American Hospital Association

Regulatory Advisory

August 23, 2017

MEDICARE INPATIENT PPS: THE FINAL RULE FOR FY 2018

AT A GLANCE

At Issue:

On Aug. 2, the Centers for Medicare & Medicaid Services (CMS) issued its hospital inpatient prospective payment system (PPS) and long-term care hospital (LTCH) PPS final rule for fiscal year (FY) 2018. The final rule affects inpatient PPS hospitals, critical access hospitals (CAHs), LTCHs and PPS-exempt cancer hospitals.

Major provisions of the rule related to inpatient PPS, CAHs, and PPS-exempt cancer hospitals are described below. A detailed summary of all provisions in this proposed rule prepared for AHA by Health Policy Alternatives, LLC is available on our website.

The AHA previously issued a separate advisory on proposals related to the LTCH PPS. The provisions of the final rule generally take effect Oct. 1.

The final rule will increase inpatient PPS rates by 1.2 percent in FY 2018, after accounting for inflation and other adjustments required by law. Hospitals that were not meaningful users of electronic health records (EHRs) in FY 2016 or that do not submit quality data will be subject to market-basket penalties. Additionally, the rule:

- Implements, beginning in FY 2018, a three-year phase in of hospitals' Worksheet S-10 data into the methodology for determining Medicare Disproportionate Share Hospital (DSH) uncompensated care payments;
- Allows hospitals to report meaningful use modified stage 2 in calendar year (CY) 2018 (rather than stage 3), and provides a 90-day reporting period for CY 2018;
- Reduces reporting requirements related to electronic clinical quality measures (eCQMs);
- Makes the CAH 96-hour certification requirement a low priority for medical reviews; and
- Does not finalize a proposal to require accrediting organizations to make hospital survey reports public.

The AHA is pleased that CMS finalized a number of proposals to reduce regulatory burden on hospitals, including those related to meaningful use, eCQMs and CAHs. However, we are disappointed CMS will begin using Worksheet S-10 data in 2018, rather than delaying its use until 2019. We continue to have concerns about the accuracy and consistency of the worksheet S-10 data, and are disappointed that CMS will move forward without a strong education and audit process. We will continue to work with CMS on steps the agency may take to improve the quality of these data.

What You Can Do:

✓ Share this advisory with your senior management team and ask your chief financial officer to examine the impact of the final payment changes on your Medicare revenue for FY 2018. Hospitals may assess the impact of these provisions on their organizations by using AHA's calculators:

- Readmissions Penalty Calculator: http://www.aha.org/readmissionscalc
- Value-based Purchasing Calculator: http://www.aha.org/vbpcalc
- Medicare DSH Payment Calculator: http://www.aha.org/dshcalc

✓ Share this advisory with your billing, medical records, quality improvement and compliance departments, as well as your clinical leadership team – including the quality improvement committee and infection control officer – to apprise them of the changes around the diagnosis-related groups and quality measurement requirements.

✓ Please also note the following submission deadlines set forth in the final rule:

- **Hospitals wishing to resubmit their FY 2014 and 2015 Worksheet S-10 data must submit this data by Sept. 30, 2017.** This data will not be used to calculate Factor 3 for FY 2018, but will be available in future years if the agency proposes and finalizes a methodology for determining Factor 3 that uses FY 2014 and FY 2015 Worksheet S-10 data in future years.
- **Current Medicare-dependent Hospitals (MDHs) wishing to apply for Sole Community Hospital (SCH) status must apply by Sept. 1, 2017 in order for SCH status to be effective upon expiration of the MDH program.**
- **Hospitals wishing to qualify for the payment adjustment for low-volume hospitals must make a written request for low-volume status no later than Sept. 1, 2017.**
- **Applications for hospital reclassifications for FY 2019 are due by Sept. 1, 2017.**

Further Questions:

For additional questions, please contact Priya Bathija, AHA senior associate director, at (202) 626-2678 or pbathija@aha.org.

American Hospital Association

Regulatory Advisory

August 23, 2017

MEDICARE INPATIENT PPS: THE FINAL RULE FOR FY 2018

SUMMARY

Inpatient PPS Rate Update

The Centers for Medicare & Medicaid Services' (CMS) final rule will increase inpatient prospective payment (PPS) rates by 1.2 percent in fiscal year (FY) 2018, after accounting for inflation and other adjustments required by law. Specifically, the update includes an initial market-basket update of 2.7 percent, less 0.6 percentage points for productivity, 0.75 percentage points mandated by the Affordable Care Act (ACA), and 0.6 percentage points to remove the one-time, temporary adjustment that CMS made in FY 2017 to restore the unlawfully instituted two-midnight policy cuts from FY 2014-2016. In addition, CMS finalizes an increase of 0.4588 percentage points to partially restore cuts made as a result of the American Taxpayer Relief Act (ATRA) requirement that the agency recoup what it claims is the effect of documentation and coding changes from FYs 2010-2012, which CMS says do not reflect real changes in case mix. Table 1 below details the factors CMS includes in its estimate.

Table 1: Impacts of FY 2018 CMS Final Policies

Policy	Average Impact on Payments
Market-basket update	2.7%
Productivity cut mandated by the ACA	- 0.6%
Additional cut mandated by ACA	- 0.75%
Two-midnight policy adjustments	- 0.6%
Partial restoration of documentation and coding cut for FYs 2010, 2011 and 2012 mandated by ATRA	+ 0.4588%
Total	**+1.2%**

The ACA, two-midnight policy and ATRA adjustments will be applied to all hospitals. However, hospitals that do not submit quality data or that failed to either meet meaningful use or qualify for hardship exemption in FY 2016 would be subject to market-basket penalties.

Specifically:

- Hospitals not submitting quality data will be subject to a one-quarter reduction in their initial market-basket rate. Thus, they will start with a market-basket rate of 2.025 percent and will receive an update of 0.5 percent.
- Hospitals that were not meaningful users of electronic health records (EHRs) in FY 2016 will be subject to a three-quarter reduction in their initial market-basket rate. Thus, they will start with a market-basket rate of 0.675 percent and will receive an update of -0.8 percent.
- Hospitals that fail to meet both of these requirements will be subject to a full reduction in their initial market-basket rate. Thus, they will start with a market basket rate of 0.0 and will receive an update of -1.5 percent.

For more information related to the penalties described above for failure to either meet meaningful use or qualify for hardship exemption, including those that apply to critical access hospitals (CAHs), please review the Aug. 13, 2010 AHA Regulatory Advisory on meaningful use.

