-10 data for FY 2014 and the low-income days proxy for FY 2012 and FY 2013 based on Medicaid days from FYs 2012 and 2013 cost reports and FYs 2014 and 2015 SSI ratios. CMS notes if it were to continue this approach for FYs 2019 and 2020, this would have the effect of transitioning the incorporation of data from Worksheet S-10 into the calculation of Factor 3. By 2020, the calculation of Factor 3 would be solely determined by data from Worksheet S-10.

CMS is finalizing its proposed policy. CMS notes that while it expects to carry forward the transition schedule it discussed for incorporating Worksheet S-10 data into the uncompensated care distribution methodology, its decision in the final rule only applies to FY 2018 and it would be premature to establish policies for future years in this year's final rule.[3]

Final Rule Methodology: For FY 2018, the computation of the average Factor 3 for each hospital would work in the following way:

Step 1: Calculate Factor 3 using the low-income insured days proxy based on FY 2012 cost report data and the FY 2014 SSI ratio;
Step 2: Calculate Factor 3 using the insured low-income days proxy based on FY 2013 cost report data and the FY 2015 SSI ratio;
Step 3: Calculate Factor 3 based on the FY 2014 Worksheet S-10 data (or using the Factor 3 calculated in Step 2 for Puerto Rico, IHS/Tribal hospitals and all-inclusive rate hospitals); and
Step 4: Average the Factor 3 values that are computed in Steps 1, 2, and 3; that is, adding the Factor 3 values from FY 2012, FY 2013, and FY 2014 for each hospital, and dividing that amount by the number of cost reporting periods with data to compute an average Factor 3.

Other Decisions:

New Hospitals: Any hospital that is new after October 1, 2014 will not receive either interim empirically justified Medicare DSH payments or interim uncompensated care payments. If the hospital is later determined to be eligible to receive empirically justified Medicare DSH payments based on its FY 2018 cost report, the hospital will also receive an uncompensated care payment using uncompensated care costs reported on Worksheet S-10 of the hospital's FY 2018 cost report.

Mergers: For FY 2018, CMS is continuing its policies from the FY 2015 IPPS/LTCH PPS final rule to address specific issues regarding the process and data to be employed in determining Factor 3 in the case of hospital mergers. CMS publishes a table on the CMS Web site, in conjunction with the issuance of each fiscal year's proposed and final IPPS rules, containing a list of the mergers known to CMS and the computed uncompensated care payment for each merged hospital. Hospitals have 60 days from the date of public display of each year's proposed rule to review the tables and notify CMS in writing of any inaccuracies. Hospitals will have until August 31, 2017, to review and submit comments on the accuracy of the table and supplemental data file published in

[3] CMS emphasizes that it is not making any policy decisions for future years. However, the rules have implied that the CMS' planned implementation schedule is to use low-income patient days from FY 2012 and FY 2013 cost reports and Worksheet S-10 data from FY 2014 to allocate FY 2018 uncompensated care payments. For FY 2019, it would switch to two years of Worksheet S-10 data (FY 2014 and FY 2015) and one year of low income patient days (FY 2013 cost report). For 2020, it would use three years of Worksheet S-10 data (FY 2014 to FY 2017).

conjunction with the final rule. Comments may be submitted to the CMS inbox at Section3133DSH@cms.hhs.gov.

Factor 3 Information: Tables published on the CMS website for the FY 2018 final rule list Factor 3 levels for all hospitals that CMS projects will receive empirically justified DSH payments and interim uncompensated care payments in FY 2018. The table also includes Factor 3 levels for the remaining IPPS hospitals that have the potential of receiving a DSH payment in the event that they receive an empirically justified DSH payment for FY 2018 as determined at cost report settlement. Hospitals have until August 31 to review the tables and notify CMS in writing of a change in a hospital's subsection (d) hospital status, such as if a hospital has closed or converted to a CAH.[4]

Interim and Final Payments: CMS will continue to make interim uncompensated care payments in FY 2018 on a per-discharge basis. The estimated per-discharge amount, which is fixed for a particular hospital and does not vary by case mix, is based on the amount of the uncompensated care payment that CMS calculates for a hospital for a fiscal year divided by the average number of discharges, or claims, in the most recently available three fiscal years of the Medicare claims dataset.

Cost report settlement will not include reconciliation of the values of Factors 1, 2, or 3 established in the final rule. Reconciliation will only include adjustments for changes in whether the hospital is actually eligible to receive empirically justified DSH payments. The MAC will recoup payments from hospitals that received interim payments but were determined at cost report settlement not to be eligible. Similarly, for a hospital that does not receive interim payments for its empirically justified DSH payments and therefore no uncompensated care payments but at cost report settlement is determined to be eligible for DSH payments, the MAC will calculate the uncompensated care payment for the hospital based on the Factor 3 value determined prospectively and published with the final rule.

Methodological Considerations for Incorporating Worksheet S-10 Data

Definition of Uncompensated Care. CMS proposed to define "uncompensated care" as charity care plus non-Medicare bad debt. Specifically:

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

[4] Final rule tables on each hospital's Factor 3, information on mergers and other information are included in file #9 at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page-Items/FY2018-IPPS-Final-Rule-Data-Files.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending. Comments on the accuracy of the table and supplemental data files can be submitted to the CMS inbox at Section3133DSH@cms.hhs.gov

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

CMS proposed to exclude Medicaid shortfalls reported on Worksheet S-10 from the definition of uncompensated care for purposes of calculating Factor 3.

CMS is finalizing its decision without change but indicates that it will consider many of the issues raised in the public comments as it seeks to improve the Worksheet S-10 and its instructions.

Worksheet S-10 audits. CMS notes that the instructions are still under development and will be provided to the MACs as soon as possible. CMS expects that cost reports beginning in FY 2017 will be the first cost reports for which the Worksheet S-10 data will be subject to a desk review. However, CMS indicates that it expects cost reports beginning in FY 2014, FY 2015, and FY 2016, to be subject to further scrutiny after submission. CMS lists a variety of issues raised in the public comments in addition to those raised above regarding the Worksheet S-10 form and instructions. CMS again indicates that it will continue to work with stakeholders to address their concerns through provider education and further refinement of the instructions to the Worksheet S-10.

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

Section 205 of MACRA extended the MDH Program through the end of FY 2017. Legislation extending or making the MDH program permanent has not been enacted into law by the date of the final rule. Thus, for discharges occurring on or after October 1, 2017, all hospitals that previously qualified for MDH status will be paid based on the Federal rate.

Current regulations at §§412.92(b)(2)(i) and (b)(2)(v) allow an MDH to apply for SCH status before the MDH program expires and make that SCH status, if approved, effective the day after the expiration of the MDH program. CMS notes that for an MDH to receive SCH status effective October 1, 2017, it must apply for SCH status at least 30 days before the MDH program expires (i.e., before September 1, 2017). The MDH must also specify in the request that if approved as an SCH, the SCH status would be effective October 1, 2017. If the MDH applies after the September 1, 2017, deadline, the usual effective date rules for SCH status would apply (i.e., 30 days after the date of CMS' written notice of approval).

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

1. HRRP Policies for FY 2018

In general, for FY 2018 CMS retains the same six conditions and the same methodology for calculating the HRRP reduction (summarized in the text box below).

Applicable Period. Excess readmissions ratios and the payment adjustment (including aggregate payments for excess readmissions and aggregate payments for all discharges) for FY 2018 will be based on data from the 3-year period of July 1, 2013 through June 30, 2016 (the "applicable period"). For the final rule, the March update of each of the respective fiscal year MedPAR files is used.

Extraordinary Circumstances Exceptions. Hospitals may request an exception to the HRRP under extraordinary circumstances. CMS finalizes three changes to the HRRP extraordinary circumstances exceptions policies to align it with the hospital IQR program.

- Requests do have to be signed by the facility's CEO, but may instead be signed by another appropriate designated contact.
- CMS indicates it will strive to complete reviews of extraordinary circumstances exception requests within 90 days of receipt.
- If CMS determines that a systemic problem with its data collection systems directly affected the ability of facilities to submit data, it may grant exceptions to affected facilities and communicate this decision through routine communication channels.

FORMULAS TO CALCULATE THE READMISSIONS ADJUSTMENT FACTOR FOR FY 18

Excess Readmissions Ratio (ERR): is calculated for each HRRP measure as the ratio of predicted-to-expected readmissions.

- **Predicted readmissions** are the number of unplanned readmissions predicted for a hospital based on the hospital's performance with its case mix and its estimated effect on readmissions (known as the hospital-specific effect, which is provided in the hospital's discharge-level data). Predicted readmissions are also referred to as "Adjusted Actual Readmissions" in Section 3025 of the Affordable Care Act.
- **Expected readmissions** are the number of unplanned readmissions expected for a hospital based on an average hospital's performance with the hospital's case mix and the average hospital effect (provided in the hospital's discharge-level data).

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

- Note: If a hospital's ERR for a condition is ≤ 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 2018 is the higher of the ratio or 0.9700.

Calculated using claims data from July 1, 2013 to June 30, 2016 for FY 2018.

2. Payment Adjustment Methodology for FY 2019

The 21st Century Cures Act (P.L. 114-255) requires the Secretary to assign hospitals to peer groups based on the proportion of Medicare inpatients who are full-benefit Medicare and

Medicaid dual eligibles,[5] and to develop a methodology that allows for separate comparisons of readmissions rates for hospitals within these groups.

Identification of dual eligibles. CMS finalizes its proposal to identify dual eligible beneficiaries using data from the Medicare Modernization Act (MMA) file of dual eligibility, which states submit monthly to CMS. This file is also used for administration of Part D benefits. A beneficiary will be counted as a full-benefit dual patient if they are identified as having full-benefit dual status in the state MMA files for the month during which they were discharged from the hospital.

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

Data period. The HRRP 3-year applicable period will be used in calculating the proportion of dual eligible stays.

Assigning Hospitals to Peer Groups. CMS finalizes its proposal to group hospitals by quintiles (five peer groups).

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

Current payment adjustment (P) =

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

Specifically, CMS adopts its preferred approach to replace the current standard of 1.000 with the median ERR for the hospital's peer group. The following equation shows the finalized formula, where NM_M is a budget neutrality factor (neutrality modifier) that is the same across all hospitals and all conditions.

$$P = 1 - \min\{.03, \sum_{dx} \frac{NM_M * Payment(dx) * \max\{(\text{ERR(dx)} - \text{Median peer group ERR(dx)}), 0\})}{All\ payments}\}$$

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

3. Impact Analysis

In the regulatory impact analysis appended to the final rule, CMS estimates that 2,577 hospitals will be penalized under the HRRP in FY 2018; with reductions totaling $566 million, $24 million more than the estimated savings for FY 2017. These estimate relies on the FY 2018 readmission adjustment factors found in Table 15 on the CMS IPPS FY 2018 final rule web page: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page-Items/FY2018-IPPS-Final-Rule-Tables.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending.

A table in the impact analysis section shows the distribution of HRRP penalties (dollars and percent of payments) by type of hospital. The groups for which HRRP penalties show as the lowest percentages of payment are those with Medicare utilization of 24 percent or less (0.42%) and hospitals in the Mountain region (0.44%). Highest percentages are shown for proprietary hospitals (0.87%) and hospitals in the East South Central region (0.81%).

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

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

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

1. VBP Payment in FY 2018

Based on the March 2017 update of the FY 2016 MedPAR file, CMS estimates that the total amount available for VBP Program payments in FY 2018 is approximately $1.9 billion. This reflects the requirement that for FY 2018 VBP Program payments equal 2.0 percent of base operating DRG payments.

CMS has posted on the FY 2018 IPPS final rule web page a Table 16A which includes proxy hospital-specific value-based incentive payment adjustment factors for FY 2018. These proxies are based on hospitals' TPSs from the FY 2017 Hospital VBP Program and reflect changes based on the March 2017 update to the FY 2016 MedPAR file. They will not be used for 2018 payment. After hospitals have been given an opportunity to review and correct their actual TPSs for FY 2018 (expected in October 2017), CMS will add Table 16B to display the actual value-based incentive payment adjustment factors, exchange function slope, and estimated amount available for the FY 2018 program year.

2. Removal of the PSI 90 Measure for FY 2019

CMS adopts its proposal to remove the PSI 90 composite patient safety measure from the VBP Program beginning with FY 2019 payment. The reason for the removal of PSI 90 is that an ICD-

10 version of the current measure is not being developed, which means that CMS could not calculate performance scores for this measure for FY 2019.

