

Vizient Office of Public Policy and Government Relations

Regulatory Update: CMS Proposed Rule – Fiscal Year (FY) 2018 Medicare Hospital Inpatient Prospective Payment System (IPPS) & Long Term Acute Care Hospital (LTCH) Prospective Payment System

May 19, 2017

On Friday, April 14, the Centers for Medicare & Medicaid Services (CMS) issued the [annual proposed rule](#) to update the 2018 Medicare payment and policies for the hospital inpatient prospective payment system (PPS) and the long-term care hospital (LTCH) PPS.

Additionally, CMS is soliciting broad feedback on ways to increase the quality of care, lower costs, improve program integrity, and make the health care system more effective, simple and accessible. The agency included a Request for Information (RFI) on ideas for additional improvements that can be made to the health care delivery system that reduce unnecessary burdens for providers, patients and their families. CMS requests feedback on “positive solutions to better achieve transparency, flexibility, program simplification, and innovation.” This, the agency says, will inform the discussion on future rulemaking for inpatient hospital care and long-term care hospitals.

Comments are due **June 13, 2017** and Vizient looks forward to working with members to help inform our letter to CMS.

Background & Summary

After accounting for inflation and other adjustments required by law, the proposed rule would increase inpatient operating payment rates by 1.6 percent in fiscal year (FY) 2018. The chart below details factors CMS includes in their estimate.

Proposed IPPS Payment Rate Update for FY 2018

Proposed Policy	Average Impact on Payments (Rate)
Estimated market-basket update	2.9%
ACA productivity adjustment	- 0.4%
ACA market-basket cut	- 0.75%
Net market-basket update	1.75%
Documentation & coding cut mandated by ATRA, altered by 21 st Century Cures Act	0.4588%
Two-midnight policy adjustment	- 0.6%
Estimated payment rate update compared to FY 2017	1.6%

The proposed rule includes an initial market-basket update of 2.9 percent, minus 0.4 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 from two-midnight policy cuts. Additionally, CMS proposes an increase of 0.4588 percentage points to partially restore cuts as a result of the American Taxpayer Relief Act (ATRA). The ACA, two-midnight policy and ATRA payment adjustments would be applied to all hospitals.

Medicare & Medicaid Electronic Health Record (EHR) Incentive Program

CMS is proposing changes to requirements pertaining to the clinical quality measurement of eligible hospitals and critical access hospitals (CAH) as well as eligible professionals (EP) participating in the Medicare and Medicaid

Electronic Health Record (EHR) Incentive Programs. For FY 2018, depending on whether a hospital submits quality data under the rules established in accordance with section 1886(b)(3)(B)(viii) of the Act (hereafter referred to as a hospital that submits quality data) and is a meaningful EHR user under section 1886(b)(3)(B)(ix) of the Act (hereafter referred to as a hospital that is a meaningful EHR user), there are four possible applicable percentage increases that can be applied to the standardized amount as specified in the following table.

**Payment Updates Based on Inpatient Quality Reporting (IQR)
& EHR Meaningful Use Incentive Programs**

FY 2018	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
Proposed Market Basket Rate-of-Increase	2.9	2.9	2.9	2.9
Proposed Adjustment for Failure to Submit Quality Data	0.0	0.0	0.725	0.725
Proposed Adjustment for Failure to be a Meaningful EHR User	0.0	-2.175	0.0	-2.175
Proposed Multifactor Productivity Adjustment	-0.4	-0.4	-0.4	-0.4
Statutory Adjustment	-0.75	-0.75	-0.75	-0.75
Proposed Applicable Percentage Increase Applied to Standardized Amount	1.75	-0.425	1.025	-1.15

Additionally, the proposed rule shortens the reporting period for the Medicare and Medicaid EHR Incentive programs to 90 days for calendar year (CY) 2018. CMS proposes to modify the EHR reporting periods for new and returning participants attesting to meaningful use from the full year to a minimum of any continuous 90-day period within CY 2018. The agency acknowledges that eligible hospitals would benefit from additional time for successful implementation of 2015-edition, certified EHRs. Additionally, CMS notes that if further changes are identified in the certification and deployment of 2015-edition, certified EHRs, CMS will consider additional flexibilities for reporting in CY 2018.

Medicare DSH Payment Changes

The ACA required changes beginning in 2014 to the way disproportionate share hospital (DSH) payments are made to hospitals. Under this new payment formula, hospitals receive 25 percent of the Medicare DSH funds that they would have received under the prior formula (“empirically justified”). The other 75 percent of funding flows into a separate pool that is reduced relative to the number of uninsured and then distributed based on the proportion of total uncompensated care each Medicare DSH hospital provides. This funding pool is then distributed based on three factors:

- **Factor 1:** Office of the Actuary estimation of total Medicare DSH payments.
- **Factor 2:** Change in the percentage of uninsured
- **Factor 3:** Proportion of total uncompensated care each Medicare DSH hospital provides

For FY 2018, CMS has proposed using a new data source for calculating the number of uninsured (Factor 2) – the National Health Expenditure Accounts (NHEA). Their estimate reflects the rate of uninsurance in the U.S. across all

age groups and residents; the previous data source was the nonpartisan Congressional Budget Office (CBO) in which the estimate reflected the uninsured rate only in the under 65 population. In using this new data source, CMS has increased the total amount (in the 75 percent pool) available to Medicare DSH hospitals, thus increasing total Medicare DSH payments to hospitals. The proposed FY 2018 uncompensated care payment (total available) is \$1 billion more than the \$5.97 billion payment total in FY 2017 – a 16.5 percent increase. The uncompensated care payment methodology has redistributive effects based on the proportion of a hospital’s uncompensated care relative to the total uncompensated care for all hospitals eligible for Medicare DSH payments.