Also by law, CMS must adjust the proportion of the standardized amount that is attributable to wages and wage-related costs (known as the labor-related share) by a factor that reflects the relative difference in labor costs among geographic areas (known as the area wage index). For FYs 2014-2017, CMS used the labor-related share of 69.6 percent for those hospitals with wage indices greater than 1.0. For FY 2018, CMS finalized its proposal to rebase and revise the inpatient PPS market basket to reflect 2014 data. As a result, the agency finalizes a labor-related share of 68.3 percent for those hospitals with wage indices greater than 1.0.

By law, the labor-related share for those hospitals with wage indices less than or equal to 1.0 will remain at 62 percent. For Puerto Rico hospitals, CMS will use a labor-related share of 62 percent in FY 2018 because the national wage index for all Puerto Rico hospitals is less than 1.0.

Two-midnight Policy Adjustment

In FY 2017, CMS instituted two adjustments to reverse the effects of the 0.2 percent cut it unlawfully instituted when implementing the two-midnight policy in FY 2014. Specifically, the agency implemented a permanent adjustment of approximately 0.2 percent to remove the cut prospectively for FYs 2017 and onward. It also instituted a *temporary* adjustment of 0.6 percent to address the retroactive impacts of this cut for FYs 2014-2016. CMS now finalizes its proposal to remove this 0.6 percent temporary adjustment from the inpatient PPS rates for FY 2018.

Documentation and Coding Adjustment

As discussed above, the final rule includes partial restoration of the ATRA documentation and coding cuts. ATRA required CMS to recoup $11 billion for what the agency claims is the effect of documentation and coding changes from FYs 2010-2012

that CMS says do not reflect real changes in case mix. The agency instituted these cuts in FYs 2014 through 2017. The Medicare Access & CHIP Reauthorization Act (MACRA) and the 21st Century Cures Act then required CMS to restore most of these cuts over a six-year period, beginning with a 0.4588 percentage point increase in FY 2018. However, in FY 2017, when completing its final ATRA recoupment, CMS finalized a cut that was almost two times what it had planned and lawmakers had expected. Yet, the agency did not propose or finalize a correction for this discrepancy when instituting this year's restoration.

We are disappointed that CMS decided not to restore last year's excess cut to reimbursement rates for hospital services. While a reduction to the hospital update factor was mandated by law in 2012, CMS ignored Congress' intent by imposing a cut that was nearly two times what Congress specified.

Disproportionate Share Hospital (DSH) Payment Methodology Changes

The ACA made changes to Medicare DSH payments beginning in FY 2014. Under these changes, hospitals initially receive 25 percent of the DSH funds they would have received under the pre-FY 2014 formula (which CMS describes as "empirically justified DSH payments"), with the remaining 75 percent flowing into a separate funding pool for DSH hospitals (the "75 percent pool"). This 75 percent pool is adjusted each year as the percentage of uninsured declines. It is distributed based on the proportion of total uncompensated care each Medicare DSH hospital provides. CMS describes payments made from this pool as "uncompensated care DSH payments." For FYs 2014-2017, the agency used inpatient days of Medicaid beneficiaries plus inpatient days of Medicare supplemental security income (SSI) beneficiaries as a proxy for measuring the amount of uncompensated care each hospital provides.

FY 2018 DSH Payments. For FY 2018, CMS states that the total amount of Medicare DSH payments that would have been made under the pre-FY 2014 formula is $15.533 billion. Due to the factors used by the agency to calculate the total amount of Medicare DSH payments that would have been made under the pre-FY 2014 formula, this number is significantly larger than in previous years, resulting in an increase in total payments to DSH hospitals.

Accordingly, CMS states that hospitals will initially receive 25 percent of these funds, or $3.888 billion, as empirically justified DSH payments. The remaining $11.665 billion will flow into the 75 percent pool. To calculate what portion of the 75 percent pool is retained, CMS determined that the percentage of uninsured for FY 2018 will be 8.15 percent. After inputting that rate into the statutory formula, the agency will retain 58.21 percent – or $6.767 billion – of the 75 percent pool in FY 2018. This amounts to an increase of about $800 million in Medicare DSH payments in FY 2018 compared to FY 2017.

CMS also finalizes its proposal to change its data source for calculating the uninsured rate from the Congressional Budget Office (CBO) to estimates produced by its Office of the Actuary as part of the development of the National Health Expenditures Account

(NHEA). The statute allows CMS to use a data source other than the CBO estimates to determine the percent change in the rate of uninsurance beginning in FY 2018. In addition, for FY 2018 and subsequent years, the statute does not require that the estimate of the percent of individuals who are uninsured be limited to individuals who are under age 65. The agency considered a variety of data sources before selecting the NHEA data, but indicates it believes the comprehensive and integrated structure of the NHEA creates an ideal tool for evaluating changes to the health care system, such as the mix of the insured and uninsured. For FY 2018, the NHEA data produce a slightly smaller reduction in the uninsured, thereby increasing the total available dollars for uncompensated care.

To distribute the 75 percent pool, the agency will continue to calculate uncompensated care provided by DSH hospitals. It then will determine what percentage of total uncompensated care each individual DSH hospital accounts for. Hospitals will receive that percentage of what remains of the 75 percent pool as their uncompensated care DSH payment. For example, if Hospital A accounts for 1 percent of the total uncompensated care provided by all DSH hospitals, it would receive 1 percent of the 75 percent pool.

Transition to Worksheet S-10. For several years, CMS discussed using the cost report's Worksheet S-10 data on hospital charity care and bad debt to determine the amount of uncompensated care each hospital provides, in place of the current formula of Medicaid and Medicare SSI days. However, because of concerns regarding variations in and the completeness of these data, CMS determined it was premature to propose the use of Worksheet S-10.

Now, for a variety of reasons, the agency believes it has reached a "tipping point" with respect to the use of Worksheet S-10 data and finalizes its proposal to, starting in FY 2018, begin incorporating hospitals' Worksheet S-10 data into the methodology for determining uncompensated care payments. CMS will continue to use a three-year average of data reported on a hospital's cost reports to calculate that hospital's uncompensated care payment.