3. New Measure for FY 2022

Beginning with FY 2022 payment, CMS finalizes addition of a hospital-level, risk standardized 30-day pneumonia episode of care payment measure to the VBP Program. The VBP Program performance period will begin in August 2018. The final rule discusses the specifications for this measure, which are similar to the 30-day payment measures for AMI and HF previously adopted for the VBP Program beginning with FY 2021 payment. Scoring for the new measure will use the same methodology used for the AMI and HF measures and the MSPB. Measure specifications are available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html.

As proposed, for FY 2022, a 36-month baseline period (July 1, 2013-June 30, 2016) and a 23-month performance period (August 1, 2018-June 30, 2020) will be used for this measure. The shorter performance period permits the measure to be adopted sooner

For FY 2023, the performance period will be expanded to 35 months (August 1, 2018-June 30, 2021) and the 36-month baseline period will remain July 1, 2013-June 30, 2016. A full 36-month performance period will begin for FY 2024, defined as beginning on July 1st 5 years prior to the applicable fiscal year and ending on the June 30th 2 years prior. The baseline period will begin July 1st 10 years prior to the applicable fiscal year and end on the June 30th 7 years prior.

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

CMS finalizes its proposal to add the Agency for Healthcare Research and Quality (AHRQ) Patient Safety and Adverse Events composite measure (NQF#0531) to the VBP Program beginning with FY 2023. This measure is also referred to as "modified PSI 90," and was adopted for the IQR Program beginning with the FY 2018 payment determination. This measure is a composite of 10 AHRQ patient safety indicators[6]. For measure specifications, CMS directs readers to the AHRQ website at:
https://www.qualityindicators.ahrq.gov/Modules/PSI_TechSpec_ICD09_v60.aspx
(An ICD-10 specified version of this measure does not yet appear to be publicly available; the proposed rule does not address this issue.)

For FY 2023, CMS adopts a 21-month baseline period for this measure (October 1, 2015-June 30, 2017) and a 24-month performance period (July 1, 2019-June 30, 2021). For FY 2024 and subsequent years, the baseline and performance periods will be 24 months. The baseline period will begin on July 1st 8 years prior to the payment year and end on the June 30th 6 years prior. (For

[6] The ten indicators included in the modified PSI 90 composite measure are: PSI-3 (pressure ulcer rate), PSI-6 (iatrogenic pneumothorax rate), PSI-8 (postoperative hip fracture rate), PSI-9 (postoperative hemorrhage or hematoma rate), PSI-10 (physiologic and metabolic derangement rate), PSI-11 (postoperative respiratory failure rate), PSI-12 (PE/DVT rate), PSI-13 (postoperative sepsis rate), PSI-14 (wound dehiscence rate), and PSI-15 (accidental puncture or laceration rate).

example, for 2024 the baseline period will be July 1, 2016-June 30, 2018.) The performance period will begin on July 1st 4 years prior to the payment year and end on the June 30th 2 years prior.

5. Performance and Baseline Periods

CMS previously adopted performance and baseline periods for most VBP Program measures based on length; the specific time periods are therefore automatically updated each year. The final rule includes tables (not reproduced here) that display the baseline and performance periods for each fiscal year beginning with 2019 through 2023.

In this rule, two changes are made related to baseline and performance periods in addition to the periods described above for the newly-finalized measures. First, for the HF and AMI payment measures, CMS previously adopted a 24-month performance period and a 36-month baseline period for FY 2021 and a 36-month baseline and performance periods for FY 2022. In this rule, CMS finalizes that for FY 2023 and future years, a 36-month performance period will be used that runs from July 1st five years prior to the program year to June 30th two years prior to the program year. The 36-month baseline period will begin July 1st 10 years prior to the program year and end June 30th 7 years prior.

Second, for the five previously adopted measures in the clinical care domain, CMS adopts baseline and performance periods of 36 months for FY 2023 and later years. Specifically, for the mortality measures (including the pneumonia mortality measure with the updated cohort), for FY 2023 the baseline period will begin on July 1st of the year 10 years prior to the payment year and end on June 30th of the year 7 years prior. The performance period will begin July 1st of the year 5 years prior to the payment year and end on June 30th of the year 2 years prior. For the THA/TKA complications measure, the baseline and performance periods will be the same except that they would begin on April 1st of the applicable year and end on March 31st three years later.

6. Performance Standards

The final rule includes tables that displays the previously adopted and newly finalized numeric performance standards for VBP Program measures for FYs 2020-2023. These tables are available in Appendix II at the end of the summary. For measures in the efficiency and cost reduction domain, performance standards are based on performance period data and therefore numeric standards for these measures cannot be published in advance. The final standards were updated from the proposed rule using more recent data.

7. Scoring Methodology

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

Several changes to domain scoring policies are made beginning in FY 2019. First, for the Safety domain, the number of measures for which a hospital must have a score to receive a domain score is reduced from three to two measures. This reflects the removal of the PSI 90 safety composite measure from that domain.

Second, hospitals currently must have a score for the MSPB measure in order to receive a score for the Efficiency and Cost Reduction domain. CMS modifies that requirement to allow hospitals with a score for any one of the domain measures to receive a domain score. This reflects the previously finalized addition of two measures to this domain beginning in FY 2021 and the addition of another measure in this rule to begin in FY 2022.

Third, the current case minimums for each measure are generally retained. However, the Patient Safety and Adverse Events composite (modified PS 90) included in FY 2023, requires at least three reported cases on any one component indicator during the baseline period in order to receive an improvement score and three cases on any component indicator during the performance period in order to receive an achievement score. These are the same minimums that apply to the current PSI 90 measure.

In addition, for the Efficiency and Cost Reduction domain measures, CMS finalizes that hospitals must report at least 25 cases per measure to receive a measure score beginning with FY 2021.

Fourth, CMS finalizes that the MSPB measure will receive a weight of 50 percent and the other condition-specific payment measures will account for the remaining 50 percent. If a hospital only meets the case minimum for the MSPB measure, that measure will receive a weight of 100 percent. If a hospital does not meet the case minimum for the MSPB measure, but meets the minimum for at least one of the condition-specific measures, these measures would be given a weight of 100 percent, with multiple measures being weighted equally.

The result of these policies and the overall 25 percent domain weight means that for a hospital with a score for the MSPB measure, that measure will constitute between 12.5 and 25 percent of the hospital's TPS.

Summary Table VBP-1: Measures and Domains for selected payment years						
Measure	**2017**	**2018**	**2019/ 2020**	**2021**	**2022**	**2023**
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	X
Heart Failure (HF) 30-day mortality rate	X	X	X	X	X	X
Pneumonia (PN) 30- day mortality rate	X	X	X	X	X	X
Complication rate for elective primary total hip arthroplasty/total knee arthroplasty			X	X	X	X
Chronic Obstructive Pulmonary Disease (COPD) 30-day mortality rate				X	X	X
CABG 30-day mortality rate					X	X
Safety						
AHRQ PSI–90 patient safety composite	X	X	Removed			
Patient Safety and Adverse Events composite						X
Central Line Associated Blood Stream Infection (CLABSI)	X	X	X	X	X	X
Catheter Associated Urinary Tract Infection (CAUTI)	X	X	X	X	X	X
Surgical Site Infection: Colon Abdominal hysterectomy	X	X	X	X	X	X
Methicillin-Resistant Staphylococcus Aureus (MRSA) Bacteremia	X	X	X	X	X	X
Clostridium Difficile infection (CDI)	X	X	X	X	X	X
Perinatal Care: elective delivery < 39 completed weeks gestation (moved from Clinical Care – Process)	In Clinical Care – Process domain	X	X	X	X	X

Patient and Caregiver Centered Experience of Care/Care Coordination *(Person and Community Engagement)*						
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)						
8 Dimensions: • Communication with Nurses • Communication with Doctors • Responsiveness of Hospital Staff • Pain Management (before 2018) * • Communication About Medicines • Cleanliness and Quietness of Hospital Environment • Discharge Information • Overall Rating of Hospital • 3-Item Care Transition measure (beginning 2018)	X	X	X	X	X	X
Efficiency and Cost Reduction						
Medicare Spending per Beneficiary	X	X	X	X	X	X
AMI payment per 30-day episode				X	X	X
HF payment per 30-day episode				X	X	X
Pneumonia (PN) payment per 30-day episode					X	X
*The pain management component of HCAHPS was removed beginning with the FY 2018 payment determination.						

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

CMS adopts time periods for the FY 2020 HAC Reduction Program and modifies changes to the extraordinary circumstances exceptions beginning in FY 2018. Comments received in response to specific solicitations in the proposed rule are described.

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

For FY 2020, CMS finalizes that a two-year period will be used for all the program measures. Under the finalized policy, for FY 2020 the Domain 1 Patient Safety and Adverse Events composite measure will have a data collection period of July 1, 2016 through June 30, 2018. For the CDC NHSN measures in Domain 2, the two-year period will be calendar years 2017 and 2018.

Summary Table: HAC Reduction Program Measures, Performance Periods, and Domain Weights						
	FY 2015	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**
Domain 1: AHRQ Patient Safety Indicators						
PSI-90 composite (see note)	X	X	X			
Patient Safety and Adverse Events Composite/modified PSI 90 (see note)				X	X	X
Applicable Time Period/Performance Period	7/1/11-6/30/13	7/1/12-6/30/14	7/1/13-6/30/15	7/1/14-9/30/15	10/1/15-6/30/17	7/1/16-6/30/18
Domain 1 weight	35%	25%	15%	*	*	*

Summary Table: HAC Reduction Program Measures, Performance Periods, and Domain Weights						
	FY 2015	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**
Domain 2: CDC HAI Measures						
Central Line-associated Blood Stream Infection (CLABSI)	X	X	X	X	X	X
Catheter-associated Urinary Tract Infection (CAUTI)	X	X	X	X	X	X
Surgical Site Infection (SSI): ◦ SSI Following Colon Surgery ◦ SSI Following Abdominal Hysterectomy		X	X	X	X	X
Methicillin-resistant staphylococcus aureus (MRSA)			X	X	X	X
Clostridium difficile			X	X	X	X
Applicable Time Period/(Performance Period)	1/1/12-12/31/13	1/1/13-12/31/14	1/1/14-12/31/15	1/1/15-12/31/16	1/1/16-12/31/17	1/1/17-12/31/18
Domain 2 weight	65%	75%	85%	*	*	*
*CMS did not propose or discuss domain weightings for FY 2018; presumably the FY 2017 weights continue.						
Note: PSI-90 is a composite of eight PSI measures: PSI-3 (pressure ulcer rate), PSI-6 (iatrogenic pneumothorax rate), PSI-7 (central venous catheter related blood stream infections rate), PSI-8 (postoperative hip fracture rate), PSI-12 (postoperative pulmonary embolism (PE) or deep vein thrombosis (DVT rate), PSI-13 (postoperative sepsis rate), PSI-14 (wound dehiscence rate), and PSI-15 (accidental puncture or laceration rate). The Patient Safety and Adverse Events composite "modified PSI 90" removed PS-07; added PSI-9 (postoperative hemorrhage or hematoma rate), PSI-10 (physiologic and metabolic derangement rate), and PSI-11 (postoperative respiratory failure rate); re-specified the PSI-12 and PSI-15 rates; and changed the weighting of component indicators.						

K. Rural Community Hospital Demonstration Program

1. Background

Section 410A(a) of the MMA required the Secretary to establish a demonstration program to test the feasibility and advisability of establishing "rural community" hospitals to furnish covered inpatient hospital services to Medicare beneficiaries. Under the demonstration a rural community hospital (RCH) in rural areas of 10 states with low population densities (as identified by the Secretary) is paid reasonable cost for covered inpatient hospital services furnished to Medicare beneficiaries. The original demonstration was required to begin on January 1, 2005 and last five years. The ACA extended the program for an additional five years and the 21st Century Cures Act extended the program for five more years.

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

- Cohort 1 refers to the 7 originally participating hospitals (selected in 2004 or 2008) that ended their scheduled 5-year periods of performance on a rolling basis during FY 2015 under the ACA extension.