In addition, CMS is proposing several modifications to the Factor 3 methodology:

- 1) to annualize Medicaid data if a hospitals’ cost report does not equal 12 months of data;
- 2) to apply a scaling factor to the uncompensated care payment amount calculated for each DSH eligible hospital so that total uncompensated care payments are consistent with the estimated amount available to make uncompensated care payments for FY 2018; and
- 3) to apply statistical trims to the CCRs on Worksheet S-10 that are considered anomalies to ensure reasonable CCRs are used to convert charges to costs for purposes of determining uncompensated care costs.

The estimated impact of the proposed changes to Factors 1, 2, and 3 across all hospitals projected to be eligible for DSH payments in FY 2018, by hospital characteristic, is presented in the following table.

Modeled Disproportionate Share Hospital Proposed Payments for Estimated FY 2018 DSHs by Hospital Type: Model DSH \$ (in millions) from FY 2017 to FY 2018

Hospital Characteristics	Number of Estimated DSHs (FY 2018)	FY 2017 Final Rule Estimated DSH \$ (in millions)	FY 2018 Proposed Rule Estimated DSH \$ (in millions)	Dollar Difference FY 2017 – FY 2018 (in millions)	Percent Change
All hospitals	2,418	\$9,553	\$10,931	\$1,378	14.4%
Geographic location					
Urban	1, 921	\$9,113	\$10,355	\$1,241	13.6%
Rural	497	\$439	\$477	\$137	31.2%
Teaching Status					
Non-Teaching	1,510	\$2,955	\$3,428	\$472	16.0%
Fewer than 100 residents	665	\$3,213	\$3,571	\$358	11.1%
100 or more residents	243	\$3,384	\$3,932	\$548	16.2%

CMS projects that 2,418 hospitals are eligible for DSH in FY 2018. It did not include hospitals that had terminated their participation in the Medicare program as of February 23, 2017, Maryland hospitals, and sole community hospitals (SCH) that are expected to be paid based on their hospital-specific rates. The proposed impact analysis found that, across all projected DSH eligible hospitals, FY 2018 DSH payments are estimated at approximately \$10.930 billion, or an increase of approximately 14.4 percent from FY 2017 DSH payments (approximately \$9.553 billion). While these proposed changes result in a net increase in the amount available to be distributed in uncompensated care payments, DSH payments to select hospital types are expected to decrease. This redistribution of DSH payments is caused by changes in the data used to determine Factor 3.

Additionally, the variation in the distribution of DSH payments by hospital characteristic is largely dependent on the change in a given hospital’s number of Medicaid days and SSI days for purposes of the low-income insured days proxy between FY 2017 and FY 2018, as well as on its uncompensated care costs as reported on Worksheet S-10, used in the Factor 3 computation.

Calculation of Proposed Factor 3 for FY 2018

CMS is proposing to begin incorporating data from Worksheet S-10 in the calculation of hospitals' share of uncompensated care by combining data on uncompensated care costs from the Worksheet S-10 for FY 2014 with proxy data regarding a hospital's share of low-income insured days for FYs 2012 and 2013 to determine Factor 3 for FY 2018. The proposal to continue to use data from three cost reporting periods to calculate Factor 3 would have the effect of transitioning from the use of the proxy data on low-income insured days toward use of uncompensated care data from Worksheet S-10. As part of this proposal, CMS is also proposing a definition of uncompensated care costs consisting of the sum of charity care and bad debt, and a trim methodology to address anomalous charges.

In prior rulemaking, CMS acknowledged that it was premature to use uncompensated care costs reported on Worksheet S-10 to allocate hospitals' shares of uncompensated care costs. CMS stated in the preamble of the FY 2017 IPPS/LTCH PPS proposed rule that they believed that, for FY 2018, many of their concerns about utilizing Worksheet S-10 data would no longer be relevant. In this proposed rule, CMS states: "That is, hospitals were on notice as of FY 2014 that Worksheet S-10 could eventually become the data source for CMS to calculate uncompensated care payments." CMS notes that recent analyses continue to demonstrate a high correlation between the amounts for Factor 3 derived using the IRS 990 data and the Worksheet S-10 data, and as this correlation continues to increase over time – the agency now believes that they "have reached a tipping point with respect to the use of the Worksheet S-10 data." CMS can no longer conclude that alternative data to the Worksheet S-10 are available for FY 2014 that are a better proxy for the costs of hospitals for treating individuals who are uninsured.

For FY 2018, CMS has 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. Consistent with the methodology used to calculate Factor 3 for FY 2017, CMS is proposing to advance the time period of the data used in the calculation of Factor 3 forward by one year and using data from FY 2012, FY 2013, and FY 2014 cost reports. Accordingly, with the proposed time period that includes three cost reporting years CMS is proposing to use Worksheet S-10 data for the FY 2014 cost reporting period and the low-income insured day proxy data for the two earlier cost reporting periods. In order to perform this calculation, CMS will draw three sets of data (2 years of Medicaid utilization data and 1 year of Worksheet S-10 data) from the most recent available hospital cost report information system (HCRIS) extract, which for FY 2018 is the December 2016 update of HCRIS for the proposed rule and the March 2017 update of HCRIS for the final rule. Further, CMS has proposed that in addition to the Worksheet S-10 data for FY 2014, they will use Medicaid days from FY 2012 and FY 2013 cost reports and FY 2014 and FY 2015 SSI ratios.

