American Hospital Association

Regulatory Advisory

August 24, 2016

MEDICARE INPATIENT PPS: THE FINAL RULE FOR FY 2017

AT A GLANCE

At Issue

The Centers for Medicare & Medicaid Services (CMS) published its fiscal year (FY) 2017 final rule for the hospital inpatient and long-term care prospective payment systems (PPS) on Aug. 2. The final rule, which takes effect Oct. 1, impacts inpatient PPS hospitals, critical access hospitals (CAHs), long-term care hospitals (LTCHs) and PPS-exempt cancer hospitals. Major provisions of the rule related to inpatient PPS, CAHs and PPS-exempt cancer hospitals are described below. The AHA will issue a separate advisory on proposals related to the LTCH PPS.

The final rule will increase inpatient PPS rates by 0.95 percent in FY 2017 compared to FY 2016, after accounting for inflation and other adjustments required by law. Hospitals that were not meaningful users of electronic health records (EHR) in FY 2015 or that do not submit quality data will be subject to market-basket penalties.

Documentation and Coding Adjustment: The rule finalizes a cut of 1.5 percentage points to inpatient PPS payments to fulfill a requirement of the American Taxpayer Relief Act of 2012 (ATRA). Specifically, the agency states that this cut, combined with the effects of previous cuts of 0.8 percentage points in FYs 2014, 2015 and 2016, will allow the agency to fulfill the $11 billion ATRA recoupment requirement. The AHA is extremely disappointed that the cut finalized by CMS is nearly two times what Congress specified in ATRA, as well as in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). **Given that this is a one-time recoupment cut, the AHA will urge the agency to restore the full amount allowed by law to the standardized amount in FY 2018.**

'Two-midnight' Policy: CMS finalizes two adjustments that will reverse the effects of the 0.2 percent cut it unlawfully instituted when implementing the two-midnight policy in FY 2014. Specifically, the agency finalizes a permanent adjustment of 0.2 percent to remove the cut prospectively for FYs 2017 and onward. In addition, it finalizes a *temporary* adjustment of 0.6 percent to address the retroactive impacts of this cut for FYs 2014, 2015 and 2016. **This change represents an important, hard-fought victory for hospitals and health systems. The AHA successfully challenged CMS's implementation of this cut in federal court and convinced CMS to restore the resources that hospitals are lawfully due. We project that $3.1 billion in Medicare funding will be returned to hospitals over the next ten years as a result of this change.**

Disproportionate Share Hospital (DSH) Payment Changes: The Affordable Care Act (ACA) required changes to the way in which DSH payments are made to hospitals. For FY 2017, CMS will further decrease the amount in the 75 percent pool to reflect additional decreases in the percentage of uninsured. As a result, DSH payments will decrease by an additional $400 million in FY 2017 compared to FY 2016. The agency also will continue to use inpatient days of Medicaid beneficiaries and Medicare supplemental security income beneficiaries as a proxy for measuring uncompensated care. In addition, CMS did not finalize its proposal to incorporate Worksheet S-10 data into the computation of uncompensated care payments beginning in FY 2018. **The AHA commends the agency for pausing the incorporation of Worksheet S-10 data in order to improve its accuracy and consistency in determining the cost of treating uninsured patients. Among other actions, the AHA will continue to urge CMS to adopt a broad definition of uncompensated care that includes Medicaid shortfalls and discounts to the uninsured and fully accounts for graduate medical education expenditures.**

Notification Procedures for Outpatients Receiving Observation Services: CMS finalizes its proposal, with modifications, to implement the Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act, which requires hospitals and CAHs to provide written and oral notification to Medicare beneficiaries receiving observation services as outpatients for more than 24 hours. Hospitals and CAHs will be required to furnish a new CMS-developed standardized notice, the Medicare Outpatient Observation Notice (MOON), to a Medicare beneficiary or enrollee who has been receiving observation services for more than 24 hours. **Citing timing issues associated with approval of the MOON, the agency will delay implementation of the NOTICE Act by at least four months beyond the Aug. 6, 2016 statutory deadline. The AHA is pleased that hospitals will have additional time to comply with the NOTICE Act and that CMS makes a number of other changes recommended by the AHA.**

Hospital-acquired Conditions (HAC) Reduction Program: As mandated by the ACA, the HAC Reduction Program imposes a 1 percent reduction in total Medicare payments for hospitals scoring in the top quartile of national HAC rates. For the FY 2018 program, CMS finalizes a change to its scoring methodology so that hospitals receive points on each HAC measure using a "Winsorized Z-Score" that compares hospital performance to the national mean. This departs from the existing scoring methodology in which hospitals are assigned points based on their decile of performance.

Hospital Readmissions Reduction Program (HRRP): As required by the ACA, the HRRP will impose a penalty of up to 3 percent on hospitals with "excess" readmission rates when compared to expected rates. The agency proposes only minor updates to the HRRP and, as previously finalized, will add a coronary artery bypass graft readmission measure to the FY 2017 HRRP. **The AHA is disappointed that the agency has again failed to adopt any sociodemographic adjustment for the HRRP. We remain concerned that hospitals that care for patients in poorer communities will be disproportionately penalized.**

Inpatient Quality Reporting Program: For FY 2019, CMS will expand its reporting requirement for electronic clinical quality measures (eCQMs). Specifically, hospitals will be required to report a full year of data on eight eCQMs. **The AHA believes much more work needs to be done to ensure that the eCQMs are valid and reliable before increasing reporting requirements.**

What You Can Do:

- ✓ Share this advisory with your senior management team and ask your chief financial officer to examine the impact of the payment changes on your Medicare revenue for FY 2017. 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
    - DSH Payment Calculator: http://www.aha.org/dshcalc

    Please note: AHA is still awaiting updated and final FY 2017 public use files (PUF) from CMS; hence these calculators still reflect the proposed rule parameters and will be updated once the final PUFs are released.

- ✓ **Verify CMS's table listing the factor used to calculate uncompensated care payments in FY 2017 for DSH hospitals.** Hospitals have until Aug. 31 to review this table on the CMS website and notify CMS in writing of any inaccuracies.
- ✓ **Determine whether your hospital will submit revisions to your Worksheet S-10 for FY 2014.** The deadline for such revisions is Sept. 30. If a hospital elects to resubmit its Worksheet S-10 for FY 2014, it should follow the instructions in place when it originally filed its cost report for FY 2014.
- ✓ **Hospitals also should verify whether they have attested to meaningful use.** Attestation status can be determined through CMS's website.
- ✓ **Consider submitting comments to the Office of Management and Budget on ways to minimize the information collection burden of the Medicare Outpatient Observation Notice (MOON).** Comments are due by Sept. 1.
- ✓ 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.

Further Questions:

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

August 24, 2016

MEDICARE INPATIENT PPS: THE FINAL RULE FOR FY 2017

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BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) released its final rule for the fiscal year (FY) 2017 hospital inpatient and long-term care hospital (LTCH) prospective payment systems (PPS) on Aug. 2. The final rule will take effect Oct.1.

A detailed summary of the inpatient portions of the final rule follows. The AHA will issue a separate advisory on policies related to the LTCH PPS.

SUMMARY

Inpatient PPS Rate Update

The final rule will increase inpatient PPS rates by 0.95 percent in FY 2017 compared to FY 2016, after accounting for inflation and other adjustments required by law. Specifically, the update includes a market-basket increase to the standardized amount of 2.7 percent. CMS finalizes a 0.3 percentage point reduction to this update for productivity, as well as an additional 0.75 percentage point reduction, as mandated by the Affordable Care Act (ACA). In addition, CMS finalizes a 1.5 percentage point reduction as required by the American Taxpayer Relief Act of 2012 (ATRA) (see "Documentation and Coding Adjustment for MS-DRG Changes" for more information). CMS also finalizes a 0.8 percent positive adjustment related to the "two-midnight" policy (see "Two-Midnight Policy Adjustments" for more information.) Table 1 below details the factors CMS includes in its estimate.

Table 1: Impacts of FY 2017 CMS Final Policies

Policy	Average Impact on Payments
Market-basket update	2.7%
Productivity cut mandated by the ACA	- 0.3%
Additional cut mandated by ACA	- 0.75%
Documentation and coding cut for FYs 2010, 2011 and 2012 mandated by ATRA	- 1.5%
Two-midnight policy adjustments	+ 0.8%
Total	**+ 0.95%**

Hospitals that were not meaningful users of electronic health records (EHRs) in FY 2015 or that do not submit quality data will 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 0.275 percent.

- Hospitals that were not meaningful users of EHRs in FY 2015 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 -1.075 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 -1.75 percent.

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 FY 2017, CMS finalizes its proposal to continue using the labor-related share the agency finalized in FYs 2014, 2015 and 2016 – 69.6 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 2017 because the national wage index for all Puerto Rico hospitals is less than 1.0.

The standardized amounts for FY 2017 are:

Area Wage Index Greater Than 1.0

Hospital submitted quality data and is a meaningful user of EHR		**Hospital did NOT submit quality data but is a meaningful user of EHR**		**Hospital submitted quality data but is NOT a meaningful user of EHR**		**Hospital did NOT submit quality data and is NOT a meaningful user of EHR**	
Labor	Non-labor	Labor	Non-labor	Labor	Non-labor	Labor	Non-labor
$3,839.57	$1,677.06	$3,814.07	$1,665.92	$3,763.08	$1,643.65	$3,737.58	$1,632.51

Area Wage Index Less Than 1.0

Hospital submitted quality data and is a meaningful user of EHR		**Hospital did NOT submit quality data but is a meaningful user of EHR**		**Hospital submitted quality data but is NOT a meaningful user of EHR**		**Hospital did NOT submit quality data and is NOT a meaningful user of EHR**	
Labor	Non-labor	Labor	Non-labor	Labor	Non-labor	Labor	Non-labor
$3,420.31	$2,096.32	$3,397.59	$2,082.40	$3,352.17	$2,054.56	$3,329.46	$2,040.63

Effective for inpatient hospital discharges on or after Jan. 1, 2016 the law requires that inpatient payments to subsection (d) Puerto Rico hospitals shall be based on 100 percent of the national standardized amount. As a result, Puerto Rico hospitals are subject to the national labor- and nonlabor-related share percentages that are applied to the national standardized amount and there is no longer a need to calculate Puerto Rico-specific values.

Penalty for Failing to Meet Meaningful Use

The Medicare payment penalties for failing to meet meaningful use under the Medicare EHR Incentive Program began in FY 2015. All hospitals either must meet meaningful use or receive a hardship exception each and every year to avoid penalties. For inpatient PPS hospitals, in FY 2017, the penalty will generally apply to hospitals that were not meaningful users of EHRs in FY 2015 and did not receive a hardship exception for that performance year. **The AHA recommends that all inpatient PPS hospitals verify whether they attested to meaningful use for FY 2015 or received a hardship exception.**

For critical access hospitals (CAHs), the penalties are based on same-year performance. Therefore, whether the CAH attested to meaningful use for 2017 or received a hardship exception will determine whether they receive a penalty in FY 2017. Any penalties leveraged on a CAH will be applied during the cost report settlement process. Attestation status can be determined through CMS's EHR Incentive Program registration and attestation website. CMS notifies hospitals about the hardship exceptions on a case-by-case basis.