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

2. Implementation of 21st Century Cures Act Provisions

a. Proposed Terms of Continuation for Previously Participating Hospitals

In the final rule, CMS will permit participating hospitals to begin the Cures Act 5-year extension on the day after the end of the prior performance period. For example, if a hospital's 5-year ACA period ended on June 30, 2015, the hospital may begin the 5-year Cures Act extension period on July 1, 2015, under the finalized policy.

b. Solicitation for Additional Participants

On April 17, 2017, CMS released its solicitation for Cohort 3 participants in the RCH demonstration; eligible hospitals had until May 17, 2017, to submit applications. CMS had not finalized the selection process as of the date of the publication of the final rule.

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

CMS is finalizing its proposal to remove the 0.6 percentage point adjustment applied to FY 2017 IPPS rates from the FY 2018 IPPS rates. This adjustment removes the one-time increase to FY 2017 rates that CMS made to compensate hospitals for a 0.2 percentage point adjustment made to FY 2014 IPPS rates and maintained on the rates for FY 2015 and FY 2016.

CMS indicates in the final rule that hospitals that closed or converted to other hospital types and were no longer being paid under the IPPS in FY 2017 and were not compensated by the one-time adjustment of +0.6 percentage points can work with their MACs to receive a cost report adjustment for any revenues lost as a result of the 2-midnight rule adjustment.

V. Changes to the IPPS for Capital-Related Costs

National Capital Federal Rate for FY 2018. For FY 2018, CMS has established a national capital Federal rate of $453.95 which is an increase of 1.60 percent from the FY 2017 national capital rate of $446.79.

The factors accounting for the FY 2018 update factor to the capital federal rate are summarized in the following table, and the other adjustments are shown in a separate table below.

CMS FY 2018 UPDATE FACTOR TO THE CAPITAL FEDERAL RATE	
Capital Input Price Index (FY 2014-based CPI)	1.3
Intensity	0.0

Case-Mix Adjustment Factors:[1]	
Real Across DRG Change	0.5
Projected Case-Mix Change	0.5
Subtotal	1.3
Effect of FY 2016 Reclassification and Recalibration	0.0
Forecast Error Correction	0.0
Total Update	1.3

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

The final rule includes the following chart to show how each of the factors and adjustments affects the computation of the FY 2018 national capital Federal rate in comparison to the FY 2017 national capital Federal rate.

Comparison of Factors and Adjustments:
FY 2017 Capital Federal Rate and FY 2018 Capital Federal Rate

	FY 2017	**FY 2018**	**Change**	**Percent Change**
Update Factor[1]	1.0090	1.0130	1.0130	1.30
GAF/DRG Adjustment Factor[1]	0.9990	0.9987	0.9987	-0.13
Outlier Adjustment Factor[2]	0.9386	0.9483	1.0103	1.03
Removal of One-time 2-Midnight Policy Adjustment Factor	1.0060	1/1.006	0.9940	-0.60
Capital Federal Rate	$446.79	$453.95	1.0160	1.60

[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 2017 to FY 2018 resulting from the application of the 0.9987 GAF/DRG budget neutrality adjustment factor for FY 2018 is a net change of 0.9987 (or -0.13 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 2018 outlier adjustment factor is 0.9483/ 0.9386 or 1.0103 (or 1.03 percent). 3 Percent change may not sum due to rounding.

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

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

VI. Changes for Hospitals Excluded from the IPPS

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

CMS is setting a 2.7 percent rate-of-increase for FY 2018 to the target amount for cancer hospitals, children's hospitals, religious nonmedical health care institutions (RNHCIs), and for short-term acute care hospitals located in the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. The FY 2018 rate-of-increase percentage would be applied to the FY 2017 target amounts to calculate the FY 2018 target amounts for these hospitals.

CMS is also applying this update to the rate-of-increase limit to a special class of LTCHs (consisting of only one hospital at this time) that CMS describes as "long-term care neoplastic disease hospitals" in response to comments that this hospital should be receiving the same update as hospitals excluded from IPPS.

B. Critical Access Hospitals (CAHs)

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

For inpatient CAH services to be payable under Medicare Part A, section 1814(a)(8) of the Act requires a physician certify that the individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH. Since October 1, 2014, CMS requires that all physician certification requirements must be completed, signed, and documented in the medical record no later than 1 day before the date on which the claim for payment for the inpatient CAH service is submitted.

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

Reviews by other entities, including, but not limited to, Zone Program Integrity Contractors (ZPICs), the Office of Inspector General, and the Department of Justice will continue as appropriate. Quality reviews and automated reviews (for example, those reviews that do not involve medical records) will also continue as appropriate.

QIOs and MACs may continue to conduct medical record review of CAH claims for the purposes of verifying compliance with other requirements, such as beneficiary complaints, quality of care reviews, higher weighted DRG reviews, readmission reviews, and the requirement that procedures be medically necessary.

VII. Changes to the Long-Term Care Hospital Prospective Payment System (LTCH PPS) for FY 2018

Key changes for FY 2018 include the following actions by CMS:

- Modifies the payment methodology for high-cost outlier payments made to LTCHs.
- Extends various moratoria on the implementation of the 25 percent payment adjustment threshold.
- Revises the requirements of the average length-of-stay criterion for LTCH classification.
- Implements a temporary exception to the site neutral payment rate for certain spinal cord hospitals and for certain wound care discharges.
- Modifies the short-stay outlier adjustment policy.

Summary of Changes to LTCH PPS Rates for FY 2018*	
Standard Federal Rate, FY 2017	$42,476.41
Final rule update factors	
Update as required by Section 1886(m)(3)(C) of the Act	+1.0%
Penalty for hospitals not reporting quality data	-2.0%
Net update, LTCHs reporting quality data	+1.0% (1.01)
Net update LTCHs not reporting quality data	-1.0% (0.99)
Final Rule Adjustments	
Average wage index budget neutrality adjustment	1.0006434
Budget neutrality adjustment for SSO payment methodology	0.9651
Standard Federal Rate, FY 2018	
LTCHs reporting quality data ($42,476.41∗1.01∗1.0006434*0.9651)	$41,430.56
LTCHs not reporting quality data ($42,476.41∗0.99 ∗1.0006434*0.9651)	$40,610.16
Fixed-loss Amount for High-Cost Outlier (HCO) Cases	
LTCH PPS standard federal payment rate cases	$27,382
Site neutral payment rate cases (same as the IPPS fixed-loss amount)	$26,601
Impact of Policy Changes on LTCH Payments in 2018	
Total estimated impact	-4.2% (-$195 million)
LTCH standard federal payment rate cases (58% of LTCH cases)	+1.0% (+$35 million)
Site neutral payment rate cases (42% of LTCH cases)**	-20% (-$230 million)
*More detail is available in Table IV, “Impact of Payment Rate and Policy Changes to LTCH PPS Payments for Standard Payment Rate Cases for FY 2018” (see page 2412 in display copy). Table IV does not include the impact of site neutral payment rate cases. ** LTCH site neutral payment rate cases are paid a rate that is based on the lower of the IPPS comparable per diem amount or 100 percent of the estimated cost of the case.	

A. Changes to the LTCH PPS Payment Rates and Other Changes to the LTCH PPS for FY 2018

1. Overview LTCH PPS Payment Rate Adjustments

Only LTCH discharges meeting the site neutral payment rate exclusion criteria are paid based upon the LTCH PPS standard federal payment rate. The LTCH PPS uses a single payment rate to cover both operating and capital-related costs, so that the LTCH market basket includes both operating and capital cost categories.

As in FY 2017, site neutral payment rate cases will be paid in FY 2018 at a rate that is based on the lower of the IPPS comparable per diem amount rate or 100 percent of the estimated cost of the cases.

"Subclause II LTCHs" are paid under reasonable cost reimbursement rules.[7] The subclause II hospital's payment target amount for the previous cost reporting period is updated annually by a rate-of-increase percentage. The rate-of-increase percentage is linked to the estimated percentage increase in the FY 2010-based IPPS operating market basket.

2. Annual Update for LTCHs

The annual update to the LTCH PPS standard federal payment rate for FY 2018 is defined by Section 411 of MACRA and set for FY 2018 at 1.0 percent. Historically, CMS has used an estimated market basket increase to update the LTCH PPS.

For LTCHs failing to submit data to the LTCH Quality Reporting Program (QRP), the annual update would be reduced by 2.0 percentage points to -1 percent.

- Hospitals reporting the required quality data will receive a 1.0 percent update.
- Hospitals not reporting the required quality date will receive a -1.0 percent update (1 percent minus 2 percentage points).

3. Area Wage Levels and Wage-Index

CMS finalizes a labor-related share of 66.2 percent (66.3 percent in the proposed rule) for FY 2018 This is based on the sum of the labor-related portion of operating costs (62.0%) and capital costs (4.2%).

CMS will compute the wage index in a manner that is consistent with prior years. Further, CMS finalizes an area wage level budget neutrality adjustment, computed as in prior years, of 1.0006434.

[7] We know of only one "Subclause II LTCH" (Calvary Hospital in the Bronx, New York).

4. LTCH Standard Federal Payment Rate Calculation

CMS finalizes the following LTCH PPS standard federal payment rates for FY 2018:

- FY 2018 payment rate = $42,476.41 (FY 2017 payment rate) * 1.01 (statutory update factor) * 1.0006434 (area wage budget neutrality factor) * 0.9651 (SSO budget neutrality factor) = $41,430.56

- For LTCHs not reporting data to the LTCH QRP: FY 2018 payment rate = $42,476.41 (FY 2017 payment rate) * 0.99 (statutory update factor less quality adjustment) * 1.0006434 (area wage budget neutrality factor) * 0.9651 (SSO budget neutrality factor) = $40,610.16

5. Cost-of-Living (COLA) Adjustment

CMS continues to update the COLA factors for Alaska and Hawaii as it has done since FY 2014 to account for higher living costs.

Cost-of-Living Adjustment Factors for Alaska and Hawaii Under the LTCH PPS for FY 2018	**FY 2014 through FY 2017**	**FY 2018**
Alaska		
City of Anchorage and 80-kilometer (50-mile) radius by road	1.23	1.25
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.23	1.25
City of Juneau and 80-kilometer (50-mile) radius by road	1.23	1.25
All other areas of Alaska	1.25	1.25
Hawaii		
City and County of Honolulu	1.25	1.25
County of Hawaii	1.19	1.21
County of Kauai	1.25	1.25
County of Maui and County of Kalawao	1.25	1.25

6. High-Cost Outlier (HCO) Case Payments

CMS finalizes a fixed loss amount for 2018 of $27,382 based on more current data (proposed amount was $30,081). CMS notes that the 2018 fixed-loss amount finalized is lower than the proposed amount, but is still significantly higher than the FY 2017 amount of $21,943.

If an HCO case is also an SSO case, the HCO payment will equal 80 percent of the estimated case cost and the outlier threshold (SSO payment plus fixed-loss amount).

Consistent with its practice since FY 2016, CMS continues to believe that the most appropriate fixed-loss amount for site neutral payment rate cases is the IPPS fixed-loss amount. For FY 2018, CMS finalizes a fixed-loss amount for site neutral payment rate cases of $26,601.

7. LTCH PPS Updates Related to IPPS DSH Payment Adjustment Methodology

CMS finalizes its proposal to continue its policy that the calculations of the "IPPS comparable amount" (§ 412.529) and the "IPPS equivalent amount" (§ 412.534 and § 412.536) continue to include an applicable operating Medicare DSH payment amount. For FY 2018, the DSH amount equals 68.51 percent of the operating Medicare DSH payment amount, based on the statutory Medicare DSH payment formula prior to the amendments made by the ACA adjusted to account for reduced payments for uncompensated care resulting from expansion of the insured population under the ACA.

B. Changes to the Short-Stay Outlier Adjustment Policy

CMS finalizes its proposal, without modification, that beginning with discharges occurring on or after October 1, 2017, it will pay SSO cases solely on the "blended" option in the current SSO payment adjustment formula described at § 412.529(c)(2)(iv). As specified in this section, the blend percentage is determined by dividing the covered length-of-stay of the case by the lesser of five-sixths of the geometric average length of stay of the LTC-DRG or 25 days, not to exceed 100 percent. This amount is then subtracted by 100 percent. CMS believes that, by paying SSO cases on this basis, it would reduce, if not eliminate, the payment "cliffs" (or payment differentials) inherent in its current payment methodology, as well as the financial incentives that appear to have resulted in potentially improper delays in patient discharges other than solely for medical reasons.