Therefore, for FY 2018, CMS is proposing to compute Factor 3 for each hospital by:

- **Step 1:** Calculating Factor 3 using the low-income insured days proxy based on FY 2012 cost report data and the FY 2014 SSI ratio;
- **Step 2:** Calculating Factor 3 using the insured low-income days proxy based on FY 2013 cost report data and the FY 2015 SSI ratio;
- **Step 3:** Calculating Factor 3 based on the FY 2014 Worksheet S-10 data (or using the Factor 3 calculated in Step 2 for Puerto Rico and IHS/Tribal hospitals); and
- **Step 4:** Averaging the Factor 3 values from 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.

CMS believes that this approach – if proposed to continue in FY 2019 and FY 2020 – would have the effect of transitioning the incorporation of data from Worksheet S-10 into the calculation of Factor 3. Starting with one year of Worksheet S-10 data in FY 2018, an additional year of Worksheet S-10 data would be incorporated into the calculation of Factor 3 in FY 2019, and the use of low-income insured days would be phased out by FY 2020. However, CMS notes that they are not making any proposals with respect to the calculation of Factor 3 for FY 2019 at this time.

CMS has again proposed that, for purposes of calculating Factor 3 and uncompensated care costs beginning in FY 2018, "uncompensated care" would be defined as the amount on line 30 of Worksheet S-10, which is the cost of charity care (Line 23) and the cost of non-Medicare bad debt (Line 29). The agency is inviting public comments on this proposal.

The agency notes that as part of their ongoing quality control and data improvement measures to continue to improve the Worksheet S-10 data over time, they have made revisions to the cost report instructions and developed an audit process. With respect to the cost reporting instructions, on November 18, 2016, CMS issued [Transmittal 10](#), which updated the instructions for Form 2552-10 (specifically updating instructions in Section 4012 of Chapter 40 of the Provider Reimbursement Manual, Part II). The instructions clarify the reporting of charges for charity care.

With respect to the audit process, CMS notes that they will provide standardized instructions to the MACs to guide them in determining when and how often a hospital's Worksheet S-10 should be reviewed. The agency will not make the MACs' review protocol public, as all CMS desk review and audit protocols are confidential and are for CMS and MAC use only. The instructions for the MACs 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. The agency does not anticipate making any further modifications to the Worksheet S-10 instructions at this time so that hospitals can begin to review and conform to the current instructions in Transmittal 10.

Hospital Readmissions Reduction Program (HRRP) Payment Adjustments

The Hospital Readmissions Reduction Program (HRRP) requires a reduction to a hospital's base operating DRG payment to account for excess readmissions of selected applicable conditions. For FY 2018 and subsequent years, the reduction is based on a hospital's risk-adjusted readmission rate during a 3-year period for acute myocardial infarction (AMI), heart failure (HF), pneumonia, chronic obstructive pulmonary disease (COPD), total hip arthroplasty/total knee arthroplasty (THA/TKA), and coronary artery bypass graft (CABG). Overall, in this proposed rule, CMS estimates that 2,591 hospitals would have their base operating DRG payments reduced by their determined proxy FY 2018 hospital-specific readmission adjustment. In this proposed rule, CMS proposes the policies outlined below.

Applicable Time Period & Calculation of Aggregate Payments for Excess Readmissions

When calculating the numerator (aggregate payments for excess readmissions), CMS determines the base operating DRG payments for the applicable period. To determine the base operating DRG payment amount for an individual hospital for such applicable period for such condition, CMS uses Medicare inpatient claims from the MedPAR file with discharge dates that are within the same applicable period to calculate the excess readmissions ratio. The agency uses MedPAR claims data as their data source for determining aggregate payments for excess readmissions and aggregate payments for all discharges, as this data source is consistent with the claims data source used in IPPS rulemaking to determine IPPS rates. CMS is not proposing any changes to existing methodology for calculating "aggregate payments for excess readmissions" for each hospital (the numerator of the ratio), and is not proposing any changes to existing methodology to calculate "aggregate payments for all discharges" (the denominator of the ratio).

CMS proposes that the "applicable period" for the HRRP for FY 2018 would be the 3-year period from July 1, 2013 through June 30, 2016. In other words, the excess readmissions ratios and the payment adjustment (including aggregate payments for excess readmissions and aggregate payments for all discharges) for FY 2018 would be calculated using data from the 3-year time period of July 1, 2013 through June 30, 2016. CMS proposes to determine aggregate payments for excess readmissions and aggregate payments for all discharges using data from MedPAR claims with discharge dates that are on or after July 1, 2013, and no later than June 30, 2016. CMS also proposes to continue to apply the same exclusions to the claims in the MedPAR file as were applied for FY 2017 for the AMI, HF, PN, THA/TKA, CABG and COPD applicable conditions.