'Two-midnight' Policy Adjustments

As part of the FY 2014 inpatient PPS final rule, CMS imposed a permanent 0.2 percent reduction to the operating PPS standardized amount, the Puerto Rico-specific standardized amount, the hospital-specific payment rates and the capital federal rate to offset what the agency claimed would be an increase of $220 million in inpatient PPS expenditures resulting from implementation of the two-midnight policy.

This reduction was based on an Office of the Actuary (OACT) estimate of an anticipated net increase in hospital inpatient encounters that would result from the implementation of the two-midnight policy. The AHA, along with four hospital associations and four hospital organizations, challenged the 0.2 percent reduction because CMS relied on indefensible assumptions when making this arbitrary and capricious cut. Other hospitals also filed suit and the cases were consolidated. In September 2015, the court rejected CMS's arguments that it met all of the procedural legal requirements for rulemaking when it made the payment cut. The court ordered the agency to provide further justification for the payment reduction and permit additional opportunity for hospitals to comment. CMS issued a notice on Dec. 1 that responded directly to that court order and provided some limited information. The AHA reviewed that notice and found that CMS's explanation still failed to establish a rational and lawful basis for the imposition of the 0.2 percent reduction.

As a result, CMS now finalizes two adjustments that will reverse the effects of the 0.2 percent cut it unlawfully instituted when implementing the two-midnight policy. Specifically, the agency finalizes a permanent adjustment of 0.2 percent to remove the cut prospectively for FY 2017 and onward. It also finalizes a *temporary* adjustment of 0.6 percent to address the retroactive impact of this cut for FYs 2014, 2015 and 2016. This temporary adjustment of 0.6 percent will be removed from the market basket as a one-time reduction in FY 2018.

This change represents an important, hard-fought victory for hospitals and health systems in reversing the unlawful 0.2 percent payment reduction for inpatient services. The AHA successfully challenged CMS's implementation of this cut in federal court and convinced CMS to restore the resources that hospitals are lawfully due.

Documentation and Coding Adjustment for MS-DRG Changes

As discussed above, the final rule includes a cut of 1.5 percentage points that CMS claims is needed to fulfill the $11 billion ATRA recoupment requirement. Specifically, Congress directed CMS to recoup what the agency claims is the effect of documentation and coding changes from FYs 2010, 2011 and 2012 that the agency says do not reflect real changes in case mix. CMS indicates that the 1.5 percentage point cut, combined with the effects of the previous cuts of 0.8 percentage points in FYs 2014, 2015 and 2016, will allow the agency to fulfill the $11 billion ATRA recoupment requirement. This 1.5 percentage point cut will not apply to sole community hospitals' (SCHs) or Medicare-dependent Hospitals' (MDHs) hospital-specific rates. CMS does not have the authority to apply recoupment cuts to payments to those hospitals. Because the cuts required by ATRA are recoupment cuts, they will be restored to the standardized amount beginning in FY 2018.

The AHA is extremely disappointed that the cut finalized by CMS is nearly two times what Congress specified in ATRA, as well as in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Given that this is a one-time recoupment cut, the AHA will urge the agency to restore the full amount allowed by law to the standardized amount in FY 2018.

Disproportionate Share Hospital (DSH) Payment Methodology Changes

The ACA requires that, beginning in FY 2014, 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 will be reduced each year as the percentage of uninsured declines and will be 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." These changes apply to DSH payments made through the operating PPS only and not the capital PPS. As required by the ACA, CMS further decreases the amount in the 75 percent pool for FY 2017 to reflect additional decreases in the percentage of uninsured that have occurred since FY 2016.

DSH Eligibility. CMS makes no changes to the eligibility requirements for either the empirically justified Medicare DSH payments or the uncompensated care payments. CMS reiterates that hospitals not eligible to receive empirically justified Medicare DSH payments in a fiscal year will not receive uncompensated care payments for that year. CMS will continue to determine initial eligibility for interim uncompensated care payments based on each hospital's estimated DSH status for the applicable fiscal year;

the final determination of the hospital's eligibility for uncompensated care payments would be based on the hospital's actual DSH status on the cost report for that payment year.

In addition, as finalized in the FYs 2014 and 2015 inpatient PPS final rules, CMS states that Puerto Rico hospitals and hospitals participating in the Bundled Payments for Care Improvement Initiative (BPCI) are eligible for payments under the ACA DSH payment methodology. CMS also indicates that Maryland hospitals, now being paid under the Maryland All-Payer Model, and hospitals participating in the Rural Community Hospital (RCH) Program are not eligible to receive DSH payments under the revised methodology. With regard to SCHs, which are paid the higher of the federal PPS amount or their hospital-specific amount, only those SCHs paid the federal PPS amount will be eligible for Medicare DSH payments.

Empirically Justified DSH Payments. Empirically justified DSH payments will continue to be distributed in the exact manner in which DSH payments were distributed prior to FY 2014, but at 25 percent of the amount of what otherwise would have been paid. CMS states that the empirically justified Medicare DSH payments for FY 2017 will total $3.599 billion.

Uncompensated Care Payments. The second portion of the DSH payment amount for each DSH hospital – the uncompensated care payment – will remain the product of three factors.

- **Factor One – The Initial Size of the 75 percent Uncompensated Care DSH Payment Pool.** Factor One is the difference between CMS's estimates of: (1) the amount that would have been paid in Medicare DSH payments for FY 2017 in the absence of the ACA payment provision; and (2) the amount of the empirically justified Medicare DSH payments that are made for FY 2017. The agency uses the most recently available projections of Medicare DSH payments to estimate the final size of this pool. That is, CMS sets the size of the pool prospectively, based on estimated Medicare DSH payments for the year, and will *not* revise or update its estimate after it knows the final Medicare DSH payments for FY 2017.

  In the rule, CMS uses data from OACT's June 2016 estimate of Medicare DSH payments to determine the size of the 75 percent pool. CMS states that the total amount of Medicare DSH payments that otherwise would have been paid for FY 2017 are $14.397 billion. As stated above, the amount of the empirically justified Medicare DSH payments for FY 2017 will be $3.599 billion. Therefore, CMS finalizes a 75 percent pool for FY 2017 of $10.797 billion.

- **Factor Two – Change in the Percentage of Uninsured.** The next step in determining hospitals' uncompensated care DSH payments is to determine how much the 75 percent pool will be reduced as a result of the decline in the uninsured population. Using the Congressional Budget Office's (CBO) March 2016 estimate of the effects of the ACA on health insurance coverage, CMS indicates that the

estimate of individuals under the age of 65 with insurance in calendar year (CY) 2016 is 90 percent and the rate of uninsurance in calendar year 2016 is 10 percent (100 percent minus 90). It also estimates that individuals under the age of 65 with insurance in calendar year (CY) 2017 will be 90 percent, making the rate of uninsurance in calendar year 2017 also 10 percent. CMS then weighted these figures to determine the rate of uninsurance for FY 2017 and after inputting that rate into the statutory formula finalizes a Factor Two equal to 0.5536. Accordingly, CMS will retain 55.36 percent – or $5.977 billion – of the 75 percent pool in FY 2017. This amounts to a reduction of about $400 million in Medicare DSH payments in FY 2017 compared to FY 2016.

- **Factor Three – Hospitals' Uncompensated Care Payments.** The last step in determining hospitals' uncompensated care DSH payments is to determine the proportion of hospitals' aggregate uncompensated care that each hospital provides. CMS will continue using inpatient days of Medicaid beneficiaries plus inpatient days of Medicare supplemental security income (Medicare SSI) beneficiaries as a proxy for measuring the amount of uncompensated care each hospital provides.

  CMS makes two modifications to the data it uses in the calculation of Factor Three for FY 2017. The first modification is a proxy for SSI days for Puerto Rico hospitals that accounts for the fact that residents of Puerto Rico are not eligible for SSI benefits. Based on an analysis by the CMS Office of the Actuary, the actuary found that, on average and across states, for every 100 Medicaid inpatient days a hospital had 14 Medicare SSI days. CMS finalizes its proposal to use this relationship to extrapolate how many patient days for Puerto Rico hospitals would be Medicare SSI days if Puerto Rico residents were eligible to receive SSI. Specifically, CMS finalizes its proposal, for purpose of calculating Factor 3, to use a proxy for Medicare SSI days for each Puerto Rico hospital equal to 14 percent (or 0.14) of its Medicaid days. This value will replace whatever value would have otherwise been computed for this hospital.

  The second modification addresses a concern from the hospital field that using only one cost-reporting period to determine a hospital's share of uncompensated care may result in unpredictable swings and anomalies in a hospital's low-income insured days between cost-reporting periods. To mitigate this issue, CMS will expand the time period for the data used to calculate Factor 3 from one cost-reporting period to three cost-reporting periods. CMS also notes that this will have the benefit of supplementing the data of hospitals that filed cost reports that are less than 12 months and would stabilize hospitals' uncompensated care payments and result in the use of the most recent data for the Factor 3 calculation.

  As a result, for FY 2017, to determine Medicaid days, CMS will use an average of data reported on hospitals' FY 2011, 2012 and 2013 cost-reporting periods extracted from the March 2015 update of the HCRIS database. CMS will determine Medicare days for FY 2017 using the SSI ratios published for FYs 2012, 2013 and 2014.

The agency calculates the total number of Medicaid inpatient and Medicare SSI days among DSH hospitals; it then determines what percentage of these days 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 Medicaid and Medicare SSI days provided by all DSH hospitals, it will receive 1 percent, or $59.7 million, of the $5.977 billion that remains in the 75-percent pool. **CMS has published on its website a table listing Factor 3 for all hospitals it estimates would receive uncompensated care payments in FY 2017. Hospitals have until Aug. 31 to review this table and notify CMS in writing of any inaccuracies.**

The AHA has created a DSH calculator for hospitals to assess the impact of the policy on their organizations. It is available at: www.aha.org/dshcalc. The calculator is designed so that 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.

Please note: AHA is still awaiting updated and final FY 2017 public use files (PUF) from CMS; hence these calculators still reflect the proposed rule parameters and will be updated once the final PUFs are released.

Worksheet S-10. In FYs 2014, 2015 and 2016, CMS discussed the alternative of using Worksheet S-10 of the Medicare cost report to determine the amount of uncompensated care each hospital provides. However, because of concerns regarding variations in the data reported on Worksheet S-10 and the completeness of these data, CMS indicated it was premature to propose the use of Worksheet S-10 for purposes of determining uncompensated care payments in each of those years. CMS agreed with that assessment for FY 2017. However, for a variety of reasons, the agency proposed to, starting in FY 2018, begin a three-year phase in of incorporating hospitals' Worksheet S-10 data into the methodology for determining uncompensated care payments. The specific details of this proposal were discussed beginning on page 25089 of the print version of the proposed rule.

However, CMS did *not* finalize its proposal to incorporate Worksheet S-10 data into the computation of uncompensated care payments beginning in FY 2018. The agency instead indicates that it will institute certain additional quality control and data improvement measures, including an audit process, to the Worksheet S-10 instructions and data prior to moving forward with its use. CMS intends to begin incorporating Worksheet S-10 data into the computation once these additional measures are in place and no later than FY 2021. The agency will re-propose a policy related to incorporation of these data prior to that time.