CMS notes that in assessing the potential impact of this policy change, it found that the change to the payment formula for SSOs would result in a net increase in aggregate Medicare LTCH payments compared to the current methodology. The decrease in expenditures from fewer delayed discharge cases is not large enough to offset the estimated increase in expenditures under the proposed SSO payment adjustment methodology.

Thus, CMS finalizes its proposal to use a budget neutrality adjustment to offset the projected net increase in Medicare spending. The LTCH PPS standard federal payment rate will be adjusted by a one-time, permanent factor that accounts for the projected change in estimated aggregate payments to LTCH PPS standard federal payment rate cases in FY 2018 due to the change in the payment methodology for SSO cases. CMS determines that the change to the SSO payment methodology would result in a net increase in payments of approximately $112 million, and the budget neutrality factor for the SSO payment methodology is 0.9651.

C. Moratorium and Regulatory Delay of the Full Implementation of the "25-Percent Threshold Policy" Adjustment

CMS finalizes its proposal, without modification, to adopt a 1-year regulatory moratorium on the implementation of the 25-percent threshold policy until October 1, 2018.

D. Impact of Payment Rate and Policy Changes to LTCH PPS Payments for FY 2018

1. CMS Impact Analysis for LTCHs

CMS projects that the overall impact of the payment rate and policy changes for all LTCHs will result in a decrease of 4.2 percent or $195 million in aggregate payments (from $4.418 billion to $4.612 billion) from FY 2017 to FY 2018. This estimated decrease in payments reflects the projected increase in payments to LTCH PPS standard federal payment rate cases of approximately $35 million and the projected decrease in payments to site neutral payment rate cases of approximately $230 million.

This does not include separate estimates from the Office of the Actuary who projects an additional increase in aggregate FY 2018 LTCH PPS payments of approximately $70 million for its policy to delay full implementation of the 25-percent threshold policy for FY 2018 and $15 million from its implementation of certain provisions of the 21st Century Cures Act. CMS modeling assumes that approximately 58 percent of LTCH cases would meet the criteria for exclusion from the site neutral payment rate (that is, those cases would be paid the LTCH PPS standard federal payment rate) and approximately 42 percent of LTCH cases would be paid the site neutral payment rate (calculated using FY 2016 LTCH claims data).

CMS was unable to model the impact of LTCH PPS payment changes for site neutral payment rate cases as it did for standard federal payment rate cases. Thus, Table IV "Impact of Payment Rate and Policy Changes to LTCH PPS Payments for Standard Payment Rate Cases for FY 2018" in the final rule shows the detailed impact by location, participation date, ownership type, region, and bed size (see page 2412 of the display copy) for only LTCH PPS standard federal payment rate cases and does not include the detailed impact in payments for site neutral payment rate cases.

The overall impact of LTCH PPS standard federal payment rate cases is estimated to result in an increase in aggregate LTCH payments in FY 2018 relative to FY 2017 of approximately $35 million ($471 average payment per discharge increase * 73,915 discharges). LTCHs located in the New England and Pacific regions would have the largest positive increases (2.5 percent and 1.8 percent respectively) among regions, largely attributable to the changes to the SSO payment method.

Summary of Impact of Changes to LTCH PPS for Standard Federal Payment Rate Cases for FY 2018*		
LTCH Classification	**Number of LTCHs**	**Estimated percent change in payments per discharge**
All LTCH providers	415	+1.0
By Location:		
Rural	21	-0.1%
Urban	394	+1.0%
By Ownership Type:		
Voluntary	72	+0.6%
Proprietary	329	+1.1%
Government	14	-0.5%
By Region		
New England	12	+2.5%
Middle Atlantic	25	+0.6%
South Atlantic	66	+1.1%

East North Central	68	+0.8%
East South Central	34	+1.2%
West North Central	28	-0.1%
West South Central	126	+0.8%
Mountain	31	+0.9%
Pacific	25	+1.8%
*More detail is available in Table IV, "Impact of Payment Rate and Policy Changes to LTCH PPS Payments for Standard Federal Payment Rate Cases, For FY 2018," (see page 2412 of display copy).		

2. Tables

The complete set of tables providing detail on the LTCH PPS for FY 2018 is at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/LTCHPPS-Regulations-and-Notices-Items/LTCH-PPS-CMS-1677-F.html

The information at that link provides:

- Table 8C: LTCH PPS Statewide Average Cost-to-Charge Ratios
- Table 11: MS-LTC-DRGs, relative weights, geometric average length of stay, SSO threshold, and IPPS comparable threshold for FY 2018
- Table 12A: LTCH PPS Wage Index for Urban Areas for FY 2018
- Table 12B: LTCH PPS Wage Index for Rural Areas for FY 2018
- Table 13A: Composition of low-volume quintiles for MS-LTC-DRGs for FY 2018
- Table 13B: No volume MS-LTC-DRG crosswalk for FY 2018
- LTCH PPS FY 2018 Impact File

VIII. Quality Data Reporting Requirements for Specific Providers and Suppliers

A. Hospital Inpatient Quality Reporting (IQR) Program

CMS finalizes several changes to the Hospital IQR Program, including refinements to two existing measures for the FY 2020 payment determination, a new voluntary readmission measure, and changes to requirements with respect to reporting of electronic clinical quality measures (eCQMs) that align with changes to the Medicare and Medicaid EHR Incentive Program described in section IX.E below. One measure refinement modifies the risk adjustment of the stroke mortality measure to include stroke severity information from the NIH Stroke Scale, and the other changes the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey questions regarding patient pain. A number of possible future measures are also discussed.

With the changes in eCQM reporting, the measure sets for FYs 2019 and 2020 include a total of 50 mandatory measures – 46 that are specified, and 4 eCQMs selected by the hospital from a list of 15 available eCQMs. One new voluntary measure is added. A summary table at the end of this section shows the previously adopted measure sets beginning with FY 2017 and the changes made for FYs 2019 and 2020.

Technical specifications for IQR Program measures are available from the CMS QualityNet website at www.qualitynet.org, and for eCQMs at http://ecqi.healthit.gov/.

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

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

HCAHPS Pain Management. The pain management questions on the HCAHPS survey will be modified to focus on the hospital's communication with patients about the patients' pain during the inpatient stay, and the composite measure will be renamed "Communication About Pain."

The current and newly finalized questions are shown in the following table. The new questions will be applicable to patients beginning with January 1, 2018 discharges.

Current "Pain Management"	**Finalized** "Communication about Pain"
12. During this hospital stay, did you need medicine for pain? 1☐☐Yes 2☐☐No ☐☐If No, Go to Question 15 13. During this hospital stay, how often was your pain well controlled? 1☐☐Never 2☐☐Sometimes 3☐☐Usually 4☐☐Always 14. During this hospital stay, how often did the hospital staff do everything they could to help you with your pain? 1☐☐Never 2☐☐Sometimes 3☐☐Usually 4☐☐Always	● HP1: "During this hospital stay, did you have any pain?" ☐☐Yes ☐☐No ☐☐If No, Go to Question __ ● "During this hospital stay, how often did hospital staff talk with you about how much pain you had?" ☐☐Never ☐☐Sometimes ☐☐Usually ☐☐Always • "During this hospital stay, how often did hospital staff talk with you about how to treat your pain? ☐Never ☐Sometimes ☐Usually ☐Always

In a change from the proposed rule, public reporting of performance on the new HCAHPS communication about pain composite measure on *Hospital Compare* will begin in October 2020 using 2019 data. CMS had proposed reporting would begin in October 2019 for 2018 data. Instead, CMS will provide 2018 performance results to hospitals in confidential preview reports once four quarters of data are available, as early as July 2019.

Refinements to the Stroke Mortality Measure. CMS finalizes the proposed refinements to the 30-day stroke mortality measure for the FY 2023 payment determination. The measure will be

modified to include the National Institutes of Health (NIH) Stroke Scale[8] in the measure risk adjustment and other changes are made that reduce the number of risk adjustment variables overall from 42 to 20.

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

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

CMS finalizes its proposal to add a new measure to the IQR Program for voluntary reporting, the Hybrid Hospital-Wide Readmission Measure with Claims and Electronic Health Record (EHR) Data. This measure combines claims data with patient data extracted from hospital EHRs, and was endorsed by the NQF in December 2016 (NQF #2879). The cohort (Medicare FFS beneficiaries age 65 and older discharged from nonfederal acute care hospitals) and outcome (unplanned readmissions within 30 days of discharge) for this measure are identical to those used for the existing hospital-wide all-cause unplanned readmission measure currently in the IQR Program.

CMS is considering proposing this measure as a required IQR Program measure as early as the FY 2023 payment determination (CY 2021 reporting period), and if finalized this would require hospitals to submit core clinical data elements from EHRs as early as 2020 to support a dry run of the measure. The final rule includes a table listing 13 data clinical elements drawn from EHRs that are used in risk adjusting this measure, their units of measurement, and the time window for first captured values.

Voluntary reporting of data on this measure will occur for discharges from January 1, 2018 through June 30, 2018. Hospitals that participate will receive confidential reports on the completeness and accuracy of the EHR data submission results and the CMS-calculated Hybrid HWR measure results for the performance period. The report will provide detailed information about the patients in the measure cohort with an unplanned readmission within 30 days of hospital discharge, including the patients' clinical risk factors drawn from claims and EHR data. CMS believes this information will inform quality improvement strategies to reduce unplanned readmissions. In addition, the reports will include the match rate between the hospital's submitted EHR data and corresponding claims data, as well as the proportion of patient data submitted relative to all qualifying admissions for each of the 13 core clinical data elements.

[8] The NIH Stroke Scale is a 15-item neurologic examination stroke scale used to provide a quantitative measure of stroke-related neurologic deficit. It evaluates the effect of acute ischemic stroke on a patient's level of consciousness, language, neglect, visual-field loss, extra-ocular movement, motor strength, ataxia (the loss of full control of bodily movements), dysarthria (difficult or unclear articulation of speech), and sensory loss.

The Hybrid HWR will be calculated by CMS using claims data to identify the index admission, to create a risk-adjustment model, and to assess the 30-day unplanned readmission outcome combined with core clinical data elements submitted from hospital EHRs for additional risk adjustment.

Electronic specifications for the measure, including for the extraction of core clinical elements from the EHR, are available under "core clinical data elements and hybrid measures" at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html.

3. Reporting of eCQMs

CMS modifies previously finalized policies for reporting of eCQMs in 2017 (for the FY 2019 payment determination) and reporting in 2018 (for the FY 2020 payment determination) to provide for a greater reduction in reporting burden than what was proposed. These changes align with the changes to the Medicare and Medicaid EHR Incentive Program summarized below. The changes are made in response to concerns of commenters that vendors need more time to work on measure specifications and data validation and that some hospitals need more time to incorporate system upgrades, data mapping and staff training.

Specifically, the final rule provides that for both the 2017 and 2018 reporting periods (FY 2019 and FY 2020 payment, respectively) hospitals must report only one self-selected quarter of data for four self-selected eCQMs out of the 15 available. This is consistent with the requirements in place for the 2016 reporting period (2018 payment) except that under this final rule hospitals may choose any quarter for reporting whereas for 2016 they were limited to the last two calendar quarters of the year.

4. Form, Manner and Timing of Data Submission

CMS finalizes changes to reporting of eCQMs and procedures for the new voluntary Hybrid HWR measure.

Reporting of eCQMs. CMS finalizes changes to certain reporting and submission requirements for eCQMs, consistent with the policies explained in item 3 above under which for both the 2017 and 2018 reporting years (2019 and 2020 payment determinations) hospitals must report on four eCQMs for one self-selected quarter of data. These finalized reporting and data submission requirements are modified from the proposed rule, and align the IQR Program requirements with the Medicare EHR Incentive Program requirements.

For the 2017 and 2018 reporting years (2019 and 2020 payment determinations) CMS finalizes its proposals to require that EHR technology be certified to all 15 available eCQMs, but recertification is not required each time the technology is updated to capture more recent eCQM specifications. In addition, hospitals are required to use the most recent version of the eCQM specifications. For the FY 2019 payment determination this is the Spring 2016 version, and for the FY 2020 payment determination the Spring 2017 version. These are available at the eCQI Resource Center website at https://ecqi.healthit.gov.

In a change from the proposed rule, for both the 2017 and 2018 reporting periods (2019 and 2020 payment) hospitals will have the flexibility to use EHR technology certified to the 2014 Edition or the 2015 Edition or a combination of these Editions.