To identify the discharges for each applicable condition for FY 2018 to calculate the aggregate payments for excess readmissions for an individual hospital, CMS is proposing to identify each applicable condition, using, for FY 2013, FY 2014 and FY 2015, the appropriate ICD-9-CM codes, and for FY 2016, the appropriate ICD-10-CM and ICD-10-PCS code sets. This proposal is consistent with established policy for identifying the discharges for each applicable condition to calculate the aggregate payments for excess readmissions. For FY 2018, a hospital subject to the HRRP would have an adjustment factor that is between 1.0 (no reduction) and 0.9700 (greatest possible reduction).

21st Century Cures Act: Changes to Payment Adjustment Factor for FY 2019

The 21st Century Cures Act requires CMS to develop a methodology for the HRRP that accounts for the percentage of dual-eligible patients (that is, patients who are eligible for both Medicare and full-benefit Medicaid coverage) cared for by a hospital. Section 15002 of that law directs the Secretary to assign hospitals to peer groups, develop a methodology that allows for separate comparisons for hospitals within these groups, and allows for changes in

the risk adjustment methodology. CMS is proposing to implement changes to the payment adjustment factor to assess penalties based on a hospital's performance relative to other hospitals treating a similar proportion of dual-eligible patients.

Under the statutory requirements, hospitals are grouped based on the proportion or ratio of full-benefit dual eligible patients (numerator) to the hospital's Medicare inpatient stays (denominator). CMS is proposing to identify full-benefit dual status (numerator) using dual eligibility status data where the original data source is the State Medicare Modernization Act (MMA) file of dual eligibility which States submit to CMS monthly. Under their proposal, an individual would be counted as a full-benefit dual patient if the beneficiary was identified as full-benefit dual status in the State MMA files for the month he/she was discharged from the hospital.

CMS considered two alternative definitions of total number of Medicare patients (denominator) that could be used to calculate each hospital's proportion of dual eligible patients. Ultimately, CMS chose to propose defining the proportion of full-benefit dual eligible beneficiaries as the proportion of dual eligible patients among all Medicare fee-for-service (FFS) and Medicare Advantage stays. This is the agency's preferred approach because using the proportion of dual eligible patients calculated among all Medicare FFS and managed care patients more accurately represents the proportion of dual eligible patients served by the hospital, particularly for hospitals in states with high managed care penetration rates. However, because the HRRP payment adjustment is only applied to Medicare FFS payments, and is based on excess readmissions among Medicare FFS patients only, CMS is including an alternative to define the proportion of full-benefit dual eligible beneficiaries as only Medicare FFS stays. The agency is inviting stakeholder input on the most appropriate data source to identify total hospital stays (e.g., MedPAR or the CMS integrated data repository), and whether such stays should include all Medicare FFS and Medicare Advantage stays or only Medicare FFS stays.

CMS is proposing to define the proportion of full-benefit dual eligible beneficiaries as the number of dual eligible patients discharged during the 3-year applicable period under the HRRP. CMS notes that they prefer this proposal, as it accounts for the influence of social risk factors on the excess readmissions ratio (ERR) – because the proportion of dual eligible patients is measured over the full period when they influenced the likelihood of excess readmissions.

However, the agency considered an alternative option to use a 1-year period, which would be calculated over the most recent year for which complete data is available. While both data periods would include the most recently available data to define dual eligibility, the most recent 1-year period would capture the most recent population served by the hospital and may enable a more accurate stratification to calibrate the impact of payment adjustments to the proportion of dual eligible patients that the hospital currently serves. CMS is inviting public comment on both their preferred proposal and alternative considerations.

CMS is also considering alternative methodologies for assigning hospitals to peer groups and their preferred approach is to stratify hospitals into quintiles (five peer groups). To understand the impact on payment adjustments of stratifying hospitals into different number of peer groups, CMS conducted an analysis that estimated payment adjustments when stratifying hospitals into two, five (quintiles), or 10 (deciles) peer groups. Based on their analysis, their preferred approach is to stratify hospitals into quintiles (five peer groups) because it creates peer groups that accurately reflect the relationship between the proportion of dual eligibles in the hospital's population without the disadvantage of establishing a larger number of peer groups. However, CMS is seeking public comment on their alternative methodologies for assigning hospitals to peer groups (i.e., stratifying hospitals into two or 10 peer groups).

CMS analyzed several modifications of the payment adjustment formula to assess payment reductions based on a hospital's performance compared to performance of other hospitals in its peer group. Their preferred and proposed approach is assessing performance compared to the peer group median ERR, rather than the current threshold of 1.0000, and scaling hospital payment adjustments by a neutrality modifier. In adopting a methodology for achieving required budget neutrality, CMS's priority is to adopt a simplified and well-known metric that allows them to be more transparent in their methodology and reduces the penalty on safety-net hospitals – while not disproportionately increasing the penalty to non-safety-net hospitals. Thus, the agency is seeking public comment on three additional approaches – using the mean ERR plus a neutrality modifier, a budget neutralizing ERR, and a standardized ERR plus a neutrality modifier. CMS notes that the median ERR plus a neutrality modifier substantially reduces the penalty as a share of total payments (from 0.64 percent to 0.55 percent with quintile peer groups) and penalty per discharge (from \$157 to \$135) for safety-net hospitals while not disproportionately increasing the payment reduction amount for non-safety-net hospitals (from 0.61 percent to 0.63 percent as share of total payments). The

median ERR plus a neutrality modifier is also preferred because it achieves more precise budget neutrality than the budget neutralizing ERR.