CMS also indicates that it intends to explore whether there is a more appropriate proxy for uncompensated care that could be used to calculate these payments for FY 2018 and until the Worksheet S-10 is fully incorporated. CMS will undertake notice-and-comment rulemaking to address this issue for FY 2018 and subsequent years.

Lastly, separate from this final rule, CMS released Transmittal 1681 on July 15, which offers hospitals the opportunity to submit revisions to the Worksheet S-10 submitted with their cost reports for FY 2014. Based on conversations the AHA has had with CMS staff, CMS intends to utilize this revised data as it analyzes the appropriateness of using the Worksheet S-10 data in the computation of uncompensated care payments. The deadline for such revisions is Sept. 30. If a hospital elects to resubmit its Worksheet S-10 for FY 2014, it should follow the instructions in place when it originally filed its cost report for FY 2014.

The AHA commends the agency for pausing the incorporation of Worksheet S-10 data in order to improve its accuracy and consistency in determining the cost of treating uninsured patients. Among other actions, the AHA will continue to urge CMS to adopt a broad definition of uncompensated care that includes Medicaid shortfalls and discounts to the uninsured and fully accounts for graduate medical education expenditures.

Notification Procedures for Outpatients Receiving Observation Services

CMS finalizes, with modifications, its proposed regulations implementing the Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act. The Act requires hospitals and CAHs to provide Medicare beneficiaries receiving observation services for more than 24 hours a written notice and an oral explanation that the beneficiary is an outpatient receiving observation services and the implications of that status.

Hospitals and CAHs will be required to furnish a new CMS-developed standardized notice, the Medicare Outpatient Observation Notice (MOON), to a Medicare beneficiary or enrollee who has been receiving observation services for more than 24 hours. The notice is required to be provided no later than 36 hours after observation services are initiated, or sooner if the individual is transferred, discharged or admitted as an inpatient.

Effective Date. **As requested by the AHA, the agency delays implementation of the NOTICE Act beyond the Aug. 6, 2016 statutory deadline, allowing hospitals at least four additional months to put systems and business practices into place to implement the requirements.** Specifically, CMS notes that the updated MOON must go through a Paperwork Reduction Act (PRA) approval process that requires a 30-day public comment period that ends on Sept. 1. **The AHA encourages hospitals to submit comments to the Office of Management and Budget (OMB) by Sept. 1 about ways to minimize the information collection burden of the updated MOON.** The MOON and supporting materials, including instructions on how to submit comments, may be found here.

In addition, CMS states that following review of the comments and final OMB approval of the MOON**, hospitals and CAHs must fully implement the MOON and comply with all of the NOTICE Act requirements no later than 90 calendar days from the**

date of approval of the MOON. CMS will announce the start of the implementation period on its Beneficiary Notices Initiative Web site.

Standardized MOON Notice. Hospitals and CAHs will be required to furnish a new CMS-developed standardized notice, the (MOON), to a Medicare beneficiary or enrollee who has been receiving observation services for more than 24 hours. CMS also will require that, in the event that a patient is subsequently admitted as a hospital inpatient directly after receiving observation services for more than 24 hours, and the inpatient admission occurs prior to delivery of the MOON, the MOON must be annotated with the date and time of the inpatient admission.

The MOON will include all the required elements specified in the NOTICE Act. In response to public comment, CMS makes a number of changes to the form, including:

- adding a text field where hospitals will be required to state the specific reason a beneficiary is an outpatient receiving observation services, rather than an inpatient;
- consistent with the AHA's recommendation, CMS deleted a number of fillable fields on the MOON that would have required the hospital to write in the physician name, the time observation services began, and the hospital name (CMS also will permit hospitals to preprint the MOON to include their hospital name and logo at the top of the notice);
- making "plain language" changes to the MOON to improve its formatting and readability;
- removing the Quality Improvement Organization (QIO) contact section; and
- simplifying and making more prominent the language regarding coverage of post-hospital skilled nursing facility (SNF) care and Part B coverage.

Further, the agency describes the type of information that hospitals and CAHs may include in the "Additional Information" section of the MOON, such as:

- the unique circumstances regarding the particular patient (such as their Medicare Accountable Care Organization (ACO) information);
- a notation that a beneficiary refused to sign the MOON;
- hospital waivers of the beneficiary's responsibility for the cost of self-administered drugs;
- Part A cost-sharing responsibilities if the beneficiary is subsequently admitted as an inpatient; and
- specific information for contacting hospital staff with questions or concerns.

CMS also responds to questions from the AHA and others about how the NOTICE Act interacts with state laws that include similar notification requirements. The agency indicates that, in some cases, delivering the MOON may also fulfill state notice requirements for the Medicare population and that hospitals and CAHs will need to make that determination on a state-by-state basis. Where state law requires content that is not included in the MOON, hospitals may utilize the "Additional Information" free

text field in the MOON for communicating such additional content. They also may attach the notice required under state law to the MOON. To the extent that there are requirements in a state law that directly conflicts with requirements in the NOTICE Act, CMS says it will address those issues of preemption as they are raised. However, the agency says that they are not currently aware of any such conflicting state laws.

Finally, consistent with longstanding practice in implementing beneficiary notices, CMS will require hospitals and CAHs to retain a signed copy of the MOON, either as a hard copy or electronically.

Oral Notice. An oral explanation of the MOON also must be provided with the delivery of the notice. CMS states that it is essential that hospital staff are available to provide a verbal explanation and answer questions in the interest of beneficiaries fully understanding the MOON. CMS will provide guidance for the oral notification in forthcoming Medicare manual provisions. However, the agency says that it expects that the oral notification will occur in conjunction with delivery of the MOON.

CMS notes that a video presentation of the MOON is acceptable if an individual is available to answer questions.

Medicare Beneficiaries Who Must Receive the MOON Notice. CMS states that the notice requirement applies only to those Medicare beneficiaries receiving treatment as outpatients and receiving observation services for more than 24 hours. The requirement applies to all Medicare beneficiaries, regardless of whether the services furnished are payable under the Medicare program. Thus, a beneficiary entitled to Part A but not enrolled in Part B will still be required to receive the notice. Medicare Advantage (or other Medicare health plan) enrollees also will be required to receive the notice.

The agency further clarifies that the MOON must be delivered even if the patient is subsequently admitted as an inpatient. CMS acknowledges that, in these circumstances, cost-sharing obligations for a patient will change due to the three-day payment window requirements[1] and the agency expects that this information will be communicated to the patient during the oral explanation of the notification. Further, if a patient receives more than 24 hours of outpatient observation services, but is admitted as an inpatient prior to the delivery of the MOON, the hospital should explain in the "Additional Information" section of the MOON that, as an inpatient, the individual may have Part A cost-sharing responsibilities.

Timing of Notice Delivery. The NOTICE Act requires that hospitals and CAHs provide notice to an individual who receives observation services for more than 24 hours, and no later than 36 hours after observation services are initiated, or sooner if the individual is transferred, discharged or admitted as an inpatient. CMS notes that its existing

[1] Related outpatient services directly preceding an inpatient admission may fall under the "3-day payment window" for outpatient services for which the costs are treated as costs of inpatient service. Outpatient services that fall under the three-day window prior to an inpatient admission will be subject to Part A cost-sharing rules.

Medicare manual instructions indicate that observation services are initiated when ordered by a physician (or a nonphysician practitioner, as permitted by state law and hospital staff bylaws), as documented in the patient medical record, and that valid medical documentation for observation services always contains the clock time when observation services are initiated.

Consistent with the AHA's recommendation, **CMS revises its regulation to clarify that hospitals and CAHs are permitted to voluntarily deliver the MOON before the patient has received more than 24 hours of outpatient observation services, provided the information contained in the notice is accurate.** However, CMS states that it does not encourage hospitals and CAHs to deliver the MOON at the initiation of outpatient observation services, noting that at the initiation of outpatient observation services, patients may be completely preoccupied with concern for their safety and well-being and also may be overwhelmed and confused by notices and hospital paperwork that are presented at the time, often simultaneously.

CMS also clarifies the following in the final rule:

- The start of observation services, for the purposes of determining when more than 24 hours of observation services have been received, is the clock time, as documented in the patient's medical record, at which observation services are initiated (i.e., furnished to the patient) in accordance with a physician's order.
- To the extent that a resident is authorized by state licensure law and hospital staff bylaws to order outpatient services, once observation services are initiated in accordance with the resident's order, the 24-hour time period will commence. That is, with regard to determining when observation commences, there is no need to wait until the attending physician "confirms" a resident's order.
- For the purposes of identifying the 24-hour timeframe during which a patient has received observation services, and thus is required by the NOTICE Act to receive notice from the hospital or CAH, observation time will be measured as the elapsed time (rather than billable time) in hours beginning at the clock time documented in the patient's medical record, which coincides with the time that observation care is initiated in accordance with a physician's order.

In the case of a "Condition Code 44" situation, when a beneficiary is initially admitted as an inpatient but subsequently determined not to meet inpatient criteria and placed in outpatient observation, CMS requires that the MOON be provided within the timeframes described above, and the period for observation notification begins at the same time that observation services are initiated under a physician's order.

In cases where a CMS reviewer denies a claim for inpatient services as not medically reasonable and necessary after the beneficiary has been discharged, CMS clarifies that there is no requirement to issue a MOON. The same policy applies where a hospital, under its own utilization review after a beneficiary has been discharged, determines the inpatient admission was not medically reasonable and necessary and bills for the services under Part B. In both cases, the patient's status remains inpatient.

Delivering the MOON. CMS notes that English and Spanish language versions of the MOON will be made available. It cautions that hospitals and CAHs must follow their usual procedures to ensure that beneficiaries comprehend the written contents and/or the oral explanation (such as use of translators, interpreters and assistive technologies), as required under Medicare's financial liability protection standards, as well as under several federal anti-discrimination laws for recipients of federal financial assistance.

Finally, as recommended by the AHA, CMS notes that it will not prescribe which staff must deliver the notice to a beneficiary, but rather agrees that the hospital and CAH is in the best position make such a determination.

Monitoring and Enforcement. CMS states that all monitoring and enforcement of the MOON will be consistent with the oversight procedures for other hospital delivered notices. The agency is reviewing its surveying protocols to identify changes that may be needed to facilitate effective monitoring and enforcement of these requirements and will implement these revised procedures in the normal course of business.

Signature Requirements. The NOTICE Act requires that the MOON must be signed by the patient, or a person acting on the patient's behalf, to acknowledge receipt and understanding. Where the patient (or person acting on their behalf) refuses to sign, the MOON must be signed by the hospital staff member who presents the notice, and must include the staff member's name and title, the certification statement that the notice was presented, and the date and time the notice was presented.

Despite an AHA request, CMS does not clarify what should occur if a patient is unable to sign the MOON, due to their medical or mental condition, and has no representative. Instead, the agency states only that, to the extent that additional guidance related to delivery of the notice is necessary, it will issue instructions in the CMS Internet Only Manual. CMS notes that it will be publishing guidance to further assist hospitals and CAHs in delivery of the MOON and intends that such guidance will be available before the end of the implementation period, after the updated MOON receives final approval.