Specifically, for FY 2018, CMS will use FY 2014 Worksheet S-10 data in combination with FY 2012 and 2013 Medicaid days and FY 2014 and 2015 SSI ratios to determine the distribution of uncompensated care payments. CMS indicates that an additional year of Worksheet S-10 data could be incorporated into the calculation in FY 2019, and the use of Medicaid and Medicare SSI days could be phased out by FY 2020. However, no official rulemaking is included for FY 2019 or 2020. In addition, CMS notes that this transition to the Worksheet S-10 will not apply for Puerto Rico hospitals and Indian Health Services and Tribal hospitals – the agency will double-weight the 2013 Factor 3 calculated for those hospitals for FY 2018.

Technical Comments related to Worksheet S-10. CMS also discusses the technical comments the agency has received from the hospital field related to the current

Worksheet S-10 and its instructions. As part of that discussion, CMS finalizes additional changes, as discussed below.

- Annualizing Cost Reports. If a hospital has cost reports that do not equal 12 months of data (in other words, are more or less than 365 days) in any given year, CMS will annualize Medicaid data for FY 2018. The agency will not annualize SSI days because that data are not obtained from hospital cost reports.

- Scaling Factor. Under the methodology adopted for FYs 2017 and 2018, if a hospital does not have data for one or more of the three cost-reporting periods, CMS averages the data from the cost reports that do exist. Commenters noted that for FY 2017, this method resulted in total uncompensated care payments that exceeded the estimate published by the agency in the inpatient PPS final rule for FY 2017. As a result, CMS finalizes its proposal to use a scaling factor in FY 2018 to adjust this calculation and ensure that total uncompensated care payments do not exceed the estimate.

- Definition of Uncompensated Care. CMS finalizes its proposal that, beginning in FY 2018, uncompensated care costs will be defined to include line 30 of the Worksheet S-10, which includes the cost of charity care and non-Medicare bad debt. In response to comments that this definition should also include discounts to the uninsured and underinsured, CMS indicates that, in general, it will attempt to address commenters' concerns in future cost-reporting clarifications to ensure that Worksheet S-10 is an appropriate instrument to collect the information necessary to implement section 3133 of the ACA.

- Trims to Apply to CCRs on Line 1 of Worksheet S-10. Generally, CMS finalizes its proposal to trim data to control for data anomalies as proposed. For FY 2018, all hospitals with a Worksheet S-10 cost-to-charge ratio (CCR) that is above a CCR "ceiling" or that is greater than 3.0 standard deviations above the geometric mean will receive the statewide average CCR. The agency modifies its proposal so that the statewide average will no longer apply to all-inclusive rate providers.

- Cost Report Revisions and Worksheet S-10 Audits. CMS also states that it continues to develop a process for auditing the S-10 data, and such instructions will be provided to the Medicare Administrative Contractors (MACs) as soon as possible and in advance of any audit. In the proposed rule, the agency indicated its expectation that cost reports beginning in FY 2017 would be the first for which the Worksheet S-10 data will be subject to a desk review. In addition to FY 2017 cost reports, the agency indicates that cost reports for FYs 2014-2016 will receive further scrutiny. **Additionally, CMS provides hospitals with an opportunity to resubmit FY 2014 and 2015 Worksheet S-10 data to their MACs by Sept. 30, 2017.** This data will not be used to calculate Factor 3 for FY 2018, but will be available in future years if the agency proposes and finalizes a

methodology for determining Factor 3 that uses FY 2014 and 2015 Worksheet S-10 data in future years.

The AHA had urged a one-year delay in the use of the Worksheet S-10 to allow CMS to further educate hospitals about how to accurately and consistently complete it. The AHA also urged the agency to implement an audit process and a stop-loss policy to protect hospitals that lose more than 10 percent in any given year as a result of transitioning to the Worksheet S-10. We are disappointed CMS chose to implement the Worksheet S-10 data in FY 2018, and that the agency did not provide these additional protections for hospitals. We will continue to communicate and work with CMS on steps the agency may take to improve the quality of these data.

The AHA has created a DSH calculator, available at: www.aha.org/dshcalc, for hospitals to assess the impact of the policy on their organizations. The calculator is designed so basic financial information regarding a hospital can be entered, including its CMS Certification Number (CCN), and the dollar amount of the hospital's DSH payment will be estimated.

Rural Hospital Provisions

96-hour Certification Requirement. As a condition of payment for inpatient services provided at a CAH, the statute requires that a physician certify that an individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH. In the final rule, CMS indicates that it reviewed the CAH 96-hour certification requirement to determine if there are ways to reduce its burden on providers. As a result, the agency states that it will direct Quality Improvement Organizations (QIOs), MACs, the Supplemental Medical Review Contractor (SMRC) and Recovery Audit Contractors (RACs) to make the requirement a low priority for medical record reviews conducted on or after Oct. 1, 2017. **This means that, absent concerns of probable fraud, waste or abuse of the coverage requirement, these contractors will *not* conduct medical record reviews to determine compliance with the CAH 96-hour certification requirement.**

The AHA commends CMS for recognizing that this condition of payment should not be enforced so that CAHs may continue to provide essential, and often life-saving health care services to rural America. The AHA will continue to advocate for a legislative solution that permanently removes the 96-hour physician certification requirement as a condition of payment for CAHs.

Medicare-dependent Hospital (MDH) Program. MACRA extended the MDH program through FY 2017 only. Therefore, unless Congress intervenes, beginning Oct. 1, 2017, the MDH program will no longer be in effect. As such, all hospitals that previously qualified for MDH status will be paid based on the federal rate. CMS reiterates its existing policy that allows MDHs to apply for sole community hospital (SCH) status and be paid as such under certain conditions, following the expiration of the MDH program.

Hospitals wishing to apply for SCH status must apply at least 30 days before the end of the MDH program, or by Sept. 1, 2017, in order for SCH status to be effective upon expiration of the MDH program. The AHA continues to urge Congress to permanently extend this program by passing the Rural Hospital Access Act of 2017 (S. 872/H.R. 1955).

Payment Adjustment for Low-volume Hospitals. MACRA also extended the enhanced low-volume payment adjustment through Sept. 30, 2017. During that time, low-volume hospitals were defined as those that are more than 15 road miles from another comparable hospital and that have up to 1,600 Medicare discharges. Qualifying hospitals received an add-on payment to their PPS rate that ranged from 25 percent for hospitals with fewer than 200 Medicare discharges to no adjustment for hospitals with more than 1,600 Medicare discharges.

As of Oct. 1, 2017, under current law, the definition of low-volume will revert back to the original, more restrictive, statutory definition, which requires qualifying hospitals to be more than 25 miles from a comparable hospital and have less than 200 discharges (i.e., less than 200 discharges total, including both Medicare and non-Medicare discharges).