Average Share of Payment Adjustments as a Percentage of All DRG Payments for Considered Approaches for the HRRP Program, by Hospital Characteristic

Hospital characteristics	Number of hospitals	Current methodology	Median plus neutrality modifier (neutrality modifier = 0.9546)	Mean plus neutrality modifier (neutrality modifier = 1.0135)	Budget neutralizing ERR	Standardized ERR plus neutrality modifier (neutrality modifier = 0.9710)
All hospitals	3,096	0.62%	0.62%	0.62%	0.62%	0.62%
Geographic location						
Urban	2,304	0.61%	0.62%	0.62%	0.62%	0.62%
Rural	792	0.65%	0.62%	0.60%	0.60%	0.60%
DSH Payment Eligibility						
Not eligible	474	0.55%	0.61%	0.65%	0.64%	0.64%
DSH payment eligible	2,622	0.63%	0.62%	0.61%	0.61%	0.61%
Teaching Status						
Non-Teaching	2,076	0.66%	0.67%	0.67%	0.67%	0.67%
Teaching	1,020	0.59%	0.58%	0.58%	0.58%	0.58%
Fewer than 100 residents	722	0.59%	0.60%	0.60%	0.61%	0.60%
100 or more residents	248	0.57%	0.55%	0.54%	0.54%	0.55%

These proposals apply to discharges that occur during and after FY 2019. The law allows the Secretary to take into account the recommendations in the reports required by the IMPACT Act related to risk adjustment and social risk factors. The first of two reports required in the IMPACT Act was released in December of 2016 and the second report is required to be completed by October 2019.

The 21st Century Cures Act also directs the Medicare Payment Advisory Commission (MedPAC) to conduct a review of overall hospital readmissions and whether such readmissions are related to any changes in outpatient and emergency services furnished. A report on the study is required to be submitted in the MedPAC's report to Congress no later than June 2018.

Updates to the Extraordinary Circumstances Exception (ECE) Policy

Many of the quality reporting and value-based purchasing programs share a common process for requesting an exception from program reporting due to an extraordinary circumstance not within a provider's control. The Hospital IQR, Hospital OQR, IPFQR, Ambulatory Surgical Center Quality Reporting (ASCQR), PCHQR Programs, as well as the HAC Reduction Program, and the Hospital Readmissions Reduction Program, all share common processes for ECE requests. CMS is making proposals to update and align the ECE policy in quality reporting programs by:

- 1) Allowing the facility to submit a form signed by the facility's CEO or designated personnel;
- 2) Clarifying that CMS will strive to provide a formal response notifying the facility of their decision within 90 days of receipt of the facility's request; and

- 3) Allowing CMS to have the authority to grant ECEs due to CMS data system issues which affect data submission.

CMS believes these proposals can improve administrative efficiencies for affected facilities or hospitals.

Value-Based Purchasing (VBP) Program

The ACA established a hospital value-based purchasing program (the Hospital VBP Program) under which value-based incentive payments are made in a fiscal year to hospitals that meet performance standards established for a performance period for such fiscal year. The applicable percent for the FY 2018 program year as required by statute is 2.00 percent. CMS estimates that the total amount available for value-based incentive payments for FY 2018 is approximately \$1.9 billion, based on the December 2016 update of the FY 2016 MedPAR file.

CMS published proxy value-based incentive payment adjustment factors in [Table 16](#) of the proposed rule. The proxy factors are based on the Total Performance Score (TPS) from the FY 2017 program year; these performance scores are the most recently available performance scores hospitals have been given the opportunity to review and correct. CMS intends to update this table as Table 16A in the final rule (which will be available on the CMS website) to reflect changes based on the March 2017 update to the FY 2016 MedPAR file. CMS will also update the slope of the linear exchange function used to calculate those updated proxy value-based incentive payment adjustment factors. The updated proxy value-based incentive payment adjustment factors for FY 2018 will continue to be based on historic FY 2017 program year TPSs because hospitals will not have been given the opportunity to review and correct their actual TPSs for the FY 2018 program year until after the FY 2018 IPPS/LTCH PPS final rule is published. After hospitals have been given an opportunity to review and correct their actual TPSs for FY 2018, the agency will add Table 16B (which will be available on the CMS website) to display the actual value-based incentive payment adjustment factors.

Retention and Removal of Quality Measures

CMS proposes to adopt the Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Pneumonia (PN Payment) measure beginning with the FY 2022 program year. The PN Payment measure would be added to the Efficiency and Cost Reduction domain. The agency will also submit the measure with the proposed expanded measure cohort for NQF review during its next re-endorsement review.

CMS proposes to remove the current PSI 90 measure from the VBP Program beginning with the FY 2019 program year and adopt a modified version of the PSI 90 measure beginning with the FY 2023 program year.

CMS is not proposing any changes to the domain weights for the FY 2018 and FY 2019 program years. For the FY 2020 program year and subsequent years, they are proposing to retain the same domain weighting for hospitals receiving a score on all four domains. The previously adopted and newly proposed domain weighting is summarized in the table below.