No Appeal Rights under the NOTICE Act. CMS states that the provisions of the NOTICE Act do not afford appeal rights to beneficiaries regarding the notice, nor does the act afford any new appeal rights beyond those already available to beneficiaries or in any way limit or restrict currently available appeal rights. Therefore, CMS amends the Medicare regulations to explain that the issuance of the MOON by a hospital or CAH does not constitute an initial determination and therefore does not trigger appeal rights under Medicare Parts A and B.

Wage Index

The area wage index adjusts payments to reflect differences in labor costs across geographic areas. The final rule would base the FY 2017 wage index on data from FY 2013 cost reports. According to CMS, the national average hourly wage increased 1.02 percent compared to FY 2016. 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 on the new 2013 Medicare Wage Index Occupational Mix Survey to compute the occupational mix adjustment for FYs 2016, 2017 and 2018. Accordingly, CMS will calculate the FY 2017 occupational mix adjustment based on data from the 2013 Medicare Wage Index Occupational Mix Survey. CMS will apply the occupational mix adjustment to 100 percent of the wage index, as it did for FY 2016.

Transitional Wage Indexes. In FY 2015, CMS finalized applying the most recent labor market delineations issued by the OMB that reflected the OMB's new 2010 standards and 2010 Census data. That update resulted in a number of significant changes to the previously existing labor markets. As a result, CMS finalized wage index transition periods applicable to all hospitals that experienced negative impacts due to the implementation of the new labor markets. In the final rule, CMS indicates how these transitions will be handled for FY 2017.

- **Transition for Urban Counties that Would Become Rural.** This transition applies to hospitals that, for FY 2014, were located in an urban county that became rural under the new labor market delineations, and had no form of wage index reclassification or redesignation in place for FY 2015. CMS will apply the urban wage index value of the core based statistical area where the hospitals are physically located in FY 2014 for a three-year period. This three-year transition period also will apply to hospitals that are deemed to be urban under Section 1866(d)(8)(B) of the Social Security Act in FY 2014 and that will lose deemed status under the new labor market delineations in FY 2015. CMS indicates in the final rule that this transition will continue in FY 2017, its third and final year. CMS notes that the wage index assignment based on this transition policy will be forfeited if the hospital obtains any form of wage index reclassification or redesignation. CMS notes that this transition policy will not apply to hospitals that have previously chosen to forego the transition by obtaining any form of reclassification or redesignation.

- **Transition for Hospitals Deemed Urban under Section 1886(d)(8)(B).** This transition applies to hospitals redesignated to urban areas under Section 1886(d)(8)(B) of the Act for FY 2014 that are no longer deemed urban under the new OMB delineations and revert to being rural. Hospitals designated as urban under section 1886(d)(8)(B) of the Act are generally referred to as "Lugar" hospitals. For FY 2017, CMS does not make any changes to this policy and will continue with the third and final year of its implementation of this transition policy. If the hospital cannot be assigned the wage index value of the Core-based Statistical Area (CBSA) in which it was geographically located in FY 2014, CMS

will continue its approach to assign the wage index of the labor market area to which it is closest. CMS notes that the wage index assignment based on this transition policy will be forfeited if the hospital obtains any form of wage index reclassification or redesignation.

Imputed Rural Floor. CMS finalizes an additional one-year extension of the imputed rural floor through Sept. 30, 2017 for those states with no rural counties. CMS will continue using both the original and alternative methodologies for computing the imputed rural floor. Under the alternative methodology, which was finalized in the FY 2014 inpatient PPS final rule, the lowest post-reclassified wage index assigned to a hospital in a state with one CBSA will be increased by a factor equal to the average percentage difference between the post-reclassified, pre-floor area wage index and the post-reclassified, rural floor wage index.

CMS anticipates that, in FY 2017, there will be 18 providers in New Jersey benefitting from the imputed rural floor policy under the original methodology. In addition, 10 hospitals in Rhode Island and two hospitals in Delaware will benefit from the policy 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 2017 reclassification requests and 265 hospitals were approved for wage index reclassifications for FY 2017. Hospitals reclassified during FYs 2015 (294 hospitals) and 2016 (258 hospitals) will continue to be reclassified, because wage index reclassifications are effective for three years.

Applications for hospital reclassifications for FY 2018 are due to the MGCRB by Sept. 1, 2016. This is also the deadline for cancelling a previous wage index reclassification withdrawal or termination. Hospitals with current reclassifications are encouraged to analyze the area wage indexes published in the final 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.

Hospital-acquired Conditions (HACs)

The HAC Reduction Program imposes a 1 percent reduction to all Medicare inpatient payments for hospitals in the top (worst performing) quartile of risk-adjusted national HAC rates. The HAC Reduction Program's eligibility criteria, basic payment adjustment approach, measures and scoring methodology were established in the FY 2014 inpatient PPS final rule and modified in the FY 2015 inpatient PPS final rule. CMS finalizes only minor policy updates to the FY 2017 HAC Reduction Program. However, the agency adopts more significant changes to the measures and scoring methodology that would take effect in FY 2018.

FY 2017 Policy Updates. As previously finalized, CMS will use two domains of quality measures to determine performance on the FY 2017 HAC Reduction Program. Domain 1 is a composite of Patient Safety Indicator (PSI) measures calculated using Medicare claims data. Domain 2 is comprised of hospital-acquired infection (HAI) measures currently reported in the Inpatient Quality Reporting (IQR) Program. The specific HAC Reduction Program domains and measures are outlined in Table 2.

Table 2: Measures and Domains for the HAC Reduction Program, FY 2015 – FY 2017

Domain 1: PSI Measures	Domain 2: HAI Measures

PSI 90, a composite of the following PSIs:
• PSI 3 - Pressure ulcer rate
• PSI 6 - Iatrogenic Pneumothorax rate
• PSI 7 - Central venous catheter-related blood stream infection rate
• PSI 8 - Postoperative hip fracture rate
• PSI 12 - Postoperative pulmonary embolism (PE) or deep vein thrombosis rate (DVT)
• PSI 13 - Postoperative sepsis rate
• PSI 14 - Wound dehiscence rate
• PSI 15 - Accidental puncture and laceration rate
	• Central Line-associated Blood Stream Infection (CLABSI)
	• Catheter-associated Urinary Tract Infection (CAUTI)
	• Surgical Site Infection (SSI) (FY 2016 onward):
	  ○ SSI Following Colon Surgery
	  ○ SSI Following Abdominal Hysterectomy
	• Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia (FY 2017 onward)
	• Clostridium difficile (C Difficile) (FY 2017 onward)

Complete Data for Domain 1. CMS adopts a change to its definition of "complete data" for the PSI 90 measure in Domain 1. Under current policy, a hospital has enough data to receive a Domain 1 score if it has three or more eligible discharges for at least one component PSI measure. For FY 2017, CMS adds one additional criterion – that is, a hospital must have 12 or more months of PSI data. The agency adds the additional criterion due to concerns that using less than 12 months of measure data may not provide a statistically valid reflection of hospital performance.

Domain 2 Data Submission Requirements for Newly Opened Hospitals. In the final rule, CMS again clarifies that newly opened hospitals are expected to submit Domain 2 HAI measure data regardless of whether they participate in the hospital IQR program. Submitting HAI measure data is a requirement of the IQR program, and nearly all hospitals eligible for the HAC Reduction Program fulfill their Domain 2 data submission requirement by participating in the IQR program. However, IQR participation is voluntary and, each year, a very small number of inpatient PPS hospitals opt out of IQR participation. Because the HAC program is mandatory for nearly all inpatient PPS hospitals, CMS must establish data submission standards for both IQR and non-IQR participating hospitals.

Therefore, CMS finalizes two different HAI submission standards for newly opened hospitals:

- *IQR-participating hospitals* will be expected to submit HAI data no later than the calendar year quarter starting after the date an IQR Notice of Participation (NOP) is signed. This is consistent with CMS's existing policy that newly opened hospitals must file an NOP to participate in the IQR within six months of opening, and begin reporting measure data in the quarter after the NOP is submitted. For example, a hospital that opens Jan. 1 must submit a signed NOP to CMS by July 1 of the same year, and begin submitting data no later than Oct. 1.

- *Non-IQR participating hospitals* will be expected to submit HAI data on the first day of the quarter following the end of a six-month period to file an IQR NOP. For example, if a hospital opens Jan. 1, it would be expected to submit data starting on July 1 of the same year.

FY 2018 Scoring Methodology Changes. In response to concerns from the AHA and numerous other stakeholders, CMS convened a technical expert panel (TEP) in late 2015 to examine ways of improving the fairness of the HAC scoring methodology. The TEP identified several concerns with the HAC Reduction Program's existing decile-based scoring methodology, which assigns hospitals 1 to 10 points on each HAC program measure based on their decile of performance. The scores for each measure are combined into domain scores, and CMS calculates a weighted sum of the domain scores to create a Total HAC Score. Hospitals whose HAC scores are in the top (i.e., worst-performing) quartile receive a penalty.

The TEP found that the decile-based scoring approach can make it difficult to distinguish the performance of high- and low-performing hospitals. For example, two hospitals whose difference in performance is meaningfully different may fall into the same decile. It also is possible that two hospitals whose performance is not statistically different may fall into different deciles of performance. In addition, CMS notes that the decile-based scoring approach has resulted in a large number of scoring ties at the penalty threshold score. As a result, the agency actually penalized less than 25 percent of eligible hospitals in FYs 2015 and 2016. Finally, CMS notes that the decile-based scoring approach can result in hospitals with small amounts of data being identified as poor performers. In FY 2016, a small number of hospitals had scores higher than the penalty threshold score even though they had zero adverse events in the PSI measure in Domain 1 and not enough data to calculate a Domain 2 score.[2]

In an effort to address the above concerns, CMS will, for the FY 2018 HAC program, replace decile-based scoring with "Winsorized z-scores." A z-score is a commonly used statistical formula that compares a hospital's score on a given measure to the national average (i.e., mean) score. Specifically, the z-score calculates the number of standard

[2] CMS notes that it waived the application of the FY 2016 HAC penalty to the small number of hospitals in this category. Low-volume hospitals can receive non-zero scores on PSI measures – even when they do not have any actual adverse events – because of the "smoothing" approach used to score PSI 90. That is, hospitals with lower volumes have scores that more heavily weight the national average score in order to improve measure reliability.

deviations between a hospital's performance on a measure and the national mean using the following formula:

Z-score = (Hospital's Performance – Mean Performance for All Hospitals) / Standard Deviation for All Hospitals

Before calculating z-scores for each measure, CMS will apply a process known as "Winsorization," in which it reassigns hospitals whose performance is considered an outlier to specified percentiles of performance. Specifically, hospitals whose measure scores are below the 5th percentile and higher than the 95th percentile are assigned the measure scores of hospitals in the 5th percentile or 95th percentiles, respectively. CMS would then calculate the mean, standard deviation and z-score for each hospital on each measure. Hospitals whose performance on a measure is better than the national average would receive *negative* z-scores, while hospitals whose measure performance is worse than the average would receive *positive* z-scores. This is because of the measures used in the HAC program – lower performance scores (i.e., lower infection and PSI rates) indicate better performance.