Although flexibility is retained in this rule, CMS encourages hospitals to employ EHR technology certified to the 2015 Edition as soon as practicable.

Responding to commenter concerns that vendors are not certifying to the 2015 Edition, CMS notes that if a hospital is unable to make the eCQM submission deadline or other submission requirements it should review criteria for an Extraordinary Circumstances Exception. The application permits hospitals to request an exception based on hardships preventing hospitals from electronic reporting. Hardships may be due to infrastructure challenges or unforeseen circumstances, such as vendor issues outside the hospital's control. More information is available in Question #5 in the ECE Policy Clarification Questions and Answers document regarding eCQM reporting available at https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228775554109.

5. Data Validation

CMS finalizes its proposals to modify data validation requirements for eCQMs for the FY 2020 payment determination. A hospital that does not meet validation requirements fails to meet all IQR Program requirements and is therefore subject to an update factor reduction. In previous rulemaking, CMS adopted a validation process for FY 2020 under which 200 hospitals are selected by random sample and 32 cases are randomly drawn from the QRDA I files submitted by each hospital. The first validation is scheduled for the spring of 2018, validating data from the 2017 reporting period for FY 2020 payment. The specific changes finalized in this rule are:

- Eight cases per quarter will be randomly selected from among the QRDA I files submitted by each hospital randomly chosen for validation. CMS notes that the finalized modifications to eCQM reporting requirements to only one quarter of data for 2017 and 2018 means that a total of 8 cases will be sampled from selected hospitals.
- Additional exclusion criteria will be applied to the hospital and case selection process. Under previously adopted policies, hospitals will be excluded from the validation sample if they are also chosen for validation of chart abstracted measures or if they have received an extraordinary circumstances exemption for the reporting year in question. In this rule, CMS adopts one more exclusion: hospitals will be excluded if they did not have at least five discharges for at least one reported eCQM among their QRDA I file submissions. In addition, each of the three exclusions will be applied before the random validation selection of 200 hospitals is made; hospitals meeting any of these exclusions will not be eligible for selection.
- A process is adopted for selecting the cases for eCQM validation. CMS finalizes its proposal to exclude cases with episodes of care that are longer than 120 days and cases with a zero denominator for each measure.
- Policies regarding medical record submission requirements adopted for the FY2020 payment determination are extended for FY 2021 and subsequent years. This means that

the accuracy of eCQM data submitted for validation will not affect a hospital's validation score. Under the requirements for successful data validation for FY 2020 that are extended, hospitals selected for eCQM validation have 30 days to submit requested medical records; must provide sufficient patient-level information to match the medical record with the originally-submitted IQR Program eCQM data record; must submit records in PDF format through QualityNet using secure file transfer; and must submit at least 75 percent of the sampled eCQM medical records in a timely and complete manner. CMS notes that the 75 percent requirement means that for the 2017 and 2018 reporting years, hospitals selected would be required to submit complete information for at least 6 records (75 percent of 8 cases).

CMS also formalizes and updates existing policies for hospitals to request an educational review for chart-abstracted measures validation. Under the formalized policy, beginning with the FY 2020 payment determination, a hospital may request from CMS an educational review to better understand whether CDAC or CMS reached a correct conclusion during validation.

For the FY 2020 payment determination and subsequent years, CMS finalizes that if an educational review for any of the first three quarters yields incorrect CMS validation results for chart-abstracted measures, the corrected quarterly score, as recalculated during the educational review process, will be used to compute the final confidence interval. The quarterly validation reports issued to hospitals will not be changed to reflect the updated score due to the burden of issuing corrected reports. The revised score identified through an educational review will be used when determining whether a hospital failed validation. Further, corrected scores identified through the educational review will only be used if they indicate that the hospital performed more favorably than previously determined.

6. Impact Analysis

In the regulatory impact analysis section of the final rule, CMS reports that 82 hospitals are estimated to not receive the full market basket increase for FY 2018 because they failed the quality data submission process or chose not to participate in IQR; 103 hospitals are estimated to not be meaningful EHR users; and 21 hospitals are estimated to be subject to both reductions.

Summary Table: IQR Program Measures by Payment Determination Year X= Mandatory Measure				
	2017	**2018**	**2019**	**2020**
Chart-Abstracted Process of Care Measures				
AMI-7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival	X	Removed		
STK-1 VTE prophylaxis	X	Removed		
STK-4 Thrombolytic therapy for acute ischemic stroke	X	X	Removed	
STK-6 Discharged on statin	X	Removed		
STK-8 Stroke education	X	Removed		
VTE-1 VTE prophylaxis*	X	Removed		
VTE-2 ICU VTE prophylaxis	X	Removed		
VTE-3 VTE patients with anticoagulation overlap therapy	X	Removed		
VTE-5 VTE discharge instructions	X	X	Removed	

Summary Table: IQR Program Measures by Payment Determination Year X= Mandatory Measure				
	2017	**2018**	**2019**	**2020**
VTE-6 Incidence of potentially preventable VTE	X	X	X	X
Severe sepsis and septic shock: management bundle (NQF #500)	X	X	X	X
ED-1 Median time from ED arrival to departure from the emergency room for patients admitted to the hospital (NQF #0495)	X	X	X	X
ED-2 Median time from admit decision to time of departure from the ED for patients admitted to the inpatient status (NQF #0497)	X	X	X	X
IMM-2 Immunization for influenza (NQF #1659)	X	X	X	X
PC-01 Elective delivery < 39 completed weeks gestation (NQF #0469)	X	X	X	X
Electronic Clinical Quality Measures				
AMI-2 Aspirin prescribed at discharge for AMI AMI-7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival AMI-8a Timing of Receipt of Primary Percutaneous Coronary Intervention (PCI) (NQF #0163) AMI-10 Statin at discharge PN-6 Appropriate initial antibiotic selection STK-2 Antithrombotic therapy for ischemic stroke (NQF #0435) STK-3 Anticoagulation therapy for Afib/flutter (NQF #0436) STK-4 Thrombolytic therapy for acute ischemic stroke STK-5 Antithrombotic therapy by end of hospital day 2 (NQF #0438) STK-6 Discharged on statin (NQF #0439) STK-8 Stroke education STK-10 Assessed for rehabilitation services (NQF #0441) VTE-1 VTE prophylaxis (NQF #0371) VTE-2 ICU VTE prophylaxis (NQF #0372) VTE-3 VTE patients with anticoagulation overlap therapy VTE-4 VTE patients receiving un-fractionated Heparin with doses/labs monitored by protocol VTE-5 VTE discharge instructions VTE-6 Incidence of potentially preventable VTE SCIP INF-1 Prophylactic antibiotic received within 1 hour prior to surgical incision SCIP-INF-2 Prophylactic antibiotic selection for surgical patients SCIP–INF-9 Postoperative urinary catheter removal on postoperative day 1 or 2 with day of surgery being day zero ED-1 Median time from ED arrival to departure from the emergency room for patients admitted to the hospital (NQF#0495) ED-2 Median time from admit decision to time of departure from the ED for patients admitted to the inpatient status (NQF #0497) PC-01 Elective delivery < 39 completed weeks gestation (NQF #0469) PC-05 Exclusive breast milk feeding (NQF #0480) Healthy term newborn EDHI-1a Hearing screening prior to hospital discharge CAC- 3 Children's asthma care – 3	voluntary reporting of 16 of 28 eCQMs listed across three NQS domains	Must report at least 4 of 28 eCQMs	Must report 4 of 15 eCQMs (8 of 15 were previously finalized) The 15 eCQMs: AMI-8a CAC-3 ED-1 ED-2 EHDI-1a PC-01 PC-05 STK-02 STK-03 STK-05 STK-06 STK-08 STK-10 VTE-1 VTE-2	
Healthcare-Associated Infection Measures				
Central Line Associated Bloodstream Infection (CLABSI)	X	X	X	X
Surgical Site Infection: Colon Surgery; Abdominal Hysterectomy	X	X	X	X
Catheter-Associated Urinary Tract Infection (CAUTI)	X	X	X	X
MRSA Bacteremia	X	X	X	X
Clostridium Difficile (C. Diff)	X	X	X	X
Healthcare Personnel Influenza Vaccination	X	X	X	X
Claims-Based Measures				

Summary Table: IQR Program Measures by Payment Determination Year X= Mandatory Measure				
	2017	**2018**	**2019**	**2020**
Mortality				
AMI 30-day mortality rate	X	X	X	X
Heart Failure (HF) 30-day mortality rate	X	X	X	X
Pneumonia 30-day mortality rate	X	X	X	X
Stroke 30-day mortality rate	X	X	X	X*
COPD 30-day mortality rate	X	X	X	X
CABG 30-day mortality rate	X	X	X	X
Readmission/ Coordination of Care				
AMI 30-day risk standardized readmission	X	X	X	X
Heart Failure 30-day risk standardized readmission	X	X	X	X
Pneumonia 30-day risk standardized readmission	X	X	X	X
Total Hip/Total Knee Arthroplasty (TKA/THA) 30-day risk standardized readmission	X	X	X	X
Hospital-wide all-cause unplanned readmission	X	X	X	X
Stroke 30-day risk standardized readmission	X	X	X	X
COPD 30-day risk standardized readmission	X	X	X	X
CABG 30-day risk standardized readmission	X	X	X	X
Hybrid (claims+EHR) hospital-wide readmission				Voluntary
Excess days in acute care after hospitalization for AMI		X	X	X
Excess days in acute care after hospitalization for HF		X	X	X
Excess days in acute care after hospitalization for PN			X	X
Patient Safety				
PSI-90 Patient safety composite (NQF #0531)	X	X	X	X
PSI-04 Death among surgical inpatients with serious, treatable complications (NQF #0351)	X	X	X	X
THA/TKA complications	X	X	X	X
Efficiency/Payment				
Medicare Spending per Beneficiary	X	X	X	X
AMI payment per 30-day episode of care	X	X	X	X
Heart Failure payment per 30-day episode of care	X	X	X	X
Pneumonia payment per 30-day episode of care	X	X	X	X
THA/TKA payment per 30-day episode of care		X	X	X
Kidney/UTI clinical episode-based payment			X	X
Cellulitis clinical episode-based payment			X	X
Gastrointestinal hemorrhage clinical episode-based payment			X	X
Aortic Aneurysm Procedure clinical episode-based payment			X	X
Cholecystectomy/Common Duct Exploration episode-based payment			X	X
Spinal Fusion clinical episode-based payment			X	X
Patient Experience of Care				
HCAHPS survey + 3-item Care Transition Measure	X	X	X	X**
Structural Measures				
Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care	X	X	Removed	
Participation in a Systematic Clinical Database Registry for General Surgery	X	X	Removed	
Safe Surgery Checklist Use	X	X	X	X
Hospital Survey on Patient Safety Culture		X	X	X
*Refinements to the stroke mortality measure, including addition of the NIH Stroke Scale score to risk adjustment are made beginning with the FY 2023 payment determination, with a dry run in 2021.				

Summary Table: IQR Program Measures by Payment Determination Year X= Mandatory Measure				
	2017	**2018**	**2019**	**2020**
**The HCAHPS Pain Management questions will be replaced with new questions on Communication about Pain beginning with the FY 2020 payment determination.				

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

The PPS-exempt Cancer Hospital Quality Reporting (PCHQR) Program began in FY 2014. Five initial measures were adopted for FY 2014, and subsequent rulemaking has added and removed measures. A total of 17 measures were previously adopted for FY 2019.

In this rule, CMS finalizes its proposal without change to remove three cancer-specific clinical process measures because it has determined they are topped out, and to add four end-of-life cancer care measures, beginning with the FY 2020 payment year. The table at the end of this section shows the specific measures that will be removed and added.

CMS finalizes without change its proposal that the measure data collection period end June 30 of the year that is two years prior to the program year. Thus, for the 2020 program year, CMS will collect data for the four new measures from July 1, 2017 through June 30, 2018.

CMS adopts as final its proposal to make the extraordinary circumstances exceptions policies consistent with those of other CMS quality programs. Specifically, the deadline for a PCH to submit a request will be extended from 30 days to 90 days following the event, and CMS will have authority to grant exceptions in situations where CMS data system issues affected PCH data submission.