Domain Weights for the FY 2019 Program Year and Subsequent Years for Hospitals Receiving a Score on All Domains

Domain	Weight
Safety	25%
Clinical Care	25%
Efficiency and Cost Reduction	25%
Person and Community Engagement*	25%

*Previously "Patient and Caregiver Experience"

CMS is proposing two changes to domain scoring policies for the FY 2019 program year and subsequent years. First, CMS proposes to change the minimum number of measures scores a hospital must receive to receive a score on the Safety domain from three measures to two measures. Second, CMS proposes that hospitals must receive a minimum of one measure score within the Efficiency and Cost Reduction domain to receive a domain score, rather than requiring that hospitals meet the requirements to receive a Medicare spending per beneficiary (MSPB) measure score.

Minimum Numbers of Cases for Measures: FY 2019 Program Year and Subsequent Years

There are no proposed changes to the minimum number of cases for both the Clinical Care and Person and Community Engagement domains. For the Safety Domain, beginning with the FY 2023 program year, CMS proposes that hospitals must report a minimum of three eligible cases on any one underlying indicator during the baseline period in order to receive an improvement score and three eligible cases on any one underlying indicator during performance period in order to receive an achievement score on the Patient Safety and Adverse Events (Composite) measure.

CMS proposed to adopt the PN Payment measure in the Efficiency and Cost Reduction domain for the FY 2022 program year and subsequent years. For these condition-specific payment measures (namely, the AMI Payment and HF Payment measures, as well as the proposed PN Payment measure, if finalized), they propose that hospitals must report a minimum number of 25 cases per measure in order to receive a measure score for the FY 2021 program year, FY 2022 program year, and subsequent years.

Hospital-Acquired Conditions Reduction Program (HACRP)

The ACA established an incentive to hospitals to reduce the incidence of hospital-acquired conditions (HAC) by requiring the Secretary to make an adjustment to payments to applicable hospitals for discharges beginning on October 1, 2014. This 1-percent payment reduction applies to a hospital whose ranking is in the top quartile (25 percent) of all applicable hospitals, relative to the national average, of conditions acquired during the applicable period and on all of the hospital's discharges for the specified fiscal year. A hospital's Total HAC score and its ranking in comparison to other hospitals in any given year will depend on several different factors. The scoring methodology for the FY 2018 HACRP will be the new winsorized z-score methodology that was finalized in the FY 2017 IPPS Final Rule. As this methodology change was finalized in the FY 2017 final rule there is no mention of the shift in the FY 2018 proposed rule. CMS notes that any significant impact due to the proposed HACRP changes for FY 2018, including which hospitals will receive the adjustment, will depend on actual experience.

CMS anticipates that they will provide hospitals with their confidential hospital-specific reports and discharge level information used in the calculation of their FY 2018 Total HAC Score in late summer 2017 via the QualityNet Secure Portal. The agency did not make any changes to the review and correction policies for FY 2017. Hospitals have a period of 30 days after the information is posted to the QualityNet Secure Portal to review and submit corrections for the calculation of their HACRP measure scores, domain scores, and Total HAC Score for the fiscal year.

Proposed Data Collection Time Periods for FY 2020

In the FY 2017 IPPS/LTCH PPS final rule CMS finalized a truncated data collection period for Domain 1, shorter than the previous 2-year data collection period for calculating the Total HAC Score for the FY 2018 and FY 2019 HAC Reduction Programs, in order to accommodate the transition to the ICD-10 classification system. For the FY 2020 program, CMS proposes to return to a two-year time period for the calculation of HACRP measure results. The agency believes that using 2 years of data for both domains balances the needs of the program and allows for sufficient time to process the claims data and calculate the measure results.

Performance Period Payment Determination	Domain 1	Domain 2
FY 2018	July 1, 2014 – Sept. 30, 2015	Jan. 1, 2015 – Dec. 31, 2016
FY 2019	Oct.1, 2015 – June 30, 2017	Jan. 1, 2016 – Dec. 31, 2017
FY 2020	July 1, 2016 – June 30, 2018	Jan. 1, 2017 – Dec. 31, 2018

Request for Comments on Additional Measures for Potential Future Adoption

As part of their ongoing efforts to evaluate and strengthen the HACRP, CMS is conducting a review of patient safety measures to include in Domain 1. They are seeking to adopt outcomes-focused patient-safety measures that focus on topic areas including but not limited to: falls with injury, adverse drug events (ADEs), glycemic events and ventilator associated events (VAEs). CMS welcomes public comments and suggestions on these measure areas, as well as additional outcome-based patient-safety measures that will help achieve program goals.

Request for Comments on Inclusion of Disability and Medical Complexity for CDC NHSN Measures

In its IMPACT Act report, the Assistant Secretary for Planning and Evaluation (ASPE) suggested payment strategies to improve the HACRP. ASPE noted that it is well-proven that higher levels of medical risk are associated with a higher risk for many (although not all) patient safety events, particularly infections. ASPE suggested that patient-level clinical data from the CDC healthcare-associated infection (HAI) measures should be examined and considered for additional risk-adjustment. ASPE also noted that the clinical risk-adjustment of the patient safety and hospital-acquired infection measures should be improved to ensure the measures adequately adjust for differences in patients' clinical risk, so that fair comparisons for hospital accountability and performance assessment can be made to hold providers to the same fair standard. ASPE recommended additional analyses for measure developers such as AHRQ and CDC to determine whether adjusting key components of the patient safety or HAI measures (for example frailty, functional limitations, prior hospitalizations or nursing home residence, or other markers of immune system deficiencies or unmeasured medical complexity) may better account for susceptibility to infection and patient safety events. Based on ASPE's analysis and considerations, CMS is requesting stakeholder feedback on risk-adjusting the CDC NHSN measures for disability or medical complexity. Although they are not proposing any specific changes to the measures at this time, the agency will consider all comments as a guide to potential future action.