CMS does not adopt changes to other aspects of the HAC Reduction Program's scoring methodology. Therefore, the agency will combine the z-scores on each measure into domain scores, then calculate a weighted sum of the domain scores to create a Total HAC Score. Hospitals with Total HAC Scores in the top (i.e., worst-performing) quartile would receive a penalty. The Total HAC Score formula would remain as follows:

Total HAC Score = 15% x (Domain 1 Score) + 85% x (Domain 2 Score)

Potential Impact of Z-Score Approach. The final rule includes the same high-level information on the potential impact of using the z-score approach as the proposed rule. CMS states the approach would change the penalty status of 217 hospitals compared to the decile-based approach. CMS estimates that 114 hospitals would be brought into the penalty zone, while 103 would be removed from the penalty zone. In addition, the z-score approach substantially reduces ties in Total HAC Scores, and will enable the agency to penalize exactly 25 percent of hospitals each year.

CMS's analysis suggests that fewer very large (i.e., 500+ beds) and very small (i.e., less than 25 beds) would be penalized. Specifically, the percentage of hospitals with 500+ beds receiving a penalty would fall from 50 percent to 42 percent, while the percentage of hospitals with less than 25 beds receiving a penalty would fall from 33 percent to 18 percent. However, the percentage of teaching, urban and high-DSH hospitals would remain unchanged.

The AHA applauds CMS's willingness to consider changes to the program's scoring methodology that are within its statutory authority. Nevertheless, the z-score approach does not meaningfully improve the fairness of HAC penalties. We remain concerned that the HAC program will disproportionately penalize hospitals caring for sicker, more complex patients. We will continue to urge CMS

to explore other ways of improving the HAC program, such as removing flawed measures.

PSI Measure Update for FY 2018. For the FY 2018 HAC Reduction Program, CMS adopts an updated version of the PSI 90 measure used in Domain 1. The updated version was recently endorsed by the National Quality Forum (NQF). CMS suggests the updated version of PSI 90 better reflects the relative importance and harm associated with the component PSIs, thereby providing a more accurate portrayal of hospital performance. **Nevertheless, the AHA remains concerned that PSI 90 measure is not reliable and accurate enough for use in any pay-for-performance application, including the HAC Reduction Program.**

The key updates to the measures are as follows:

- The measure adds three component PSI measures and removes one component PSI measure (PSI 7 – Central venous catheter-associated blood stream infection). The updated PSI measure now includes 10 components – the new components have been bolded below:

    - PSI 3 – Pressure ulcer rate
    - PSI 6 – Iatrogenic pneumothorax rate
    - PSI 8 – Postoperative hip fracture rate
    - **PSI 9 – Postoperative hemorrhage or hematoma rate**
    - **PSI 10 – Physiologic and metabolic derangement rate**
    - **PSI 11 – Postoperative respiratory failure rate**
    - PSI 12 – Postoperative PE or DVT rate
    - PSI 13 – Postoperative sepsis rate
    - PSI 14 – Wound dehiscence rate
    - PSI 15 – Accidental puncture and laceration rate

- The updated measure includes refinements to PSI 12 and PSI 15. For example, PSI 12 now excludes extracorporeal membrane oxygenation (ECMO) procedures. PSI 15 also was modified so that it only includes discharges for abdominal/pelvic operations. CMS suggests these changes respond to stakeholder concerns and help the measure better focus on clinically significant and preventable clinical events.

- The relative weights of each component PSI towards the overall PSI 90 score have been modified so that they are no longer solely based on the volume of a particular PSI. Instead, the weights are based on an empirical analysis of volume, excess harm associated with the PSI and "disutility" (i.e., patient preferences for a health state linked with harm, like death or disability).

Performance Periods for FYs 2018 and 2019. CMS previously finalized a two-year performance period for both measure domains of the HAC program for all program years. At the time this policy was finalized, CMS suggested that using two years of

measure performance data – in particular for the PSI 90 measure – provides an appropriate level of statistical reliability and validity.

However, the transition from ICD-9 to ICD-10 coding on Oct. 1, 2015 impacts CMS's calculation of PSI 90, which is derived from the ICD codes Medicare claims. CMS is developing an ICD-10 version of PSI 90, but it will not be finalized until late 2017. Moreover, CMS believes it is not feasible to calculate PSI 90 using a combination of data collected under ICD-9 and ICD-10.

As a result, CMS finalizes the use of shortened performance periods for Domain 1 in FYs 2018 and 2019. For FY 2018, CMS will use a 15-month performance period of July 1, 2014 through Sept. 30, 2015. For FY 2019, CMS will use a 21-month performance period of Oct. 1, 2015 through June 30, 2017. CMS states these timeframes allow for sufficient measure reliability and lessen disruptions to the program. CMS would retain a 24-month performance period for the HAI measures in Domain 2. CMS's proposed HAC Reduction Program performance periods are summarized in Table 3 below.

Table 3: HAC Reduction Program Performance Periods, FYs 2017 – 2019

	FY 2017 Final	FY 2018 Final	FY 2019 Final
Domain 1: PSI 90	July 1, 2013 – June 30, 2015	July 1, 2014 – Sept. 30, 2015	Oct. 1, 2015 – June 30, 2017
Domain 2 HAIs	Jan. 1, 2014 – Dec. 31, 2015	Jan. 1, 2015 – Dec. 31, 2016	Jan. 1, 2016 – Dec. 31, 2017

Hospital Readmissions Reduction Program (HRRP)

The HRRP penalizes hospitals for having "excess" readmission rates when compared to expected rates. The agency finalizes only minor updates to the HRRP, and will continue to impose a maximum payment penalty of 3 percent of base Medicare payments in FY 2017, as required by the ACA. As previously finalized, CMS will add a coronary artery bypass graft (CABG) readmission measure to the FY 2017 program**.** In addition, CMS will implement its previously finalized expansion of the patient population included in the pneumonia readmissions measure. CMS estimates these changes will result in aggregate readmission penalties of $528 million in FY 2017, an increase of $108 million compared to FY 2016 penalties.

As the financial stakes for readmissions performance continue to rise, the AHA is dismayed that CMS has once again failed to adopt any sociodemographic adjustment for the HRRP. We remain especially concerned that hospitals caring for patients from poorer communities will be disproportionately penalized. We continue to strongly support legislation that would require CMS to incorporate sociodemographic adjustment in the HRRP

Applicable Period for FY 2017. For FY 2017, the "applicable period" for the Hospital Readmissions Reduction Program will be the three-year period from July 1, 2012

through June 30, 2015. Thus, the excess readmissions ratios and the payment adjustment for FY 2017 will be created with data from the time period of July 1, 2012 through June 30, 2015.

Timeline for Public Reporting of Excess Readmission Ratios on *Hospital Compare* for the FY 2017 Payment Determination. CMS clarifies that excess readmission ratios will be posted on an annual basis to the *Hospital Compare* website as soon as is feasible following the review period. CMS notes that this could, but may not always, occur as early as October.

Incorporation of CABG Measure. The HRRP currently includes five applicable conditions: acute myocardial infarction (AMI), heart failure (HF), pneumonia (PN), total hip arthroplasty/total knee arthroplasty (THA/TKA) and chronic obstructive pulmonary disease (COPD). For FY 2017, CMS will add Hospital-Level, 30-Day, All-Cause, Unplanned Readmission Following Coronary Artery Bypass Graft (CABG) Surgery. In the rule, CMS reviews the methodology to incorporate the CABG condition into the calculation of the existing readmissions payment adjustment. The methodology is consistent with CMS's approach in prior years.

Exclusions. CMS will exclude some admissions in calculating aggregate payments for excess readmissions, similar to previous years. Exclusions specific to CABG include admissions for patients with subsequent qualifying CABG procedures during the measurement period. CMS explains that a repeat CABG procedure during the measurement period "probably represents a complication of the original CABG procedure and is a clinically more complex and higher risk surgery." Thus, CMS will use the first CABG admission to include in the measure.

Hospital Value-based Purchasing (VBP) Program

As required by the ACA, CMS will fund the budget-neutral FY 2017 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 $1.8 billion for FY 2017.

PSI-90 Measure Performance Period. CMS will shorten the PSI 90 measure performance period for the FY 2018 program year in part due to concerns about combining performance information that includes both ICD-9 and ICD-10 data. The agency proposes a 15-month performance period from July 1, 2014 through Sept. 30, 2015 for the FY 2018 program year and would only use ICD-9 data. (Similar modifications are proposed for the HAC and IQR programs.) The FY 2019 performance period may have similar issues related to combined ICD-9 and ICD-10 data, which CMS will address in future rulemaking.

Expansion of CAUTI and CLABSI. CMS will incorporate CAUTI and CLABSI measure data collected from non-ICU locations into hospitals' VBP performance beginning with the FY 2019 program year. As part of the hospital IQR program, CMS began to require the collection of non-ICU CAUTI and CLABSI data on Jan. 1, 2015. The agency

signaled its intent to include non-ICU data in VBP scoring in the FY 2016 inpatient PPS proposed rule. The baseline period for CAUTI and CLABSI is Jan.1, 2015 through Dec. 31, 2015. The performance period will be Jan. 1, 2017 through Dec. 31, 2017.

FY 2021 Pneumonia Mortality Measure Update. CMS will incorporate updates to an existing measure, *Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Pneumonia Hospitalization (NQF #0468).* This measure underwent a substantive revision to expand the measure cohort. The new cohort includes: (1) patients with a principal discharge diagnosis of pneumonia; (2) patients with a principal discharge diagnosis of aspiration pneumonia; and (3) patients with a principal discharge diagnosis of sepsis (excluding severe sepsis) with a secondary diagnosis of pneumonia coded as present on admission. The measure changes have been incorporated into the IQR Program, and initial measure data were posted on *Hospital Compare* in late July. **The AHA continues to be concerned that this measure expansion has not been reviewed and endorsed by the NQF and will continue to urge CMS to seek NQF endorsement of the updated measure.**

New Measures for FY 2021 and FY 2022. CMS adds two new measures to the VBP program for the FY 2021 program year and one new measure for FY 2022. The VBP program's previously finalized and proposed measures are listed in Appendix A of this advisory.

Episode-based Payment Measures for the 2021 Program Year. CMS adds two episode-based payment measures to the Efficiency and Cost Reduction domain for two conditions – AMI and HF. These measures calculate total payments for Medicare fee-for-service (FFS) patients with a primary discharge diagnosis of AMI and HF 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, neither measure includes an adjustment for sociodemographic factors.

The AHA opposed the adoption of these measures for the VBP, and remain concerned that the overlap between these measures and Medicare Spending per Beneficiary (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. Indeed, we share the concerns of the Measure Applications Partnership (MAP), which voted against the inclusion of both measures in the program, in part because they overlap with the MSPB measure and are not adjusted for socioeconomic status.

CMS will score the AMI and HF payment measures using the same methodology as the MSPB measures. (See the proposed rule for the proposed methodologies for

achievement and improvement points.) Note that CMS does propose to amend its regulations to revise definitions for "achievement threshold and "benchmark" to reflect the methodologies used for all measures in the Efficiency and Cost Reduction domain.

New Measure for the 2022 Program Year. For the FY 2022 program year, CMS adds the measure, Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery (NQF #2558). This measure is already included in the IQR program and initial measure data were posted on *Hospital Compare* in July 2015. The measure assesses hospitals' 30-day, all-cause risk standardized rate of mortality for Medicare FFS patients aged 65 or older who receive a qualifying CABG procedure. CMS believes that the measure "would provide hospitals with an incentive to reduce mortality through improved coordination of perioperative care and discharge planning."