If a hospital believes it would qualify under this definition, for FY 2018, it must make a written request for low-volume hospital status that is received by its MAC no later than Sept. 1, 2017. Under this procedure, a hospital that qualified for the low-volume hospital payment adjustment for FY 2017 may continue to receive a low-volume hospital payment adjustment for FY 2018 without reapplying if it meets both the discharge criterion and the mileage criterion applicable for FY 2018. As in previous years, CMS states that such a hospital must send written verification that is received by its MAC no later than Sept. 1, 2017, stating that it meets the mileage criterion applicable for FY 2018. For FY 2018, the agency further proposes that this written verification must also state, based upon the most recently submitted cost report, that the hospital meets the discharge criterion applicable for FY 2018 (that is, less than 200 discharges total, including both Medicare and non-Medicare discharges).

The AHA continues to urge Congress to permanently extend the enhanced low-volume adjustment by passing the Rural Hospital Access Act of 2017 (S. 872/H.R. 1955).

Extension of the Rural Community Hospital (RCH) Demonstration Program. The 21st Century Cures Act extended the RCH Demonstration for an additional five years and expanded the program to rural areas in all states. This program, which allows rural hospitals with fewer than 51 acute care beds to test the feasibility of cost-based reimbursement, was established under the Medicare Prescription Drug, Improvement and Modernization Act. The ACA extended the program an additional five years, increased the maximum number of participating hospitals from 15 to 30, and expanded the eligible sites to rural areas in 20 states with low-population densities. Under law, the ACA limit for the maximum number of participating hospitals – 30 – would remain in place.

Solicitation of New Participants. CMS issued requests for applications in the spring. CMS has not yet finalized the selection of additional participants to participate in the demonstration, and the start dates for the five-year extension period for the additional hospitals will be announced after selections are announced.

Existing Hospitals. CMS proposed to align the periods of performance for both previously participating hospitals and newly selected hospitals during the extension period such that the performance periods for any of the hospitals would start with a hospital's first cost-reporting period beginning on or after Oct. 1, 2017 following the announcement of the selection of the additional hospitals. This proposal would have resulted in a gap in the reasonable cost payment methodology paid to RCH demonstration hospitals that previously participated in the program. In the final rule, in response to concerns from the AHA and the hospital field, CMS modifies this proposal so that there is no gap – the performance period for previously participating hospitals will begin immediately after the date the period of performance under the first five-year extension period ended. **We are pleased that CMS implemented this alternate proposal, which will allow these hospitals to continue delivering essential health care services to their communities.**

Wage Index

The area wage index adjusts payments to reflect differences in labor costs across geographic areas. The final rule will base the FY 2018 wage index on data from FY 2014 cost reports. In addition, CMS will continue using the labor market delineations adopted by the Office of Management and Budget (OMB) that reflect the OMB's 2010 standards and 2010 census data, with updates as reflected in OMB Bulleting No. 15-01. According to CMS, the national average hourly wage increased 1.02 percent compared to FY 2017. As a result, a number of hospitals could see a decline in their wage indices relative to last year because, even though their wages rose, they did not rise as quickly as those at other hospitals.

Occupational Mix. The purpose of the occupational mix adjustment is to control for the effect of hospitals' employment choices on the calculation of the wage index. CMS is required to collect data every three years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program. CMS collected data in the 2013 Medicare Wage Index Occupational Mix Survey with the intent of computing the occupational mix adjustment for FYs 2016, 2017 and 2018. Accordingly, CMS will calculate the FY 2018 occupational mix adjustment based on data from the 2013 Medicare Wage Index Occupational Mix Survey. CMS also will apply the occupational mix adjustment to 100 percent of the wage index, as it did for FY 2017.

Imputed Rural Floor. The imputed rural floor for those states with no rural counties is set to expire Oct. 1, 2017. CMS did not propose to extend the policy for FY 2018 indicated that it has at many points, expressed reservations about establishment of an imputed floor, considering that the methodology creates a disadvantage in the application of the wage index to hospitals in states with rural hospitals but no urban hospitals receiving the rural floor. In the final rule, however, CMS states that it will temporary extend the

imputed floor for an additional year while the agency considers the comments it has received from the hospital field and further assesses the effects of this policy and whether to continue or discontinue the policy for the long term.

CMS anticipates that, in FY 2018, there will be 17 hospitals in New Jersey that will receive an increase in their FY 2018 wage indices due to the continued application of the imputed floor policy under the original methodology, and 10 hospitals in Rhode Island and six hospitals in Delaware that will benefit under the alternative methodology.

Hospital Redesignations and Reclassifications. Hospitals may apply to the Medicare Geographic Classification Review Board (MGCRB) for geographic reclassifications for purposes of inpatient PPS payment. Generally, hospitals must be proximate to the labor market area to which they are seeking reclassification and must demonstrate characteristics similar to hospitals located in that area. At the time the final rule was drafted, the MGCRB had completed its review of FY 2018 reclassification requests and 374 hospitals were approved for wage index reclassifications for FY 2018. Hospitals reclassified during FYs 2016 (245 hospitals) and 2017 (246 hospitals) will continue to be reclassified, because wage index reclassifications are effective for three years.

Applications for hospital reclassifications for FY 2019 are due to the MGCRB by Sept. 1, 2017. Hospitals with current reclassifications are encouraged to analyze the area wage indexes published in the proposed rule, and confirm that the areas to which they have been reclassified still result in a higher wage index than their geographic area wage index. Hospitals may withdraw their reclassifications by contacting the MGCRB within 45 days of the publication of the proposed rule.

Key Coding and MS-DRG Changes

CMS is changing the deadline to request updates to Medicare-severity Diagnosis-related Groups (MS-DRGs) from Dec. 7 to Nov. 1 of each year. This will provide CMS an additional five weeks for the data analysis and review process.

- **Major Diagnostic Category (MDC) 14 (Pregnancy, Childbirth and the Puerperium).**
  Vaginal Delivery and Complicating Diagnoses. The MS-DRG logic involving a vaginal delivery under MDC 14 is technically complex as a result of the requirements that must be met to satisfy assignment to the affected MS-DRGs. CMS is soliciting public comments on which diagnosis or procedure codes, or both, should be considered in the logic to identify a vaginal delivery and which diagnosis codes should be considered in the logic to identify a complicating diagnosis.

  CMS will review public comments received in response to this solicitation and, if warranted, will propose refinements for FY 2019. CMS requests that all comments be directed to the CMS MS-DRG Classification Change Request Mailbox located at: MSDRGClassificationChange@cms.hhs.gov by Nov. 1, 2017.