Inpatient Quality Reporting (IQR) Program/CQM Reporting Changes

CMS is proposing to refine two previously adopted measures. The first is an update of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey measure. CMS proposes replacing the three existing questions about Pain Management with three new questions that address Communication About Pain During the Hospital Stay, beginning with the FY 2020 payment determination (beginning Jan. 1, 2018). The new proposed questions are:

- 1) During this hospital stay, did you have any pain?
- 2) During this hospital stay, how often did hospital staff talk with you about how much pain you had?
- 3) During this hospital stay, how often did hospital staff talk with you about how to treat your pain?

The second is an update to the stroke mortality measure to include the use of NIH Stroke Scale claims data for risk adjustment, beginning with the FY 2023 payment determination.

Hospital-Wide All-Cause Unplanned Readmission Hybrid Measure

CMS is proposing to adopt the Hospital-Wide All-Cause Unplanned Readmission Hybrid Measure as a voluntary measure for the CY 2018 reporting period. CMS notes that they are considering proposing this measure as a required measure as early as the CY 2021 reporting period/FY 2023 payment determination. If it is finalized as a required measure, CMS would require hospitals to submit the core clinical data elements and linking variables used in the measure as early as CY 2020 to support a dry run of the measure during which hospitals would receive a confidential preview of their results in 2021.

eCQM Reporting Requirements & Additional Proposals

CMS is also proposing modifications of previously finalized eCQM reporting requirements. For the CY 2017 reporting period/FY 2019 payment determination, CMS proposes that hospitals would be required to select and submit six of the available eCQMs included in the Hospital IQR Program measure set and provide two, self-selected, calendar year quarters of data. For the CY 2018 reporting period/FY 2020 payment determination, they are proposing that hospitals would be required to select and submit six of the available eCQMs, and provide data for the first three calendar quarters (Q1-Q3).

Discharge Reporting Period	Submission Deadline
Two quarters in 2017	February 28, 2018
First three quarters in 2018	February 28, 2019

These modifications are being proposed in alignment with proposals for the Medicare and Medicaid EHR Incentive Programs, and would decrease the required number of eCQMs and quarters of reporting as compared with the previously finalized requirements in the FY 2017 IPPS/LTCH PPS final rule. If CMS finalizes their proposals to modify the eCQM reporting requirements, they propose to modify the eCQM validation process – whereby hospitals would be required to submit a reduced number of cases for eCQM data validation for the FY 2020 and FY 2021

payment determinations. Additionally, they propose policies related to the exclusion criteria for hospital selection and the data submission requirements for participating hospitals.

The agency is proposing to modify the educational review process for chart-abstracted measures for the FY 2020 payment determination and subsequent years, such that educational reviews would be offered quarterly for the first three quarters of validation. Hospitals would be allowed 30 calendar days following the date the results of validation are posted to request an educational review. Additionally, if an educational review demonstrates that the abstraction score calculated by CMS is incorrect, they would use the corrected quarterly score to compute the final confidence interval.

CMS is making proposals related to the Hospital IQR Program Extraordinary Circumstances Extension or Exemptions (ECE) policy, including a change to the name of the policy to 'Extraordinary Circumstances Exceptions' policy.

The agency is also inviting public comment on accounting for social risk factors in the Hospital IQR Program, as well as the confidential and potential future public reporting of clinical quality measure data stratified by patients' dual-eligible status.

Future Clinical Quality Measures Under Consideration

CMS includes a list of clinical quality measures that are being considered for future inclusion in the IQR Program:

- 1) Quality of Informed Consent Documents for Hospital-Performed, Elective Procedures measure
- 2) Four End-of-Life process and outcome measures for cancer patients
 - a. The Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (EOLChemo) (NQF #0210)
 - b. The Proportion of Patients Who Died from Cancer Not Admitted to Hospice (EOL-Hospice) (NQF #0215)
 - c. The Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than Three Days (EOL-3DH) (NQF #0216)
 - d. The Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life (EOL-ICU) (NQF #0213)
- 3) Two nurse staffing measures
 - a. Skill Mix (Registered Nurse [RN], Licensed Vocational/Practical Nurse [LVN/LPN], Unlicensed Assistive Personnel [UAP], and Contract) (Nursing Skill Mix) Measure (NQF #0204)
 - b. Nursing Hours per Patient Day Measure (NQF #0205)
- 4) Eleven newly specified electronic clinical quality measures (eCQMs) – EHR & IQR
 - a. Safe Use of Opioids – Concurrent Prescribing
 - b. Malnutrition Measures (4)
 - c. Tobacco Use Measures (3)
 - d. Substance Use Measures (3)

Socioeconomic Status (SES)/Socio-Demographic Status (SDS) Adjustments

CMS notes that social risk factors such as income, education, race and ethnicity, employment, disability, community resources, and social support (certain factors of which are also sometimes referred to as socioeconomic status (SES) factors or socio-demographic status (SDS) factors) play a major role in health. In this Proposed Rule, CMS has requested stakeholder feedback on how best to factor SES/SDS adjustment into the Value-Based Purchasing (VBP), Hospital-Acquired Condition (HAC), and Inpatient Quality Reporting (IQR) programs – and all quality programs. CMS states that they seek to ensure that the quality of care furnished by providers and suppliers is assessed as fairly as possible under these programs while ensuring that beneficiaries have adequate access to excellent care. However, CMS continues to have concerns about holding providers to different standards for the outcomes of their patients with social risk factors because they do not want to mask potential disparities or minimize incentives to improve the outcomes for disadvantaged populations.