Previously Adopted and Newly Proposed Baseline and Performance Periods. CMS traditionally has adopted a new baseline and performance period for each program year for each domain in each final inpatient PPS payment rule. This year, CMS proposed to establish specific baseline and performance periods **for all future program years,** unless otherwise noted in future rulemaking. For example, for the MSPB measure, CMS will adopt a 12-month baseline period (that runs on the calendar year) four years prior to the relevant program year, as well as a 12-month performance period (that runs on the calendar year) two years before the relevant program year.

See the final rule for detailed charts outlining the baseline and performance periods for each measure going forward. The AHA has concerns that the performance periods CMS proposes for certain measures may be too short to provide a reliable assessment of hospital performance, such as the new HF and AMI payment measures for the 2021 program year; the PSI-90 measure for the 2018 program year; and the pneumonia mortality measure for the 2021 program year.

Proposed Immediate Jeopardy Policy Changes. Currently hospitals are not eligible for the VBP program if they have been cited for immediate jeopardy (IJ) on at least two surveys during the performance period. CMS points out that the program currently uses measures with 12-month, 24-month and 36-month performance periods. Thus, IJ citations could result in excluding a hospital from the program for several program years. **In the rule, CMS finalizes its proposal to increase the number of IJs needed to exclude a hospital from the program from two to three.** Thus, a hospital will need to be cited for IJ on at least three surveys during the performance period in order to be excluded.

Generally a hospital is formally notified of an IJ citation after it receives a Form CMS-2567 following a hospital survey. The survey end date is used to assign an IJ citation to a particular performance period.

However, a different process is used for EMTALA violations. The CMS regional office must issue the Form CMS 2567 in the case of an EMTALA-related IJ citation. CMS

states that notification in these instances is often delayed and could take several months. For EMTALA cases only, CMS proposes to change its policy regarding the date of the IJ citation for the purposes of excluding hospitals from the program. Instead of the survey end date, the agency will use the date that Form CMS-2567 is sent by the CMS regional office to the hospital.

In instances where a survey results in both EMTALA and non-EMTALA IJ citations, the default date will be the survey end date. CMS states that, "Even though there may be separate enforcement actions resulting from the same survey, we will consider each Form CMS-2567 with immediate jeopardy findings to be one citation for the purposes of the Hospital VBP program."

Proposed Performance Standards. See the detailed charts in the proposed rule for the measure performance standards CMS proposes to adopt for the 2019-2021 performance years.

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 for the FY 2018 IQR program. For FY 2019 IQR, CMS removes two registry participation measures and two chart-abstracted measures, while adding four new claims-based measures.

CMS also finalizes its proposal to increase the number of electronic clinical quality measurers (eCQMs) that hospitals report for the FY 2019 IQR program. The agency will require hospitals to report eight eCQMs for a full year for FYs 2019 and 2020. This increase was made in advance of any learning from the first year of required eCQM reporting, which includes only four measures collected for one quarter of CY 2016. CMS states that increasing the reporting requirement balances requests to have more time to improve and refine eCQM reporting capabilities while still furthering CMS' goals to expand electronic data reporting and validation. CMS also finalizes the proposal that hospitals submit a full year of data for the eCQMs reported for the FYs 2019 and 2020 IQR program.

The AHA remains concerned about the feasibility of collecting and reporting eCQMs and the accuracy of eCQM data. We are disappointed that CMS has finalized a doubling of the eCQM reporting requirements before obtaining data from the CY 2016 eCQM reporting period to inform its policy approach.

Additional details about CMS's eCQM reporting policies for the IQR program are provided in the next section of this advisory. A summary of the changes to the measures in the program through FY 2019 can be found in Appendix B.

Measure Refinements. CMS finalizes changes to two previously finalized hospital IQR measures for FYs 2018 and 2019. First, for FY 2018, the agency finalizes an updated

version of the PSI 90 composite measure. For additional details on the changes to the measure, see the HAC Reduction Program section of this advisory.

Second, the agency will expand the patient population included in the PN episode of care payment measure. These changes are nearly identical to the changes adopted for the pneumonia mortality measure in the VBP program. For additional details, see the VBP section of this advisory.

FY 2019 Measure Removal. CMS removes two chart-abstracted measures from the IQR program – STK-4 (Thrombolytic therapy) and VTE-5 (VTE discharge instructions) – because performance on both measures has "topped out." As detailed in the next section of the advisory, CMS also will remove the eCQM versions of these measures.

In addition, CMS removes two "structural" measures that reflect whether hospitals participate in systematic clinical data base registries for nursing sensitive care and general surgery. The measures ask only whether hospitals participate in registry and do not reflect performance on process or outcomes. As a result, the agency does not believe the measures add value to the IQR program.

FY 2019 New Measures. CMS finalizes four new measures for the FY 2019 IQR program, all of which would be calculated using Medicare claims data. **The AHA is disappointed that none of these measures is NQF-endorsed. Indeed, the MAP did not support three of the four measures, and urged that all four measures receive NQF endorsement before being placed into the IQR.** The new measures are summarized below:

- **Clinical Episode-based Payment Measures.** CMS adopts three new measures intended to reflect Medicare "resource use" during episodes of care. In contrast to the similar MSPB measure, which is intended to reflect overall Medicare resource use, the proposed measures are specific to three clinical conditions and procedures – aortic aneurysm, cholecystectomy and common duct exploration, and spinal fusion. The detailed methodology for the measures is available on CMS's *QualityNet* website. CMS adopted several similar measures for other conditions and procedures in the FY 2016 inpatient PPS final rule.

  The measures capture Medicare FFS payments during episodes of care that span the three days before an initial (or "trigger") hospital admission to 30 days after hospital discharge. An episode is attributed to the hospital from which the patient was discharged for his/her trigger stay, and the measure excludes episodes that involve transfers between hospitals. Payment for the initial hospitalization is included in an episode, as well as payments for a broad range of subsequent care, including inpatient, outpatient, physician, laboratory and post-acute care services. The payment amounts are "standardized" by removing geographic payment adjustments and other payment factors. The measures use "grouping rules" intended to ensure the measures include those payments that are "clinically related" to the given condition or procedure. The measure also

includes a risk-adjustment methodology to account for certain patient characteristics, such as age, prior procedures and co-morbid conditions, which influence resource use and, therefore, payment.

- **Excess Acute Care Days after PN Hospitalization.** CMS finalizes a measure intended to assess excess "all-cause acute care utilization" in the 30-days after discharge for PN. CMS adopted similar measures for AMI and HF in the FY 2016 inpatient PPS final rule. In contrast to the existing all-cause readmissions measures, the measures include both emergency department (ED) visits and observation stays, in addition to hospital readmissions. The measure calculates a rate of excess acute care days per 100 discharges, and employs a risk-adjustment approach similar to that of the existing readmission measures.

  CMS suggests this measure improves upon the existing hospital readmissions measures because "there exists concern that the high use of observation stays could in some cases replace readmissions, and hospitals with high rates of observation stays may therefore have low readmission rates that do not more fully reflect the quality of care." **The AHA is concerned that these measures lack both NQF endorsement and sociodemographic adjustment. Indeed, the MAP's support of the measures was conditional on CMS obtaining NQF endorsement and considering the appropriateness of sociodemographic adjustment.**

Electronic Clinical Quality Measures (eCQMs) in the IQR Program

eCQMs Available in IQR. For the FY 2019 IQR program, CMS finalizes the removal of 13 eCQMs from the IQR program. Of the 13 eCQMs removed, eight eCQMs (AMI-2, AMI-10, SCIP-Inf-1a, SCIP-Inf-2a, STK-4, VTE-3, VTE-4, VTE-5) were deemed topped out because measure performance was determined to be high and unvarying. CMS also states that four eCQMs (AMI-7a, PN-6, SCIP-Inf-9, VTE-6) were removed because the data capture requirements cannot be represented adequately in the eCQM form due to their conceptual complexity. One eCQM (HTN) was removed because the measure steward no longer supports the eCQM version of the measure. CMS received anecdotal comments about performance level differences between chart-abstracted and eCQM data but lacks sufficient data to confirm or refute the accuracy of those comments. However, the comments prompted a reconsideration of the use of topped-out measures to meaningfully monitor eCQM measure performance. CMS acknowledges the time, effort and resources that hospitals have expended to build systems for reporting the removed eCQMs but finalized the removal of measures from the IQR program measure set. CMS intends to introduce additional eCQMs into the IQR program as eCQMs become available.

Table 4 lists the eCQMs finalized for removal from the IQR program.

Table 4: eCQMs Removed from Hospital IQR Program for the FY 2019 Payment Determination and Subsequent Years

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

* Retained in chart-abstracted form

eCQM Reporting Requirements. CMS finalizes the requirement that hospitals electronically submit data for eight self-selected eCQMs among the 15 eCQMs available in the IQR program. This is a reduction from the proposal that hospitals report on 15 eCQMs for the IQR program for CY 2017 reporting period but is an increase from the CY 2016 reporting requirement to submit one calendar quarter (Q3 or Q4) of data for four eCQMs. CMS states that reporting eight eCQMs allows choice in measures reported while advancing toward the goal of reporting on all eCQMs in the IQR program. CMS states that hospitals have had adequate time to understand and correct any processing issues that may arise during data submission and delaying the implementation of electronic reporting would hinder efforts to improve the reliability and validity of electronic data but CMS finalized.

CMS also finalizes the requirement of duplicate submission of clinical quality measure data in both chart-abstracted and eCQM form for ED-1, ED-2 and PC-01. The agency states this redundant requirement is necessary in order to continue publicly reporting the measures. CMS acknowledges that maintaining different reporting mechanisms is

costly, may appear redundant and requires expertise in different areas of health IT, clinician workflow and medical coding. Table 5 lists the eCQMs that will be available for IQR reporting.

Table 5: eCQMs Included in Hospital IQR Program for FYs 2019 and 2020

NQF Number	Electronic Clinical Quality Measures
0163	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

The AHA appreciates the reduction in the number of eCQMs that must be reported but believes that reporting eight eCQMs is premature given the hospital field's eCQM experience to date. We strongly disagree with CMS's decision,

which appears to prioritize reporting through a particular data collection mechanism (i.e., eCQMs) over ensuring that the quality data reported are accurate, meaningful and used to improve care.

Sampling and Case Threshold Exemptions. CMS will continue the minimum exemption threshold policy that allows hospitals to enter a value of zero to demonstrate that they had no clinical cases for a selected eCQM. CMS states that utilization of the zero denominator declaration and case threshold exemptions are considered as part of the criteria for successful submissions when reporting eCQMs to the hospital IQR and Medicare and Medicaid EHR Incentive programs.

eCQM Reporting Periods and Submission Deadlines. CMS finalizes the proposal that hospitals submit a full calendar year, four quarters, of data for eight eCQMs by an annual submission deadline. CMS acknowledges increasing the eCQM reporting requirement from one quarter of data to a full year of data, before data from the CY 2016 reporting period are available for analysis. CMS states that hospitals have sufficient time between the final rule publication and the beginning of the CY 2017 reporting period to make health IT and workflow adjustments to support a full year eCQM reporting period.