- **MDC 23 (Factors Influencing Health Status and Other Contacts with Health Services): Updates to MS-DRGs 945 and 946 (Rehabilitation with and without CC/MCC, respectively).**
  In FY 2016, CMS received several requests to examine the MS-DRG logic for MS-DRGs 945 and 946 (Rehabilitation with CC/MCC and without CC/MCC, respectively) because the logic does not replicate the ICD-9-CM MS-DRGs. In order to replicate the ICD-9-CM MS-DRG logic using ICD-10-CM and ICD-10-PCS codes, CMS developed the new logic included in the MS-DRG Version 33. In order to be assigned to ICD-10 MS-DRG 945 or 946, a case must first have a principal diagnosis from MDC 23 (Factors Influencing Health Status and Other Contacts with Health Services), where MS-DRGs 945 and 946 are assigned. If the case does not have a principal diagnosis code from the MDC 23 list, but does have a procedure code from the list included under the Rehabilitation Procedures for MS-DRGs 945 and 946, the case will not be assigned to MS-DRGs 945 or 946. The case will instead be assigned to a MS-DRG within the MDC where the principal diagnosis code is found.

  In FY 2017, CMS received comments offering several different options to replicate the ICD-9-CM MS-DRG logic. CMS did not change the structure of MS-DRGs 945 and 946 and offered to reconsider the issue when ICD-10 claims data became available prior to proposing any updates.

  In June 2016, the AHA submitted a proposal to the Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), the federal agency responsible for the creation and maintenance of the ICD-10-CM code set, to create a single new ICD-10-CM diagnosis code ("Z-code") to replicate the ICD-9-CM code category V57, Care involving use of rehabilitation procedures. The proposal was addressed at the March 2017 meeting of the ICD-10 Coordination and Maintenance Committee. Any new codes approved after this meeting would be available on the CMS and CDC websites in June 2017 and implemented on Oct. 1, 2017. New codes also would be included in the FY 2018 IPPS/LTCH PPS final rule.

  CMS's analysis indicated there was a decrease of 3,320 MS-DRG 945 cases (from 3,991 to 671) from FY 2015, when claims were submitted with ICD-9-CM codes, to FY 2016 when ICD-10 codes were submitted. There was a decrease of 1,027 MS-DRG 946 cases (from 1,184 to 157) from FY 2015 to FY 2016. The average length of stay increased 0.5 days (from 10.3 to 10.8 days) for MS-DRG 945 and decreased 0.7 days (from 8.0 to 7.3 days) for MS-DRG 946. CMS also examined possible MS-DRGs where these cases may have been assigned in FY 2016 based on increases in the number of claims. Because there is not a diagnosis code that could be reported as a principal diagnosis, which would indicate if the admissions were for rehabilitation services, CMS was unable to determine if these were cases admitted for rehabilitation that moved from MS-DRGs 945 and 946 because of the lack of a code for encounter for rehabilitation, or if there was simply a change in the number of cases.

Given the lack of a diagnosis code to capture the principal diagnosis of encounter for rehabilitation, CMS was unable to update MS-DRGs 945 or 946 to better identify those cases in which patients are admitted for rehabilitation services. CMS indicated that if the CDC creates a new ICD-10-CM code for encounter for rehabilitation services, CMS would consider proposing updates to MS-DRG 945 and 946 utilizing these new codes in future rulemaking. In the meantime, CMS welcomes other specific recommendations on how to update MS-DRGs 945 and 946.

- **O.R. Procedures to Non-O.R. Procedures**. For FY 2018, CMS continues to address the recommendations for changing the designation of specific ICD-10-PCS procedure codes. CMS proposes to change the designation of 43 groups of procedures (824 ICD-10-PCS codes) from O.R. to non-O.R. procedures. The procedures generally would not require the resources of an operating room and can be performed at bedside. The detailed lists of procedure are shown in Tables 6P.4a. through 6P.4p. associated with the proposed rule (display copy pages 247-276).

- **Non-O.R. Procedures to O.R. Procedures**. CMS proposes to remove 55 ICD-10-PCS procedure codes as non-O.R. procedures affecting the MS-DRG from the logic for MS-DRGs 823, 824, and 825 (Lymphoma and Non-Acute Leukemia with Other O.R. Procedure with MCC, with CC and without CC/MCC, respectively) and MS-DRGs 829 and 830 (Myeloproliferative Disorders or Poorly Differentiated Neoplasms with Other O.R. Procedure with CC/MCC and without CC/MCC, respectively). The specific ICD-10-PCS codes are listed in Table 6P.3c. associated with this proposed rule. CMS also is proposing to revise the titles for these five MS-DRGs by deleting the reference to "O.R." in the title.

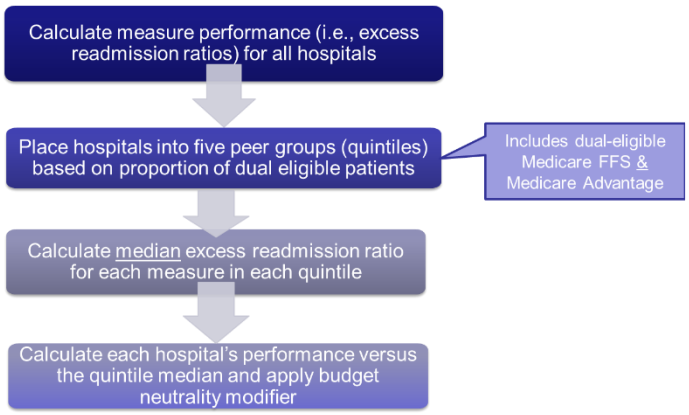
Hospital Readmissions Reduction Program (HRRP)

The HRRP imposes penalties of up to 3 percent of base inpatient PPS payments for having "excess" readmissions rates for selected conditions when compared to expected rates. CMS uses a total of six Medicare-claims-based readmission measures to assess performance in the program – acute myocardial infarction (AMI), heart failure (HF), pneumonia, chronic obstructive pulmonary disease (COPD), isolated coronary artery bypass grafts, and elective hip and knee replacements. There are no major updates to the HRRP for FY 2018. For FY 2019 penalties, however, CMS will implement the socioeconomic adjustment approach mandated by the 21st Century Cures Act.