PCHQR Program Measures for 2020	
Measure	**Public Display**
Safety and Healthcare Associated Infection	
NHSN CLABSI (NQF #0139)	Deferred
NHSN CAUTI (NQF #0138)	Deferred
NHSN SSI (NQF #0753)	
NHSN CDI (NQF #1717)	
NSHN MRSA bacteremia (NQF #1716)	
NHSN Influenza vaccination coverage among health care personnel (NQF #0431)	
Clinical Process/Cancer-Specific Treatments	
Adjuvant chemotherapy is considered or administered within 4 months of surgery for certain colon cancer patients (NQF #0223)	2014 Remove from measure set
Combination chemotherapy is considered or administered within 4 months of diagnosis to certain breast cancer patients (NQF #0559)	2014 Remove from measure set
Adjuvant hormonal therapy for certain breast cancer patients (NQF #0220)	2015 Remove
Clinical Process/Oncology Care	
Oncology-Radiation Dose Limits to Normal Tissues (NQF #0382)	2016
Oncology: Plan of Care for Pain (NQF #0383)	2016
Oncology: Pain Intensity Quantified (NQF #0384)	2016
Prostate Cancer-Avoidance of Overuse Measure-Bone Scan for Staging Low-Risk Patients (NQF #0389)	2016
Prostate Cancer-Adjuvant Hormonal Therapy for High-Risk Patients (NQF #0390)	2016

PCHQR Program Measures for 2020	
The Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (EOLChemo) (NQF #0210)	
The Proportion of Patients Who Died from Cancer Not Admitted to Hospice (EOL-Hospice) (NQF #0215)	
Intermediate Clinical Outcomes	
The Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than Three Days (EOL-3DH) (NQF #0216)	
The Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life (EOL-ICU) (NQF #0213)	
Patient Experience of Care	
HCAHPS (NQF #0166)	2016
Clinical Effectiveness	
External Beam Radiotherapy for Bone Metastases (NQF#1822)	2017
Claims-Based Outcomes	
Admissions and ED Visits for Patients Receiving Outpatient Chemotherapy	

C. Long-Term Care Hospital Quality Reporting Program (LTCH QRP)

An LTCH that does not meet the requirements of participation in the LTCH QRP for a rate year is subject to a 2.0 percentage point reduction in the update factor for that year. In the impact analysis presented in Appendix A to the final rule, CMS reports that 41 out of 424 LTCHs were found to be noncompliant with the LTCH QRP and therefore did not receive the full update factor for the FY 2017 payment determination. CMS expects that fewer LTCHs will receive the reduction for FY 2018 as they become more familiar with program requirements.

1. Collection of Standardized Patient Assessment Data under the LTCH QRP

The IMPACT Act requires that beginning in FY 2019, LTCHs must report standardized patient assessment data as required for at least the quality measures with respect to certain categories, summarized here as functional status; cognitive function; special services and interventions; medical conditions and comorbidities; impairments; and other categories deemed necessary and appropriate. The standardized patient assessment data must be reported at least with respect to LTCH admissions and discharges, but the Secretary may require the data to be reported more frequently.

To implement this requirement, CMS adopts its proposal to define “standardized patient assessment data” as patient assessment questions and response options that are identical in all four post-acute care (PAC) assessment instruments, and to which identical standards and definitions apply. CMS intends to use the standardized patient assessment data for several purposes, including facilitating exchange among providers to enable high quality care and care coordination; calculation of quality measures; and identifying comorbidities that increase the medical complexity of an admission.

CMS finalizes as proposed that the policy for retaining LTCH QRP measures until they are removed, suspended or replaced will also be applied to the standardized patient assessment data adopted for the LTCH QRP. Similarly, CMS will apply the use of a subregulatory process

adopted for LTCH QRP measures to incorporate nonsubstantive updates to the standardized patient assessment data.

In the proposed rule, CMS identified a list of specific data elements that it proposed to require that LTCHs report as standardized patient assessment data. A total of 25 new standardized patient assessment data elements would have been required with respect to LTCH admissions and 17 new data elements with respect to LTCH discharges. In making these proposals, CMS described its work with stakeholders and a Technical Expert Panel in identifying appropriate standardized patient assessment data. Data elements in the four existing PAC provider patient assessment instruments were considered, along with a literature search. Public meetings and public comment opportunities were provided.

The elements proposed for two of the five patient assessment categories (functional status and medical conditions and co-morbidities) are finalized. These elements are already included in the current Long-Term Care Hospital Continuity Assessment Record and Evaluation Data Set (LTCH CARE Data Set or LCDS) and are used to calculate the pressure ulcer measure (both current and newly finalized) or the measure assessing the percent of patients with a functional assessment at admission and discharge and a care plan that addresses function (NQF #2631).

The table below lists the elements by category (including those that were not finalized) identifies the current PAC patient assessment instruments that include the elements (or similar ones) and indicates whether the data elements are included in the current LCDS or would be newly added.

Standardized Patient Assessment Data Elements, by Category Note: The Shaded Categories were Proposed, but NOT Finalized		
Data Elements	**Current Use/Test of Elements***	**Change to LCDS**
Functional Status		
Elements to calculate the measure: Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)	LCDS	No change
Medical Condition and Comorbidity Data		
Elements to calculate the current and proposed pressure ulcer measures: Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) and Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	LCDS	No change
Cognitive Function and Mental Status–NOT FINALIZED		
Brief Interview for Mental Status (BIMS)	MDS 3.0 IRF-PAI PAC PRD	Add to LCDS assess at admission only
Confusion Assessment Method	LCDS MDS 3.0 PAC PRD	No change
Behavioral Signs and Symptoms	MDS 3.0 OASIS-C2 PAC PRD	Add to LCDS (MDS version)

Standardized Patient Assessment Data Elements, by Category Note: The Shaded Categories were Proposed, but NOT Finalized		
Data Elements	**Current Use/Test of Elements***	**Change to LCDS**
Patient Health Questionnaire-2	MDS 3.0 OASIS-C2 PAC PRD	Add to LCDS
Special Services, Treatments, and Interventions–NOT FINALIZED		
Cancer Treatment: Chemotherapy (IV, Oral, Other)	MDS 3.0 PAC PRD	Add to LCDS
Cancer Treatment: Radiation	MDS 3.0	Add to LCDS
Respiratory Treatment: Oxygen Therapy (Continuous, Intermittent)	MDS 3.0 OASIS-C2 PAC PRD	Add to LCDS
Respiratory Treatment: Suctioning (Scheduled, As needed)	MDS 3.0 PAC PRD	Add to LCDS
Respiratory Treatment: Tracheostomy Care	MDS 3.0 PAC PRD	Add to LCDS
Respiratory Treatment: Non-invasive Mechanical Ventilator (BiPAP, CPAP)	LCDS MDS 3.0 OASIS-C2 PAC PRD	Expand LCDS
Respiratory Treatment: Invasive Mechanical Ventilator	LCDS MDS 3.0 PAC PRD	No change
Other Treatment: Intravenous (IV) Medications (Antibiotics, Anticoagulation, Other)	MDS 3.0 OASIS-C2 PAC PRD	Add to LCDS
Other Treatment: Transfusions	MDS 3.0 OASIS-C2 PAC PRD	Add to LCDS (MDS version)
Other Treatment: Dialysis (Hemodialysis, Peritoneal dialysis)	LCDS MDS 3.0 PAC PRD	Expand LCDS
Other Treatment: Intravenous (IV) Access (Peripheral IV, Midline, Central line, Other)	MDS 3.0 OASIS PAC PRD	Add to LCDS
Nutritional Approach: Parenteral/IV Feeding	LCDS MDS 3.0 IRF-PAI OASIS-C2 PAC PRD	No change except renaming
Nutritional Approach: Feeding Tube	MDS 3.0 OASIS-C2 IRF-PAI PAC PRD	Add to LCDS
Nutritional Approach: Mechanically Altered Diet	MDS 3.0 OASIS-C2 IRF-PAI	Add to LCDS

Standardized Patient Assessment Data Elements, by Category Note: The Shaded Categories were Proposed, but NOT Finalized		
Data Elements	**Current Use/Test of Elements***	**Change to LCDS**
	PAC PRD	
Nutritional Approach: Therapeutic Diet	MDS 3.0 PAC PRD	Add to LCDS
Impairment–NOT FINALIZED		
Hearing	MDS 3.0 OASIS C-2 PAC PRD	Add to LCDS (MDS version) assess at admission only
Vision	MDS 3.0 OASIS C-2 PAC PRD	Add to LCDS (MDS version) assess at admission only
*This column reflects whether the proposed rule indicated that the specific elements proposed or similar or related elements are included in the current PAC assessment instruments or tested in the PAC PRD. The PAC instruments referenced are: Long-Term Care Hospital Continuity Assessment Record and Evaluation Data Set (LTCH CARE Data Set or LCDS); MDS for Skilled Nursing Facilities; OASIS C-2 for home health agencies; and Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI). The Continuity Assessment Record and Evaluation (CARE) Item Set is a standardized patient assessment tool developed as part of the PAC-PRD for use at acute hospital discharge and at post-acute care admission and discharge.		

2. LTCH QRP Measures for FY 2020

Beginning with the FY 2020 payment determination, CMS replaces one measure in the LTCH QRP, removes another measure, and adds two new measures. Measure specifications and other information are available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Measures-Information.html.

Replacement of Pressure Ulcer Measure. The current pressure ulcer measure -- Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short Stay) (NQF #0678) will be replaced by a modified version with a new name – Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury. Implementation will begin July 1, 2018.

Addition of Mechanical Ventilation Measures. Two new measures related to mechanical ventilation will be added to the LTCH QRP measure set with an implementation date of July 1, 2018.

- Mechanical Ventilation Process Quality Measure: Compliance with Spontaneous Breathing Test by Day 2 of the LTCH Stay

- Mechanical Ventilation Outcome Quality Measure: Ventilator Liberation Rate.

Removal of All-Cause Unplanned Readmission Measure. The All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from LTCHs is removed from the LTCH QRP beginning with the FY 2019 LTCH QRP. CMS has reconsidered comments it received during last year's rulemaking expressing concern about the multiplicity of readmission measures and the overlap between this measure and the All-Cause Readmission and Potentially Preventable Readmission (PPR) 30-Day Post-Discharge measures. CMS believes that removing this measure will prevent duplication.

3. Public Reporting

CMS previously adopted policies for public display of LTCH QRP data on the *LTCH Compare* website, and for confidential feedback reports on these LTCH QRP measures to LTCHs prior to public reporting.

CMS finalizes its proposal to publicly report data on additional LTCH QRP measures. A table in the final rule lists the 7 previously finalized measures, 6 measures finalized for reporting in 2018 and one additional measure for reporting in 2020. These measures are indicated in the summary table below. The all-cause readmission measure finalized in this rule for removal from the LTCH QRP will be removed from public display by October 2018. The current pressure ulcer measure will be removed from display prior to the addition of the new measure to avoid overlap.

4. List of LTCH Measures FY 2018 – FY 2020

LTCH QRP Measures, by Year				
Measure Title	**FY 2018**	**FY 2019**	**FY 2020**	**Public Reporting in CY 2018**
NHSN Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138)	X	X	X	X
NHSN Central line-associated Blood Stream Infection (CLABSI) Outcome Measure (NQF #0139)	X	X	X	X
Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short-Stay) (NQF #0678)	X	X	Replace	X
Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury			X	
Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay) (NQF #0680)	X	X	X	X
Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431)	X	X	X	X
NHSN Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF #1716)	X	X	X	X
NHSN Facility-Wide Inpatient Hospital-onset Clostridium Difficile Infection (CDI) Outcome Measure (NQF #1717)	X	X	X	X

LTCH QRP Measures, by Year				
Measure Title	**FY 2018**	**FY 2019**	**FY 2020**	**Public Reporting in CY 2018**
All-Cause Unplanned Readmissions for 30 Days Post Discharge from LTCHs (NQF #2512)	X	Removed		Remove
Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (Application of NQF #0674)	X	X	X	X
Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)	X	X	X	X
Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631)	X	X	X	X
Change in Mobility among Long-Term Care Hospital Patients Requiring Ventilator Support (NQF #2632)	X	X	X	2020
NHSN Ventilator Associated Event Outcome Measure	X	X	X	
Medicare spending per beneficiary MSPB-PAC LTCH	X	X	X	X
Discharge to Community PAC LTCH	X	X	X	X
Potentially Preventable Readmissions 30 Days Post LTCH Discharge	X	X	X	X
Drug Regimen Review Conducted with Follow-up			X	
Mechanical Ventilation Process Measure: Compliance with Spontaneous Breathing Test by Day 2 of the LTCH Stay			X	
Mechanical Ventilation Outcome Measure: Ventilator Liberation Rate			X	

D. Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program

In Appendix A to the final rule, CMS reports that 49 out of 1,647 IPFs did not receive the full update factor for the FY 2017 payment determination due to the IPFQR Program; 22 of these chose not to participate and the other 27 did not meet program requirements. CMS anticipates that fewer IPFs will receive the reduction for FY 2018 as familiarity with program requirements improves.