CMS adds that the agency is working to ensure its infrastructure is ready to receive the eCQM data transmissions from hospitals by the Feb. 28, 2018 deadline for the CY 2017 reporting period.

eCQM Submission Requirements. CMS will permit hospitals to submit Quality Reporting Document Architecture Category I (QRDA-I) files for the IQR Program during the CY 2017 reporting period rather than waiting until the end of the reporting period. The CMS data receiving system will re-open late spring 2017 to receive test QRDA-I files and QRDA-I files for submission. Hospitals and vendors will be permitted to submit QRDA-I files on a quarterly, semi-annual basis during the 2017 reporting period. Hospitals also will have the option to submit all QRDA-I files following the end of the reporting period.

CMS finalizes that the CMS data receiving system requires eCQM data submitted in a QRDA-I file format and each QRDA-I file must include data for one patient, for one quarter, per the reporting CCN. CMS expects the QRDA-I files to allow for the combination of data from multiple sources and contain all the episodes of care and the measures associated with the patient file for the same reporting quarter. CMS disagrees that the eCQM data submission timeline does not allow sufficient time if problems arise with the QRDA-I files and/or pre-submission validation efforts.

CMS encourages hospitals to test electronic capture of data after their EHR is updated or upgraded or to work with their vendors to do so. Additionally, CMS encourages hospitals to test their preparedness to submit QRDA-I data files prior to annual reporting with an available pre-submission testing tool for electronic reporting—such as the CMS Pre-Submission Validation Application (PSVA), available for download from the Secure

File Transfer (SFT) section of the *QualityNet Secure Portal* at: https://cportal.qualitynet.org/QNet/pgm_select.jsp.

Public Reporting of eCQMs. CMS did not propose any changes to the public display requirements for eCQMs. In the final rule, CMS states that eCQM data submitted for the CY 2017 reporting period/FY 2019 payment determination will not be made publicly available.

eCQM Validation. CMS finalizes an update to the validation of IQR program data to include eCQM validation of up to 200 hospitals for the FY 2020 payment determination and subsequent years. The hospitals will be randomly selected for eCQM validation. CMS will exclude any hospital selected for chart-abstracted measure validation as well as any hospital that has been granted an IQR Program Extraordinary Circumstances Exemption for the applicable eCQM reporting period. Hospitals selected for eCQM validation will be required to submit timely and complete medical record information from the certified EHR for at least 75 percent of sampled records. CMS will randomly select 32 cases from the QRDA-I file submitted by the hospitals selected for eCQM validation. The validation of eCQM data will not occur until spring of 2018 and will validate data from the CY 2017 reporting period. The accuracy of the data submitted for eCQM validation will not impact the hospital's APU for purposes of the IQR Program for at least the first year of the validation process. However, hospitals selected for validation that fail to submit timely and complete information for at least 75 percent of requested records would not meet the eCQM validation requirement and would be subject to payment reduction.

CMS summarizes findings from the 2015 eCQM validation pilot that included 29 hospitals and 29 EHR systems. The 2015 pilot yielded measure record matching rates of less than 50 percent for all of the measures reported. Required information documented in free text notes, dictation and scanned pdf documents could not be extracted or mapped to create the data elements in the QRDA-I files. CMS states that a broader validation process with mandatory participation better serves the goal of improving the accuracy of eCQM data reported.

Extraordinary Circumstances Extensions/Exemptions Policy. CMS finalizes the establishment of a separate submission deadline for Extraordinary Circumstances Extensions (ECE) requests for eCQM reporting. The deadline for ECE requests related to eCQM reporting is April 1 following the end of the reporting period. CMS states that current policy allows hospitals to use the existing ECE form to request an exemption from the eCQM reporting requirement in the IQR program based on hardships preventing hospitals from electronically reporting. CMS adds that hardships include but are not limited to infrastructure challenges, such as the hospital location in an area with insufficient internet access, or unforeseen circumstances, such as vendor issues outside of the hospital's control.

Alignment of the Hospital IQR Program with the Medicare and Medicaid EHR Incentive Programs. CMS finalizes requirements to align the IQR program with the Medicare and Medicaid EHR Incentive Program. CMS finalizes that hospitals must use the 2014 Edition or 2015 Edition certified EHR to report eCQM data for the CY 2017 reporting period.

CMS finalizes that hospitals must submit eCQM data via QRDA I files or may continue to use a third party to submit QRDA-I files on their behalf. CMS also finalizes that hospitals may either use abstraction or pull the data from non-certified sources in order to then input these data into the certified EHR for capture and reporting of the QRDA-I file.

The AHA appreciates the continued flexibility for bringing data into the EHR as hospitals continue to spend significant time and effort in data mapping to capture required clinical information in discrete structured data fields to support the QRDA-I file reporting.

eCQM Reporting Period and Submission Requirements. CMS states that deadlines for the Medicaid EHR Incentive Program differ by state, and, therefore, the alignment of data submission deadlines for eCQMs applies only to the IQR program and the Medicare EHR Incentive Program.

Clinical Quality Measurement for Eligible Hospitals and CAHs Participating in the EHR Incentive Programs in 2017

eCQMs Available in the Medicare and Medicaid EHR Incentive Programs. CMS finalizes that hospitals electronically reporting eCQMs must report eight of the available eCQMs for the Medicare and Medicaid EHR Incentive Programs in 2017. Attestation remains an option for eCQM reporting in 2017. Hospitals that meet the quality measure reporting requirement by attestation must attest to all 16 eCQMs included in the EHR Incentive Program. The set of available measures include the 15 measures included in IQR (see Table 5 on page 28), as well as one outpatient eCQM, ED-3 (Median Time from ED Arrival to ED Departure for Discharged ED Patients).

eCQM Reporting Requirements. For the Medicare EHR Incentive Program, CMS finalizes the proposed submission periods for eligible hospitals and CAHs reporting CQMs by attestation and finalized with modification the proposed submission periods for eligible hospitals and CAHs electronically reporting CQMs. Table 6 provides the eCQM reporting requirements for the Medicare EHR Incentive Program. Requirements vary for hospitals in their first year in the program and hospitals that are beyond their first year. Hospitals may choose to submit Medicare eCQMs electronically or report eCQMs via attestation in 2017. CMS provides the states the flexibility to determine the submission periods for reporting CQMs for the Medicaid EHR Incentive Program, and hospitals are advised to check with their state Medicaid agency.

Table 6: eCQM Reporting for Medicare EHR Incentive Program: Submission Method, Reporting Period and Data Reported

CY 2017 eCQM Reporting Medicare and Medicaid EHR Incentive Program Participants			
Submission Method	**Reporting Period**	**Data Reported**	**Submission Deadline**
Attestation: Available for any EH or CAH in the first year of MU in 2017	Any continuous 90-day reporting period within CY 2017	Report on all 16 available eCQMs (15 inpatient eCQMs and 1 outpatient eCQM) through the EHR Registration & Attestation System	Two months following the close of the reporting period (Feb. 28, 2018)
Attestation: Available for an EH or CAH beyond the first year of MU in 2017	One calendar year (four quarterly data reporting periods) for CY 2017	Report on all 16 available eCQMs (15 inpatient eCQMs and 1 outpatient eCQM) through the EHR Registration & Attestation System	Two months following the close of the reporting period calendar year (Feb. 28, 2018)
Electronic Submission to the EHR Incentive Program Only: Available for any EH or CAH in first year or beyond of MU in 2017	One calendar year (four quarterly data reporting periods) for CY 2017	Report on 8 of the available 16 eCQMs (15 inpatient eCQMs and 1 outpatient eCQM) through the QualityNet Portal	Begins late spring 2017 and continues through the two months following the close of the reporting period calendar year (Feb. 28, 2018)
Electronic Submission to the EHR Incentive Program and Hospital IQR: Available for any EH or CAH in the first year or beyond of MU in 2017	One calendar year (four quarterly data reporting periods) for CY 2017	Report on 8 of the available 15 inpatient eCQMs through the QualityNet Portal	Begins late spring 2017 and continues through the two months following the close of the reporting period calendar year (Feb. 28, 2018)

CMS states that, starting in 2018, eligible hospitals and CAHs participating in the Medicare EHR Incentive Program must electronically report CQMs using certified EHRs where feasible and attestation to eCQMs will no longer be an option except in certain circumstances where electronic reporting is not feasible. For the Medicaid EHR

Incentive Program, states will continue to be responsible for determining whether and how eligible hospitals and CAHs report eCQMs.

Version of Electronic Specifications Supporting Electronic Reporting of eCQMs. CMS finalizes the proposal to accept the use of EHR technology certified to the 2014 or 2015 Edition for CQM reporting in 2017. CMS also states that, if the 2014 edition certified EHR technology is not certified to the 16 available eCQMs, the eligible hospital or CAH is still required to have its EHR certified to the eCQMs in order to meet the reporting requirements for 2017.

CMS finalizes the continuation of policy that electronic submission of eCQMs will require the use of the most recent version of the eCQM electronic specification for each eCQM. CMS also continues current policy that a 2014 edition EHR certified for eCQMs does not need to be recertified each time it is updated to a more recent version of the eCQM electronic specifications.

CMS states future rulemaking will address the questions presented in the December 2015 Request for Information: Certification Frequency and Requirements for the Reporting of Quality Measures Under CMS Programs.

Outlier Payments

CMS finalizes that cases will qualify for outlier payments in FY 2017 if their costs exceed the hospital's inpatient PPS rate for the MS-DRG, including indirect medical education (IME), DSH and new technology payments, plus a fixed-loss threshold of $23,570. This threshold is higher than the final FY 2016 outlier fixed-loss threshold of $22,544. For FY 2017, CMS projects this threshold will result in outlier payments that will equal 5.1 percent of operating diagnosis-related group (DRG) payments and 6.14 percent of capital payments based on the federal rate.

Capital PPS Rate Update

CMS is required to pay for a portion of the capital-related costs of inpatient hospital services. These costs include depreciation, interest, taxes, insurance and similar expenses for new facilities, renovations, clinical information systems and high-tech equipment (e.g., MRIs and CAT scanners). This is done through a separate capital PPS, which is structured similarly to the operating PPS. Under the capital PPS, there is a standard federal payment rate that is adjusted by the Medicare-Severity DRG (MS-DRG) relative weight for each discharge, with additional payment adjustments for teaching and disproportionate share hospitals. CMS finalizes a FY 2017 update of 0.9 percent to the capital federal rate (after accounting for budget neutrality and the outlier adjustment factor). As a result, the capital standard federal payment rate for FY 2017 will be $446.81.

Changes to MS-DRG Classifications

As of Oct. 1, 2015, providers use the International Classification of Diseases, 10th Revision (ICD-10) coding system to report diagnoses and procedures for Medicare hospital inpatient services. In the FY 2016 inpatient PPS/LTCH PPS final rule, CMS

implemented the final ICD-10 MS-DRG Version 33 as the replacement logic for the ICD-9-CM based MS-DRG Version 32.

FY 2017 MS-DRG Updates. For the FY 2017 final rule, CMS does not perform any further MS-DRG analysis. CMS's analysis is based on claims data from the December 2015 update of the FY 2015 MedPAR file, which contains hospital bills received through Sept. 30, 2015, for discharges occurring through Sept. 30, 2015. CMS notes that some of the issues being evaluated for the FY 2017 MS-DRG update continue to relate to the need for the ICD-10 MS-DRGs to accurately replicate the logic of the ICD-9-CM based version.