Performance Period for FY 2018. FY 2018 payment adjustments under the HRRP will be based on measure performance from July 1, 2013 to June 30, 2016. CMS notes that the performance period will combine Medicare claims data collected under both ICD-9 (through Sept. 30, 2015) with data collected using ICD-10 (starting Oct., 1, 2015). Updated measure specifications reflecting how the measure will be collected using ICD-10 are available on CMS's website. **The AHA remains concerned that the ICD-10 versions of the readmission measures have not yet been fully tested and endorsed by the National Quality Forum (NQF).**

Socioeconomic Adjustment for FY 2019. For the FY 2019 HRRP, CMS finalizes a socioeconomic adjustment approach mandated by the 21st Century Cures Act. Starting in FY 2019, the agency must implement a budget-neutral methodology in which readmission penalties are based on hospitals' performance relative to other hospitals with similar proportions of patients who are dually eligible for Medicare and Medicaid. Figure 1 below summarizes CMS's approach.

Figure 1: HRRP Socioeconomic Adjustment Approach



The AHA has long urged CMS to implement socioeconomic adjustment in the HRRP because of the significant body of research showing that readmissions performance is affected by poverty, availability of resources and other factors beyond hospitals' control. We believe the approach is a good first step to providing relief to many hospitals caring for large numbers of patients facing socioeconomic challenges.

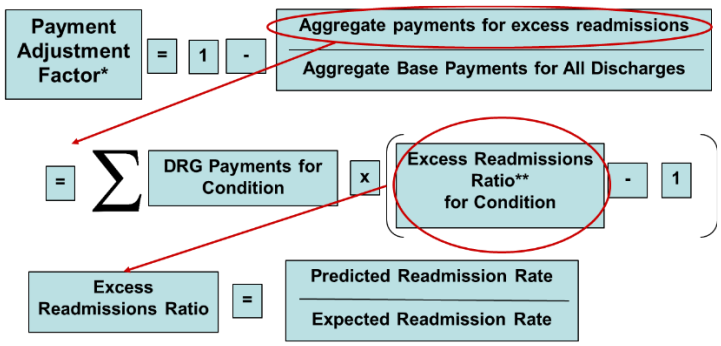
Defining the Dual-eligible Peer Groups. As a first step to applying the adjustment required under the statute, CMS will place each hospital into one of five peer groups (i.e., quintiles) based on the proportion of its Medicare fee-for-service (FFS) *and* Medicare Advantage patients that are full-benefit, dual-eligible patients. While the HRRP applies to Medicare inpatient PPS payments only, the agency believes the inclusion of Medicare Advantage patients will more accurately represent the totality of dual-eligible patients served by hospitals. Dual-eligible patients will be identified using the state Medicare Modernization Act (MMA) file, which states submit to CMS monthly and that CMS believes is the most accurate source of information on dual-eligible patients.

Maintaining Budget Neutrality. As required by the statute, CMS's methodology ensures the peer grouping approach is budget neutral. That is, the aggregate readmission penalties with the new peer grouping approach will be the same as they would under the current methodology, though the penalties for individual hospitals can change.

CMS's approach to budget neutrality relies on changing how it uses the excess readmission ratios (ERRs) in the payment penalty formula. The current readmissions

penalty formula is outlined in Figure 2 below. ERRs are calculated using the readmission measures for the six conditions in the program. To determine aggregate payments, CMS sums the payment for excess readmissions for each condition.

Figure 2: Current Approach to Calculating HRRP Payment Adjustment Factor

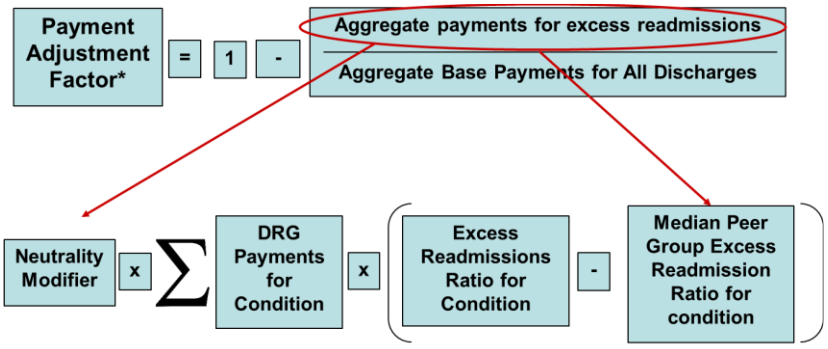


*Payment adjustment factors cannot be less than 0.97 (i.e., 3 percent cap on penalties

**Ratios less than 1.0000 mean no penalty assessed for that condition

To achieve budget neutrality, CMS will alter the formula used to calculate aggregate payments for excess readmissions and apply a multiplicative budget neutrality modifier. These changes are summarized in Figure 3 below, and the significant changes are highlighted with red arrows. First, CMS will determine the median ERR for each program measure in each dual-eligible quintile. The agency then will compare each hospital's performance to the quintile median by subtracting the quintile median ERR from a hospital's own ERR. Once CMS has summed the payments for excess readmissions for each condition, it will apply a "neutrality modifier" to ensure HRRP penalties across all hospitals under the proposed method are the same as under the current method.

Figure 3: Approach to Calculating HRRP Adjustment Factors Starting in FY 2019



*Payment adjustment factors cannot be less than 0.97 (i.e., 3 percent cap on penalties

Hospital Value-based Purchasing (VBP) Program

As required by the ACA, CMS will fund the budget-neutral FY 2018 VBP program by reducing base operating diagnosis-related group payment amounts to participating hospitals by 2.0 percent. CMS estimates the pool of available VBP funds will be $1.9 billion for FY 2018.

PSI-90 Measure Changes. Starting with the FY 2019 VBP program, CMS will remove the current version of the claims-based patient safety indicator (PSI) composite because it does not yet have the software to calculate it in ICD-10. However, CMS will reintroduce a revised version of the PSI composite based on ICD-10 data as part of the FY 2023 VBP program. In addition to being based on ICD-10 data, the updated composite will include revisions to the underlying component PSI indicators. **The AHA continues to oppose the use of any version of the PSI measure in hospital pay-for-performance programs. The PSI indicators fail to provide accurate, meaningful data on hospital safety performance.**

Changes to the Efficiency/Cost Measure Domain. CMS adopts two significant changes to the efficiency and cost measure domain for FYs 2021 and 2022, outlined below.