CMS had proposed a number of changes to the IPFQR Program. CMS has not finalized adoption of its proposed new measure; all of its other proposed changes have been finalized without modification.

- As proposed, effective beginning October 1, 2017, measure removal and retention factors and a definition for "topped out" measures will be adopted consistent with those used in the IQR Program.

- Medication Continuation Following Inpatient Psychiatric Discharge (NQF #3205). CMS does not finalize at this time its proposed new measure (which would have begun with the FY 2020 payment determination).

- CMS finalizes as proposed that beginning with the FY 2019 payment determination, data submission periods (currently July 1 through August 15 of the year preceding the payment year) will be modified. Specifically, the 45-day submission period will begin at least 30 days following the end of the data collection period, and the exact dates will be determined through sub-regulatory guidance.

- CMS finalizes its proposal that the deadline for an IPF to submit a Notice of Participation (NOP) or withdrawal from the program will coincide with the end of the data submission period. That is, NOPs and withdrawals would be accepted any time prior to the end of the data submission period before the payment determination year.

Below is a list of the IPFQR program measures for FY 2020.

IPFQR Program Measures for FY 2020	
Measure ID	**Measure Description**
HBIPS-2	Hours of Physical Restraint Use (NQF #0640)
HBIPS-3	Hours of Seclusion Use (NQF #0641)
HBIPS-5	Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification (NQF #0560)
FUH	Follow-Up After Hospitalization for Mental Illness (NQF #0576)
SUB-1	Alcohol Use Screening (NQF #1661)
SUB-2 and SUB-2a	Alcohol Use Brief Intervention Provided or Offered and the subset, Alcohol Use Brief Intervention (NQF #1663)
TOB-1	Tobacco Use Screening (NQF #0651)
TOB-2 and TOB-2a	Tobacco Use Treatment Provided or Offered and the subset, Tobacco Use Treatment (during the hospital stay) (NQF #1654)
TOB-3 and TOB-3a	Tobacco Use Treatment Provided or Offered at Discharge and the subset, Tobacco Use Treatment at Discharge (NQF #1656)
IMM-2	Influenza Immunization (NQF #1659)
	Transition Record with Specified Elements Received and Discharged Patients (NQF #0647)
	Timely Transmission of Transition Record (NQF #0648)
	Screening for Metabolic Disorders
	Influenza Vaccination Coverage Among Healthcare Personnel
	Assessment of Patient Experience of Care
	Use of an Electronic Health Record (EHR)
Sub-3 and Sub3a	Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and the subset measure Alcohol & Other Drug Use Disorder Treatment at Discharge (NQF #1664)

IPFQR Program Measures for FY 2020	
Measure ID	**Measure Description**
	Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an IPF (NQF #2860)

E. Clinical Quality Measurement for Eligible Hospitals and Critical Access Hospitals (CAHs) Participating in the EHR Incentive Programs

A hospital that is not identified as a meaningful EHR user under the Medicare EHR Incentive Program is subject to an estimated reduction of 2.025 percentage points in the update factor for FY 2018. In the impact analysis section of this rule, 103 hospitals are estimated to not meet the meaningful use requirements for FY 2018 payment; 21 hospitals are estimated to fail to meet both the meaningful use and IQR Program requirements, and are subject to an estimated total update factor reduction of 2.7 percentage points.

1. 2017 CQM Reporting Requirements

CMS finalizes changes to the 2017 requirements for hospitals and CAHs electronically reporting under the Medicare and Medicaid EHR Incentive Programs that reduce the CQM reporting requirements further than it had proposed. First, the number of quarters for which hospitals are required to submit eCQM data is reduced from a full calendar year to one self-selected quarter during 2017 (rather than two as proposed). Second, the number of eCQMs required for reporting is reduced from eight to four (in lieu of six as proposed) of the 16 available eCQMs.[9] CMS notes that the previously finalized data submission period is unchanged (beginning late spring 2017 through February 28, 2018).

2. 2018 CQM Reporting Requirements

The finalized 2018 reporting period, reporting criteria and data submission periods are the same requirements that apply for the finalized 2017 requirements described above. The reporting period is changed from the full calendar year to one self-selected quarter of CY 2018 data. The data submission period will end February 28, 2019. The number of eCQMs is reduced to 4 of the 16 available eCQMs.

Attestation will no longer be an option for reporting in 2018 except in circumstances where electronic reporting is not feasible and except as provided in state Medicaid EHR Incentive programs. In these cases, reporting is required for a full calendar year on all 16 eCQMs. The attestation deadline is also February 28, 2019. (An exception was previously provided for hospitals and CAHs demonstrating meaningful use for the first time under a state Medicaid EHR Incentive Program; in these cases, the reporting period is any continuous 90-day period during 2018. States also establish submission periods for reporting CQMs subject the CMS' approval.)

[9] The list of available eCQMs appears in the table of IQR measures at the end of section IX.A above, except for measure ED-3, Median Time from ED Arrival to ED Departure for Discharged ED Patients which is an outpatient measure not included in the IQR Program measure set.

CMS finalizes its proposal to continue to require that hospitals and CAHs report using the most recent version of the CQM electronic specification for each CQM to which the EHR is certified (i.e., the Spring 2017 version of the CQM electronic specifications and any applicable addenda available on the eCQI Resource Center webpage at: https://ecqi.healthit.gov/).

CMS previously finalized for 2018 that eligible hospitals and CAHs must use EHR technology certified to the 2015 Edition. Later in the final rule (described below) CMS modifies that policy to make use of 2015 Edition voluntary in 2018. Accordingly, CMS finalizes a corresponding modification to that policy for the CY 2018 CQM reporting period; eligible hospitals and CAHs may use EHR technology certified to the 2014 Edition, the 2015 Edition, or a combination of both Editions.

An eligible hospital or CAH must have its EHR technology certified to all 16 available CQMs in order to meet the reporting requirements for CY 2018. However, an EHR certified for CQMs under the 2014 Edition or 2015 Edition certification criteria will not need to be recertified each time it is updated to a more recent version of the CQMs.

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

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

1. Modification to the CQM Reporting Period for EPs

2017. CMS finalizes a uniform minimum 90-day CQM reporting period during CY 2017 for all Medicaid EPs regardless of submission method.

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

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

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

With strong support from commenters, CMS also finalizes its proposal to remove the requirement for EPs to report on CQMs across 3 of the 6 National Quality Strategy domains; it believes this change will improve alignment with data submission criteria for the MIPS quality performance

category. Thus, for 2017, Medicaid EPs would be required to report on any six measures "that are relevant to" the EPs' scope of practice. CMS will continue allowing zero denominators to be reported for EPs to meet the EHR Incentive Program CQM reporting requirements. For future years, Medicaid EHR Incentive Program CQM reporting requirements will be established in rulemaking as MIPS policies are developed for 2018 and succeeding years.

G. Changes to the Medicare and Medicaid EHR Incentive Programs

1. Revisions to EHR Reporting Period in 2018

Taking into account stakeholder feedback that additional time might be necessary to test and implement the Stage 3 application programming interface (API) requirements and the objectives for Patient Electronic Access to Health Information and Coordination of Care Through Patient Engagement, CMS finalizes its proposal to modify the EHR reporting periods for 2018 for all participants (new and returning) attesting to CMS or to a State Medicaid agency to a minimum of any continuous 90-day period within CY 2018.

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

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

Section 4002 of the 21st Century Cures Act added an exception to the payment adjustment penalties for EPs, eligible hospitals and CAHs that could not meet the requirement to be a meaningful EHR user because the CEHRT used had been decertified under the ONC Health IT Certification Program. CMS finalizes all its proposals to implement section 4002. The exceptions apply beginning with the CY 2018 payment adjustment for EPs, the FY 2019 payment adjustment year for eligible hospitals, and the FY 2018 payment adjustment year for CAHs.

Generally, to qualify for the exception,

1. The CEHRT must be decertified during the 12-month period preceding the applicable EHR reporting period for the payment adjustment year or during that applicable EHR reporting period.
2. The EP, eligible hospital or CAH must apply for the exception (in a form and manner CMS establishes) and must, in the application, demonstrate both (i) the intention to attest for a certain EHR reporting period and (ii) a good faith effort to adopt and implement another CEHRT in advance of that EHR reporting period.

EPs may qualify for the exception for the CY 2018 payment adjustment year which is the final year of payment adjustments for EPs for meaningful use under section 1848(a)(7)(A) of the Act. In the proposed rule, CMS noted that the application would be due October 1, 2017, or a later date if the agency specifies one. CMS does not specify a later date in the final rule.

Eligible hospitals may qualify for the exception beginning with the FY 2019 payment adjustment year. The application is due July 1 of the year before the applicable payment adjustment year. Thus, for the FY 2019 payment adjustment year, the application is due July 1, 2018, or a later date if CMS specifies one. CMS does not specify a later date in the final rule.

CAHs may qualify for the exception beginning with the FY 2018 payment adjustment year. The application is due November 30 after the end of the applicable payment adjustment year. Thus, for the FY 2018 payment adjustment year, the application is due November 30, 2018, or a later date if CMS specifies one. CMS does not specify a later date in the final rule.

3. Ambulatory Surgical Center (ASC)-based Eligible Professionals

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

CMS finalizes the use of the 75-percent threshold and believes this will reduce burden for ASC-based EPs who have little control over EHR decisions in the practice.

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

4. Certification Requirements for 2018

CMS will allow health care providers to use either 2014 Edition or 2015 Edition CEHRT, or a combination of 2014 Edition and 2015 Edition CEHRT, for an EHR reporting period in CY 2018. As noted above, for the CY 2018 CQM reporting period, eligible hospitals and CAHs may also use 2014 Edition or 2015 Edition CEHRT, or a combination of both Editions.

All new and returning participants attesting to CMS or their State Medicaid agency have the option to attest to the Modified Stage 2 objectives and measures under §495.22 of the regulations for the 2018 EHR reporting period using 2014 Edition CEHRT, 2015 Edition CEHRT, or a combination of 2014 and 2015 Edition CEHRT, as long as the EHR technology they possess can support the objectives and measures to which they plan to attest. Similarly, all new and returning participants attesting to CMS or their State Medicaid agency have the option to attest to the Stage 3 objectives and measures under §495.24 for the 2018 EHR reporting period using 2015 Edition CEHRT or a combination of 2014 and 2015 Edition CEHRT, as long as their EHR technology can support the functionalities, objectives and measures for Stage 3.

IX. Revisions of Medicare Cost Reporting and Provider Requirements

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

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

CMS is finalizing its proposal to allow providers to use an electronic signature that may be placed on the signature line of the certification statement and may be (1) any format of the original signature that contains the first and last name of the provider's administrator or chief financial officer (for example, photocopy or stamp) or (2) an electronic signature that must be the first and last name of the provider's administrator or chief financial officer entered in the provider's electronic program. To indicate the provider's election to sign the certification statement with an electronic signature, CMS is adding an electronic signature checkbox placed immediately after the certification statement and above the signature line on the Certification and Settlement Summary page of the Medicare cost report that reads:

> I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

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

CMS is further finalizing its proposal that if the provider signs the certification statement with an electronic signature, the provider also may submit the Certification and Settlement Summary page electronically to the contractor at the same time and in the same manner in which the Medicare cost report is submitted. For example, if the provider submits the electronic cost report file via electronic mail to the contractor, the provider may also include the Certification and Settlement Summary page signed with an electronic signature.

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

The policy will be effective for cost reporting ending on or after December 31, 2017 or nine months earlier than proposed considering that a 12-month cost reporting period beginning October 1, 2017 would not end until September 30, 2018.