With these concerns in mind, the agency continues to seek public comment on whether they should account for social risk factors in quality programs, and if so, what method or combination of methods would be most appropriate for accounting for social risk factors. Examples of methods include: adjustment of the payment adjustment methodology under quality programs; adjustment of provider performance scores (for instance, stratifying providers based on the proportion of their patients who are dual eligible); confidential reporting of stratified measure rates to providers; public reporting of stratified measure rates; risk adjustment of a particular measure as appropriate based on data and evidence; and redesigning payment incentives (for instance, rewarding

improvement for providers caring for patients with social risk factors or incentivizing providers to achieve health equity).

The agency states that they look forward to working with stakeholders as they consider the issue of accounting for social risk factors and reducing health disparities in CMS programs. Of note, implementing any method would be taken into consideration in the context of how it and other CMS programs operate (for example, data submission methods, availability of data, statistical considerations relating to reliability of data calculations, among others). Therefore, CMS also welcomes comment on operational considerations. It is likely that we will continue to see SES/SDS adjustments develop in Medicare's pay-for-performance and quality reporting programs in the future.

Medicare-Dependent Hospitals

Under the IPPS, special payment protections are provided to Medicare-dependent, small rural hospitals (MDH). Unless Congress enacts funding to extend these payment protections, the MDH program provisions will expire at the end of FY 2017. Thus, without Congressional action – beginning with discharges occurring on or after October 1, 2017, all hospitals that previously qualified for MDH status will be paid based on the Federal rate versus the Federal rate plus an enhanced payment amount.

Survey & Certification Requirements/Accrediting Organizations

Health care facilities must demonstrate compliance with Medicare conditions of participation (CoPs), conditions for coverage (CfCs), or conditions of certifications in order to be eligible to receive Medicare payments. Health care facilities that are “provider entities” can demonstrate this compliance through accreditation by an accreditation program of a private, national accrediting organization (AO) that is approved by CMS. CMS has responsibility for oversight and approval of AO accreditation programs used for Medicare certification purposes, and for ensuring that providers and suppliers that are accredited under an approved AO accreditation program meet the quality and patient safety standards required by the Medicare conditions and requirements. AOs perform their own accreditation surveys and issue their own survey reports which provide information on accredited facilities’ compliance with Federal standards. These facilities include: hospitals, psychiatric hospitals, CAHs, home health agencies (HHAs), hospices, ambulatory surgery centers (ASCs), outpatient physical therapy and speech-language pathology services (OPTs), and rural health clinics (RHCs). These facilities participate in Medicare based on their accreditation from a CMS-approved AO and are not subject to routine surveys from State survey agencies.

CMS is proposing to require accrediting organizations (AOs) to make hospital survey reports and acceptable plans of correction (PoCs) public. CMS cites that there have been increasing concern in terms of AO disparity rates based on the AO deficiency findings compared to serious, condition-level deficiencies found by the State Survey Agencies. This continued trend of high disparity rates raises serious concerns regarding the AOs’ ability to appropriately identify and cite health and safety deficiencies during the survey process. Therefore, the agency believes that posting AO survey reports and acceptable PoCs would address “some of the concerns of reporting hospital information from both CMS and AOs, as well as the disparity between serious deficiency findings, and provide a more comprehensive picture to health care consumers and the public in general.”

Under the provisions of the proposed rule, each national AO that applies or reapplies for CMS-approval of its Medicare provider or supplier accreditation program must agree to make all Medicare provider or supplier final accreditation survey reports and PoCs within the last three years publicly available on its website. CMS is proposing a new standard which requires that each national AO applying or reapplying for CMS-approval of its Medicare provider or supplier accreditation program provide a statement acknowledging that it agrees to make all Medicare provider or supplier final accreditation survey reports (including statements of deficiency findings) as well as acceptable PoCs publicly available on its website within 90 days after such information is made available to those facilities for the most recent 3 years. This provision would include all triennial, full, follow-up, focused, and complaint surveys, whether they are performed onsite or offsite. CMS invites public comment on this proposal.

What’s Next?

CMS publishes the final IPPS regulation around Aug. 1, and the changes are effective at the beginning of the federal fiscal year (Oct. 1, 2017). The 60-day comment period closes on June 13, 2017. Vizient’s Office of Public Policy and Government Relations looks forward to hearing continued member feedback on this proposed rule. Stakeholder input plays a major role in shaping future changes to policy. We encourage you to reach out to our office if you have any questions or regarding any aspects of this proposed regulation – both positive reactions and provisions that cause you concern.

As always, it is possible that we will see substantial shifts between the proposed and final rule based on public comments and further analysis by CMS. Look for another detailed summary from our office when the final rule is released in August.

Additional Resources

[Chelsea Arnone](#), Regulatory Affairs and Government Relations Director in Vizient's Washington, D.C. office, can be reached at (202) 354-2608, and is monitoring this rule and other regulatory developments. Please reach out to her if you have any questions or if Vizient can provide any assistance as you consider these issues.