Weighting of Measures within Domain for FY 2021. Last year, CMS adopted two condition-specific episode-based payment measures (AMI and HF) for the FY 2021 VBP program, adding to the Medicare spending per beneficiary (MSPB) measure already in the program. As a result, CMS adopts policies for how it will weight MSPB and the condition-specific measures in the program towards a hospital's efficiency/cost domain score. In general, MSPB will comprise 50 percent of a hospital's domain score, while the condition-specific measures, weighted equally, will comprise the other 50 percent of the score. Hospitals that do not meet the case minimum (i.e., 25 cases) for the condition-specific measures will have their cost/efficiency scores based solely on MSPB. If a hospital has enough data to be scored on MSPB and only one of the condition-specific measures, the domain score will be 50 percent MSPB, and 50 percent the measure(s) for which hospitals have enough data.

Pneumonia Episode-based Payment Measures for the 2022 Program Year. CMS adopts a pneumonia episode-based payment measure to the Efficiency and Cost Reduction for FY 2022. As with the AMI and HF measures, the proposed measure calculates total payments for Medicare FFS patients with a primary discharge diagnosis of pneumonia from the date of the initial hospital admission through 30 days post-admission. Payments for the initial hospitalization are included in the measures, as are payments for a broad range of subsequent care, including inpatient, outpatient, physician, laboratory and post-acute care services. The measures also includes a risk-adjustment methodology to account for patient characteristics, such as age, prior procedures and co-morbid conditions, which influence resource use and, therefore, payment. However, the measures do not include an adjustment for sociodemographic factors. **The AHA remains concerned that the overlap of condition-specific measures and the MSPB measures may lead to confusion among hospitals. Furthermore, we are concerned that the measures lack adjustment for**

sociodemographic status, which may disadvantage those hospitals caring for poorer patients.

Hospital Inpatient Quality Reporting (IQR) Program

The IQR program is CMS's pay-for-reporting program in which hospitals must submit measures in order to avoid a payment reduction equal to one quarter of the annual market-basket update. CMS adopts refinements to two IQR measures and finalizes a voluntarily reported measure. CMS also finalizes changes to its requirements for electronic clinical quality measure reporting, which are detailed in the next section.

Pain Management Questions. Starting with January 2018 surveys, CMS will implement reworded versions of the pain management questions used in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. The reworded questions are intended to respond to concerns raised by the AHA and other stakeholders that the existing pain management questions may inadvertently place too much emphasize on the use of opioids and other medications to treat pain. The new questions are worded as follows:

- During your hospital stay, did you have pain?
  - *Answers*: Yes/No (if answering "yes," go to next question)
- During this hospital stay, how often did hospital staff talk with you about how much pain you had?
  - *Answers:* Never, Sometimes, Usually, Always
- During this hospital stay, how often did hospital staff talk with you about how to treat your pain?
  - *Answers:* Never, Sometimes, Usually, Always

In response to CMS's proposal, the AHA expressed appreciation for CMS's responsiveness to stakeholder concerns. At the same time, we urged CMS to more fully test and obtain NQF endorsement of the new survey items prior to adopting them in the IQR. In response, CMS will delay the public reporting of data on the new items by one year (i.e., until October 2020).

Updated Stroke Mortality Measure. For the FY 2023 IQR program, CMS will use an updated version of the stroke 30-day mortality measure that incorporates stroke severity into the measure's risk-adjustment model. Stroke severity will be captured using ICD-10 codes.

Voluntary Hybrid Readmission Measure. CMS finalizes the voluntary reporting of a "hybrid" hospital-wide 30-day readmission measure in which hospitals submit certain "core data elements" from EHRs to supplement the claims data used to calculate the measure. These elements include patient-level data such as heart rate, blood pressure, and creatinine levels. CMS has long been interested in moving towards the use of EHRs to collect and submit quality data, and views "hybrid" measures combining EHR-derived data with claims data as a way of improving the risk adjustment of outcome measures. Hospitals opting to report the measure would submit data from the first two quarters of calendar year (CY) 2018 using the quality reporting document architecture

(QRDA) currently used for hospital eCQMs. Specifically, CMS would require the use of the QRDA-I (patient-level) standard.

Electronic Clinical Quality Measures (eCQMs) in the IQR Program

CMS finalizes proposals to revise the electronic clinical quality measure (eCQM) reporting requirement in Hospital IQR, align the Hospital IQR requirements with Medicare and Medicaid Electronic Health Record (EHR) Incentive Program eCQM reporting, and revise requirements on certified EHRs that support eCQM reporting.

FY 2019 eCQM Reporting Requirement and Reporting Period. For the FY 2019 IQR program, hospitals will report at least four self-selected eCQMs, a decrease from CMS's proposal of six and the FY 2017 inpatient PPS final rule requirement to report eight. CMS also finalizes that hospitals submit one self-selected quarter of eCQM data from calendar year (CY) 2017, a decrease in the CMS proposal to report two self-selected quarters of data and the FY 2017 inpatient PPS final rule requirement to report one full calendar year of data. CMS states the finalized requirements will provide hospitals additional time to plan for data processing, report quality data to CMS, and focus on system upgrades, data mapping and staff training. CMS states they will review the results of the first year of required eCQM data collection before increasing requirements for subsequent years. CMS also states it will engage hospitals regarding their experiences as the agency develops future eCQM policy.

FY 2020 eCQM Reporting Requirement and Reporting Period. For the FY 2020 payment determination, CMS finalizes that hospitals will report at least four self-selected eCQMs, a decrease from the CMS proposal to report at least six eCQMs. CMS also finalizes that hospitals submit one self-selected quarter of eCQM data from CY 2018, a decrease from the CMS proposal to report data for Q1, Q2 and Q3 of CY 2018. CMS states that many hospitals, especially small, rural, and Indian Health Service hospitals, as well as hospitals with fewer financial resources, need additional time and flexibility to successfully implement all of the eCQM reporting requirements. CMS adds it intends to review the results of the first year of required eCQM data collection prior to increasing requirements for subsequent years. **The AHA strongly supports the finalized eCQM reporting requirements.**

CMS finalizes the proposal to align the electronic eCQM reporting requirements of the Medicare EHR Incentive Program for eligible hospitals and CAHs and the Hospital IQR electronic eCQM requirements for the CY 2017 and CY 2018 reporting periods.