Clarifications Relating to the Items Required to be Submitted by Providers with the Medicare Cost Report:

CMS is concerned that regulatory language may imply:

- a “settlement summary”;
- a “statement of certain worksheet totals found within the electronic file”; and
- a “statement signed by its administrator or chief financial officer certifying the accuracy of the electronic file or the manually prepared cost report”

are three separate items that must be submitted with the cost report. CMS is finalizing without change a clarification to the regulations that these items are all contained on the Certification and Settlement Summary page of the Medicare cost report. “A statement of certain worksheet totals found within the electronic file” is not a separate item but rather intended as a descriptor of the “settlement summary.”

Appendix I: MS-DRGs with Payment Changes Greater than +/- 9.9%

FY 2018 Final RULE, —LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS-DRGS), with Changes in Payment Greater than +/-9.9%		
MS-DRG	**MS-DRG Title**	**FY 2018 Final Rates compared to FY 2017 Rates (% Change)**
780	FALSE LABOR	-19.1%
454	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W CC	-19.1%
215	OTHER HEART ASSIST SYSTEM IMPLANT	-19.1%
333	RECTAL RESECTION W CC	-19.1%
332	RECTAL RESECTION W MCC	-19.1%
517	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC/MCC	-19.1%
734	PELVIC EVISCERATION, RAD HYSTERECTOMY & RAD VULVECTOMY W CC/MCC	-19.1%
867	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W MCC	-19.1%
455	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W/O CC/MCC	-19.1%
770	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	-17.9%
334	RECTAL RESECTION W/O CC/MCC	-17.8%
327	STOMACH, ESOPHAGEAL & DUODENAL PROC W CC	-17.4%
769	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	-15.3%
423	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W MCC	-14.6%
326	STOMACH, ESOPHAGEAL & DUODENAL PROC W MCC	-14.3%
830	MYELOPROLIFERATIVE DISORDERS OR POORLY DIFFERENTIATED NEOPLASMS W OTHER PROCEDURE W/O CC/MCC	-14.1%
951	OTHER FACTORS INFLUENCING HEALTH STATUS	-13.3%

290	ACUTE & SUBACUTE ENDOCARDITIS W/O CC/MCC	-12.5%
712	TESTES PROCEDURES W/O CC/MCC	-12.4%
344	MINOR SMALL & LARGE BOWEL PROCEDURES W MCC	-12.0%
981	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	-11.9%
777	ECTOPIC PREGNANCY	-10.3%
914	TRAUMATIC INJURY W/O MCC	10.0%
264	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	10.1%
499	LOCAL EXCISION & REMOVAL INT FIX DEVICES OF HIP & FEMUR W/O CC/MCC	10.3%
289	ACUTE & SUBACUTE ENDOCARDITIS W CC	10.4%
880	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	10.4%
274	PERCUTANEOUS INTRACARDIAC PROCEDURES W/O MCC	10.6%
316	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC/MCC	10.6%
422	HEPATOBILIARY DIAGNOSTIC PROCEDURES W/O CC/MCC	10.6%
570	SKIN DEBRIDEMENT W MCC	10.6%
079	HYPERTENSIVE ENCEPHALOPATHY W/O CC/MCC	10.7%
497	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W/O CC/MCC	10.8%
955	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	10.8%
097	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W MCC	10.9%
504	FOOT PROCEDURES W CC	10.9%
928	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC/MCC	11.0%
828	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W/O CC/MCC	11.0%
041	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W CC OR PERIPH NEUROSTIM	11.1%
496	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W CC	11.2%
433	CIRRHOSIS & ALCOHOLIC HEPATITIS W CC	11.4%
573	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W MCC	11.4%
694	URINARY STONES W/O ESW LITHOTRIPSY W/O MCC	11.4%
548	SEPTIC ARTHRITIS W MCC	11.4%
342	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	11.4%
913	TRAUMATIC INJURY W MCC	11.5%
298	CARDIAC ARREST, UNEXPLAINED W/O CC/MCC	11.5%
958	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W CC	11.5%
134	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES W/O CC/MCC	11.6%

376	DIGESTIVE MALIGNANCY W/O CC/MCC	11.9%
746	VAGINA, CERVIX & VULVA PROCEDURES W CC/MCC	12.0%
624	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W/O CC/MCC	12.1%
297	CARDIAC ARREST, UNEXPLAINED W CC	12.1%
017	AUTOLOGOUS BONE MARROW TRANSPLANT W/O CC/MCC	12.3%
881	DEPRESSIVE NEUROSES	12.9%
421	HEPATOBILIARY DIAGNOSTIC PROCEDURES W CC	13.1%
572	SKIN DEBRIDEMENT W/O CC/MCC	13.2%
341	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W MCC	13.2%
030	SPINAL PROCEDURES W/O CC/MCC	13.5%
903	WOUND DEBRIDEMENTS FOR INJURIES W/O CC/MCC	13.5%
135	SINUS & MASTOID PROCEDURES W CC/MCC	14.0%
865	VIRAL ILLNESS W MCC	14.4%
571	SKIN DEBRIDEMENT W CC	14.4%
010	PANCREAS TRANSPLANT	14.8%
976	HIV W MAJOR RELATED CONDITION W/O CC/MCC	14.9%
836	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W/O CC/MCC	15.1%
263	VEIN LIGATION & STRIPPING	15.1%
488	KNEE PROCEDURES W/O PDX OF INFECTION W CC/MCC	15.3%
776	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	15.4%
245	AICD GENERATOR PROCEDURES	15.5%
761	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W/O CC/MCC	16.9%
906	HAND PROCEDURES FOR INJURIES	17.3%
505	FOOT PROCEDURES W/O CC/MCC	17.5%
295	DEEP VEIN THROMBOPHLEBITIS W/O CC/MCC	17.7%
420	HEPATOBILIARY DIAGNOSTIC PROCEDURES W MCC	18.1%
117	INTRAOCULAR PROCEDURES W/O CC/MCC	18.4%
136	SINUS & MASTOID PROCEDURES W/O CC/MCC	18.5%
927	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV >96 HRS W SKIN GRAFT	18.5%
717	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXC MALIGNANCY W CC/MCC	18.7%
575	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W/O CC/MCC	19.1%
716	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC FOR MALIGNANCY W/O CC/MCC	19.2%

663	MINOR BLADDER PROCEDURES W CC	19.5%
122	ACUTE MAJOR EYE INFECTIONS W/O CC/MCC	19.8%
940	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W CC	19.9%
869	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W/O CC/MCC	20.1%
718	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXC MALIGNANCY W/O CC/MCC	20.9%
697	URETHRAL STRICTURE	22.4%
599	MALIGNANT BREAST DISORDERS W/O CC/MCC	24.5%
949	AFTERCARE W CC/MCC	24.8%
688	KIDNEY & URINARY TRACT NEOPLASMS W/O CC/MCC	24.9%
022	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W/O CC/MCC	25.3%
886	BEHAVIORAL & DEVELOPMENTAL DISORDERS	29.4%
941	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W/O CC/MCC	31.0%
782	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	31.2%
080	NONTRAUMATIC STUPOR & COMA W MCC	39.7%
950	AFTERCARE W/O CC/MCC	43.7%

Appendix II: Value-Based Purchasing Performance Standards

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

Measure short name	Achievement threshold	Benchmark
Safety Domain ♦		
CAUTI *†	0.828	0.000.
CLABSI *†	0.784	0.000.
CDI *†	0.852	0.091.
MRSA Bacteremia *†	0.815	0.000.
Colon and Abdominal Hysterectomy SSI *†	• 0.781	• 0.000.
	• 0.722	• 0.000.
PC–01 *	0.000000	0.000000.
Clinical Care Domain		
MORT–30–AMI ±	0.853715	0.875869.
MORT–30–HF ±	0.881090	0.906068.
MORT–30–PN ±	0.882266	0.909532.
THA/TKA *±	0.032229	0.023178.
Efficiency and Cost Reduction Domain		
MSPB *±	Median Medicare Spending Per Beneficiary ratio across all hospitals during the performance period.	Mean of the lowest decile Medicare Spending Per Beneficiary ratios across all hospitals during the performance period.

In section V.J.3.b. of the preamble of this final rule, we are removing the current PSI 90 measure beginning with the FY 2019 program year. As a result, the previously finalized performance standards for this measure are not included in this table.

♦ The performance standards displayed in this table for the Safety domain measures are updated using four quarters of CY 2016 data in this final rule.

† In section III.F.2.e. of preamble of the FY 2016 IPPS/LTCH PPS final rule (80 FR 49554 thorough 49555), we finalized our proposal to use the CDC's new standard population data to calculate performance standards for the NHSN measures beginning with the FY 2019 program year. We refer readers to that final rule for additional information regarding the NHSN measures' standard population data. In addition, we note that a technical update was released for these measures for the FY 2019 program year in order to ensure that hospitals have the correct performance standards for the applicable performance period.

* Lower values represent better performance.

± Previously adopted performance standards.

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

HCAHPS survey dimension	Floor (percent)	Achievement threshold (percent)	Benchmark (percent)
Communication with Nurses	51.80	79.08	87.12
Communication with Doctors	50.67	80.41	88.44
Responsiveness of Hospital Staff	35.74	65.07	80.14
Communication about Medicines	26.16	63.30	73.86
Hospital Cleanliness & Quietness	41.92	65.72	79.42
Discharge Information	66.72	87.44	92.11
Care Transition	20.33	51.14	62.50
Overall Rating of Hospital	32.47	71.59	85.12

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

± The performance standards displayed in this table were calculated using four quarters of CY 2016 data in this final rule.

PREVIOUSLY ADOPTED PERFORMANCE STANDARDS FOR THE FY 2021 PROGRAM YEAR

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

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

PREVIOUSLY ADOPTED AND NEWLY FINALIZED PERFORMANCE STANDARDS FOR THE FY 2022 PROGRAM YEAR

Measure short name	Achievement threshold	Benchmark
Clinical Care Domain		
MORT–30–AMI ±	0.861793	0.881305.
MORT–30–HF ±	0.879869	0.903608.
MORT–30–PN (updated cohort) ±	0.836122	0.870506.
MORT–30–COPD ±	0.920058	0.936962.
MORT–30–CABG ±	0.968210	0.979000.
THA/TKA * ±	0.029833	0.021493.
Efficiency and Cost Reduction Domain		
MSPB * ±	Median Medicare Spending Per Beneficiary ratio across all hospitals during the performance period.	Mean of the lowest decile Medicare Spending Per Beneficiary ratios across all hospitals during the performance period.
AMI Payment * ±	Median Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care across all hospitals during the performance period.	Mean of the lowest decile Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care across all hospitals during the performance period.
HF Payment * ±	Median Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care across all hospitals during the performance period.	Mean of the lowest decile Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care across all hospitals during the performance period.
PN Payment *#	Median Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care across all hospitals during the performance period.	Mean of the lowest decile Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care across all hospitals during the performance period.

±Previously adopted performance standards.
†After publication of the FY 2017 IPPS/LTCH PPS final rule, we determined there was a display error in the performance standards for this measure. Specifically, the Achievement Threshold and Benchmark values, while accurate, were presented in the wrong categories. We have corrected this issue in the table above, and the correct performance standards are displayed here.
*Lower values represent better performance.
#Scored the same as the MSPB, AMI Payment, and HF Payment measures, as discussed in section V.J.4.a.(2) of the preamble of this final rule.

NEWLY FINALIZED PERFORMANCE STANDARDS FOR THE FY 2023 PROGRAM YEAR

Measure short name	Achievement threshold	Benchmark
Clinical Care Domain		
MORT–30–AMI	0.866548	0.885499.
MORT–30–HF	0.881939	0.906798.
MORT–30–PN (updated cohort)	0.840138	0.871741.
MORT–30–COPD	0.919769	0.936349.
MORT–30–CABG	0.968747	0.979620.
THA/TKA*	0.027428	0.019779.
Efficiency and Cost Reduction Domain		
MSPB*	Median Medicare Spending Per Beneficiary ratio across all hospitals during the performance period.	Mean of the lowest decile Medicare Spending Per Beneficiary ratios across all hospitals during the performance period.
AMI Payment*#	Median Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care across all hospitals during the performance period.	Mean of the lowest decile Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care across all hospitals during the performance period.
HF Payment*#	Median Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care across all hospitals during the performance period.	Mean of the lowest decile Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care across all hospitals during the performance period.
PN Payment*#	Median Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care across all hospitals during the performance period.	Mean of the lowest decile Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care across all hospitals during the performance period.

*Lower values represent better performance.
#Scored the same as the MSPB, AMI Payment, and HF Payment measures, as discussed in section V.J.4.a.(2) of the preamble of this final rule.