Table 2: eCQMs Available for Hospital IQR Reporting for FYs 2019 and 2020

NQF Number	Electronic Clinical Quality Measures
+	AMI-8a: Primary PCI received within 90 minutes of hospital arrival
+	CAC-3: Home Management Plan of Care document given to patient/caregiver
0495	ED-1: Emergency Department – Median time from ED arrival to ED departure for admitted ED patients *****
0497	ED-2: Emergency Department Throughput – Admit decision time to ED departure time for admitted patients *****
01354	EHDI -1a: Hearing screening prior to hospital discharge
0469	PC -01: Elective delivery prior to 39 completed weeks gestation *****
0480	PC-05: Exclusive Breast Milk Feeding
0435	STK-2: Stroke – Discharged on anti-thrombotic therapy
0436	STK-3 :Stroke – Anticoagulation therapy for Atrial Fibrillation/Flutter
0438	STK -5: Stroke – Antithrombotic therapy by end of hospital day two
0439	STK -6: Stroke – Discharged on Statin Medication
+	STK-8: Stroke – education
0441	STK-10: STK Stroke – Ischemic or hemorrhagic stroke – assessed for rehabilitation
0371	VTE -1: VTE prophylaxis
0372	VTE -2: VTE Intensive Care Unit (ICU) VTE prophylaxis

**For three measures (ED-1, ED-2, and PC-01), hospitals must submit a full year of chart-abstracted data on a quarterly basis, regardless of whether data also are submitted electronically. The data submitted via chart-abstraction will be publicly displayed.*
+ NQF endorsement removed

Certification Requirement and Form Required for eCQM Submission. CMS finalizes flexibility for hospitals to use the 2014 Edition, 2015 Edition or a combination of the 2014 and 2015 Edition certified EHRs for eCQM reporting for the CY 2018 reporting period/FY 2020 payment determination. This revises the previously finalized policy that required use of the 2015 Edition certified EHR for eCQM reporting for CY 2018.
CMS also finalizes the proposal that certified EHRs support the reporting of all available eCQMs. CMS states that requiring EHRs to be certified to all available eCQMs for the Hospital IQR Program would streamline the process of collecting electronic data by allowing hospitals flexibility in the particular eCQMs they want to select for data capture and reporting. CMS also states that EHRs certified to all available eCQMs will mitigate

the need for hospitals to consult their health IT vendors and certify individual measures when they decide to report on an eCQM different than one selected for prior data collection and reporting.

eCQM Public Reporting. CMS reiterates that analysis of the first year of eCQM data validation will determine whether the data should be publicly reported on the *Hospital Compare* website. CMS acknowledges concerns expressed about the accuracy of eCQM data or the comparability of eCQM data to non-electronic CQMs.

Medicare and Medicaid EHR Incentive Programs CY 2018 Reporting Period

For CY 2018, CMS finalizes its proposal to revise the EHR reporting period to a minimum of any continuous 90-day period within CY 2018 for new and returning participants attesting to the Medicare or Medicaid EHR Incentive Programs. This is a reduction from the previous requirement of a full-year reporting period. CMS states that the 90-day EHR reporting period will allow eligible hospitals, CAHs and eligible professionals (EPs) additional time for testing and implementation of the 2015 Edition, including the new application programming interface functionality requirement for Stage 3. CMS declined to make permanent a reporting period of any continuous 90-day period. CMS also states that comments about the objectives and measures or the structure of the EHR Incentive Program were out of the scope of the rule. **The AHA appreciates the finalized 90-day reporting period for CY 2018.**

CMS also finalizes a policy to allow health care providers in the Medicare or Medicaid EHR Incentive Programs to choose the certified EHR technology used for the CY 2018 reporting period. As a result, eligible hospitals, CAHs and EPs can attest to modified Stage 2 or Stage 3 objectives and measures in CY 2018. CMS states that additional flexibility is in response to several stakeholder concerns about the inability to fully implement the 2015 Edition certified EHR, including issues implementation of new functionalities and testing new workflows to support the technology. **The AHA appreciates the availability of modified Stage 2 reporting in CY 2018**.

Survey and Certification Requirements

As urged by the AHA, CMS *did not* finalize its proposal to require accrediting organizations (AOs) with CMS-approved accreditation programs to make hospital survey reports public. Under the proposed rule, AOs would have been required to make Medicare provider final accreditation survey reports, including deficiency information and plans of correction, publicly available on their websites. In the final rule, CMS withdrew this provision because the Social Security Act restricts CMS's ability to disclose survey reports. The final rule did contain erroneous regulatory language indicating that the proposal had been approved. CMS has communicated to the AHA that this language will be removed through a technical correction by Oct. 1.

Hospital-within-Hospital (HwH) Regulations

Under current rules, HwHs must meet certain separateness and control standards. Among other provisions, they must have separate governing bodies, medical staffs, chief executive officers and chief medical officers. In the final rule, CMS adopts a

proposal to apply the separateness and control rules only when an HwH is an inpatient PPS-excluded hospital that occupies space in the same building as an inpatient PPS hospital, or that occupies space in one or more separate buildings on the same campus as those used by an inpatient PPS hospital. CMS also finalizes a proposal to remove other HwH requirements related to performance of basic hospital functions.

NEXT STEPS

Given the changes included in this year's final rule, the AHA encourages hospital leaders to estimate the impact of the provisions on their facilities. To that end, the **AHA has created a readmissions penalty calculator, a VBP calculator and a DSH payment calculator:**

- Readmissions Penalty Calculator: www.aha.org/readmissionscalc
- VBP Calculator: www.aha.org/vbpcalc
- DSH Payment Calculator: www.aha.org/dshcalc

The calculators are designed so that you enter your hospital's CCN (and some additional financial information for the DSH calculator) and the calculator will then estimate the dollar amount of your potential readmissions penalty, net VBP gain or loss, and DSH payment.

Please also note the following submission deadlines set forth in the final rule:

- **Hospitals wishing to resubmit their FY 2014 and 2015 Worksheet S-10 data must submit this data by Sept. 30, 2017.** This data will not be used to calculate Factor 3 for FY 2018, but will be available in future years if the agency proposes and finalizes a methodology for determining Factor 3 that uses FY 2014 and FY 2015 Worksheet S-10 data in future years.
- **Current MDHs wishing to apply for SCH status must apply by Sept. 1, 2017 in order for SCH status to be effective upon expiration of the MDH program.**
- **Hospitals wishing to qualify for the payment adjustment for low-volume hospitals must make a written request for low-volume status no later than Sept. 1, 2017.**
- **Applications for hospital reclassifications for FY 2019 are due to the MGCRB by Sept. 1, 2017.**

FURTHER QUESTIONS

For additional questions, please contact Priya Bathija, AHA senior associate director, at (202) 626-2678 or pbathija@aha.org.