CMS rejects a request to make the FY 2017 finalized MS-DRG GROUPER logic proposals retroactive to Oct. 1, 2015 for current FY 2016 claims. The commenter stated that if the corrected replication issues were made retroactive, private payers would be able to appropriately adjust claims that had an inappropriate MS-DRG assignment. Consistent with CMS's general approach for implementing updates to the MS-DRGs, the MS-DRG updates adopted as final policy in this FY 2017 inpatient PPS/LTCH PPS final rule will apply beginning with the FY 2017 MS-DRGs.

- **Pre-Major Diagnostic Category (Pre-MDC): Total Artificial Heart Replacement.** In ICD-10-PCS, a "cluster" is the term used when a combination of ICD-10-PCS procedure codes are needed to fully satisfy the equivalent meaning of an ICD-9-CM procedure code for it to be considered a plausible translation. CMS finalized its proposal to assign ICD-10-PCS procedure codes 02RK0JZ (Replacement of right ventricle with synthetic substitute, open approach) and 02RL0JZ (Replacement of left ventricle with synthetic substitute, open approach) as a code cluster to MS-DRGs 001 and 002 (Heart Transplant or Implant of Heart Assist System with and without MCC, respectively). The change accurately replicates the Version 32 ICD-9-CM based MS-DRG logic of procedure code 37.52 (Implantation of total internal biventricular heart replacement system).

- **Major Diagnostic Category (MDC) 1 (Diseases and Disorders of the Nervous System).** *Mechanical Complication Codes.* CMS finalizes its proposal to reassign four ICD-10-CM diagnosis codes under MS-DRGs 919, 920 and 921 (Complications of Treatment with MCC, with CC, and without CC/MCC), to MS-DRGs 091, 092 and 093 (Other Disorders of the Nervous System with MCC, with CC, and without CC/MCC, respectively). The ICD-9-CM predecessor diagnosis code 996.59 (Mechanical complication due to other implant and internal device, not elsewhere classified) did not describe the location of the device. However, the more specific ICD-10-CM diagnosis codes relate to epidural and subdural infusion catheters and provide additional detail that describes the location of the mechanical complication as being within the nervous system.

  Based on public comments and CMS's review, 18 additional diagnosis codes are also reassigned from MS-DRGs 919, 920 and 921 to MS-DRGs 091, 092 and 093. The codes may be found in Table 6E of the final rule.

- **Major Diagnostic Category (MDC) 4 (Diseases and Disorders of the Ear, Nose, Mouth and Throat).** *Diagnosis Code R22.2 (Localized Swelling, Mass and Lump, Trunk**).*** CMS finalizes its proposal to reassign code R22.2 from MDC 4 to MDC 9 (Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast) under MS-DRGs 606 and 607 (Minor Skin Disorders with and without MCC, respectively).

- **Major Diagnostic Category (MDC) 5 (Diseases and Disorders of the Circulatory System).**

  - *Implant of Loop Recorder.* CMS finalizes its proposal to designate the following four ICD-10-PCS codes as operating room (O.R.) procedures within Appendix E Operating Room Procedures and Procedure Code/MS-DRG Index of the Version 34 ICD-10 MS-DRG Definitions Manual:

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

    CMS also finalizes its proposal for the ICD-10 MS-DRG assignment for these four ICD-10-PCS codes to replicate the ICD-9-CM based MS-DRG assignment for procedure code 37.79 (Revision or relocation of cardiac device pocket); that is, the following MS-DRGS:

    - MS-DRGs 040, 041, 042, (Peripheral, Cranial Nerve and Other Nervous System Procedures with MCC, with CC or peripheral neurostimulator, and without CC/MCC, respectively);
    - MS-DRGs 260, 261, 262, (Cardiac Pacemaker Revision Except Device Replacement with MCC, with CC, and without CC/MCC, respectively);
    - MS-DRGs 579, 580, 581, (Other Skin, Subcutaneous Tissue and Breast Procedures with MCC, with CC and without CC/MCC, respectively);
    - MS-DRGs 907, 908, 909, (Other O.R. Procedures for Injuries with MCC, with CC, and without CC/MCC, respectively); and
    - MS-DRGs 957, 958, and 959, 957, 958, and 959 (Other O.R. Procedures for Multiple Significant Trauma with MCC, with CC, and without CC/MCC, respectively).

  - *Endovascular Thrombectomy of the Lower Limbs.* CMS finalizes the proposed restructuring the ICD-10-PCS MS-DRG configuration for 20 procedures describing endovascular thrombectomy of the lower limbs and assigns them to ICD-10 MS-DRGs 270, 271 and 272 (Other Major Cardiovascular Procedures with MCC, with CC, and without CC/MCC, respectively). The specific ICD-10-

PCS codes involved are listed in the Table on page 191 of the display copy of the final rule. The restructuring is consistent with the MS-DRG assignments for the other procedures describing lower extremity thrombectomy, and accurately replicates the logic of the ICD-9-CM MS-DRGs Version 32.

- *Pacemaker Procedures Code Combinations.* CMS finalizes is proposal to modify the MS-DRG logic to establish that cases reporting one ICD-10-PCS code describing procedures involving pacemaker devices and one ICD-10-PCS code describing procedures involving pacemaker leads would be assigned to MS-DRGs 242, 243, and 244 (Permanent Cardiac Pacemaker Implant with MCC, with CC and without CC/MCC).

  CMS also revises the MS-DRG logic for MS-DRGs 258 and 259 (Cardiac Pacemaker Device Replacement with and without MCC, respectively). Under this approach, if one of the procedure codes involving pacemaker device insertions is reported, and there are no other procedure codes involving the insertion of a pacemaker lead, the case will be assigned to MS-DRG 258 and 259.

  CMS is modifying the logic for MS-DRGs 260, 261 and 262 (Cardiac Pacemaker Revisions Except Device with MCC, with CC, and without CC/MCC, respectively) so that cases reporting any one of the ICD-10-PCS codes involving pacemaker devices and related procedures and associated devices listed in the tables on pages 205-208 of the display copy of the final rule will be assigned to MS-DRGs 260, 261 and 262. CMS also corrects some of the code title errors in the table published in the proposed rule.

Transcatheter Mitral Valve Repair with Implant. CMS finalizes its proposal to collapse MS-DRGs 228, 229 and 230 (Other Cardiothoracic Procedures with MCC, with CC, and without CC/MCC, respectively) from three severity levels to two severity levels by deleting MS-DRG 230 and revising MS-DRG 229. CMS will also reassign cases reporting ICD-10-PCS procedure code 02UG3JZ (Supplement mitral valve with synthetic substitute, percutaneous approach) from MS-DRGs 273 and 274 (Percutaneous Intracardiac Procedures with and without MCC, respectively) to MS-DRG 228 and revised MS-DRG 229. The title of MS-DRG 229 will be modified to reflect the “without MCC” designation. CMS also will remove ICD-10-PCS procedure code 02UG3JZ from the PTCA list in MS-DRGs 231 and 232 (Coronary Bypass with PTCA with MCC and without MCC, respectively).

- **Major Diagnostic Category (MDC) 6 (Diseases and Disorders of the Digestive System): Excision of Ileum.** CMS finalizes its proposal to reassign ICD-10-PCS codes 0DBB0ZZ (Excision of ileum, open approach) and 0DBA0ZZ (Excision of jejunum, open approach) from MS-DRGs 347, 348 and 349 (Anal and Stomal Procedures with MCC, with CC, and without CC/MCC, respectively) to MS-DRGs 329, 330 and 331 (Major Small and Large Bowel Procedures with MCC, with CC and without CC/MCC, respectively) to correct a replication error.

- **Major Diagnostic Category (MDC) 7 (Diseases and Disorders of the Hepatobiliary System and Pancreas): Bypass Procedures of the Veins.** CMS finalizes its proposal to assign ICD-10-PCS procedure code 06183DY (Bypass portal vein to lower vein with intraluminal device, percutaneous approach) to MS-DRGs 405, 406 and 407 (Pancreas Liver and Shunt Procedures with MCC, with CC, and without CC/MCC, respectively) to correct a replication error. Currently, ICD-10-PCS procedure code 06183DY is assigned to MS-DRGs 270, 271 and 272 (Other Major Cardiovascular Procedures with MCC, with CC and without CC/MCC, respectively).

- **Major Diagnostic Category MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue).**

    - *Combination Codes for Removal and Replacement of Knee Joints.* CMS finalizes its proposal to move 58 ICD-10-PCS codes so that joint revision cases involving the removal of a spacer and subsequent insertion of a new knee joint prosthesis are assigned to MS-DRGs 466, 467 and 468 (Revision of Hip or Knee Replacement with MCC, with CC and without CC/MCC, respectively) so that the same logic is used in the ICD-10 version of the MS-DRGs as is used in the ICD-9-CM version. However, CMS rejects several requests for the update to be made retroactive to FY 2016 because this was a replication error of the ICD-9-CM MS-DRGs.

    - *Decompression Laminectomy.* CMS does not finalize its proposal to reassign the 18 ICD-10-PCS procedure codes describing a decompression laminectomy coded to “release” of a specified area of the spinal cord from MS-DRGs 515 through 517 (Other Musculoskeletal System and Connective Tissue O.R. Procedures with MCC, with CC and without CC/MCC, respectively) to MS-DRGs 028 through 030 (Spinal Procedures with MCC, with CC or Spinal Neurostimulators, or without CC/MCC, respectively) and MS-DRGs 518 through 520 (Back and Neck Procedures Except Spinal Fusion with MCC or Disc Device or Neurostimulator, with CC or without CC/MCC, respectively). CMS will wait until ICD-10-PCS data are available for analysis. CMS will then have the opportunity to examine the detailed ICD-10-PCS codes and assess their impact on the proposed MS-DRGs.

    - *Lordosis.* CMS finalizes its proposal to address a replication issue involving four diagnosis codes related to lordosis in MS-DRGs 456, 457 and 458 (Spinal Fusion Except Cervical with Spinal Curvature or Malignancy or Infection or Extensive Fusions with MCC, with CC and without CC/MCC). These MS-DRGs contain specific logic that requires a principal diagnosis describing a spinal curvature, a malignancy, or infection or a secondary diagnosis that describes a spinal curvature disorder related to another condition. CMS is removing diagnosis codes M40.50 (Lordosis, unspecified, site unspecified); M40.55 (Lordosis, unspecified, thoracolumbar region); M40.56 (Lordosis, unspecified, lumbar region); and M40.57 (Lordosis, unspecified, lumbosacral region) from the secondary diagnosis list for MS

DRGs 456, 457, and 458. These four codes are retained in the logic for the principal diagnosis list.

- **Major Diagnostic Category (MDC) 13 (Diseases and Disorders of the Female Reproductive System): Pelvic Evisceration.** ICD-10-PCS requires a code cluster consisting of seven codes to fully satisfy the equivalent meaning of the ICD-9-CM code for pelvic evisceration. Pelvic evisceration (or exenteration) is a procedure performed to treat gynecologic cancers (cervical, uterine, vulvar and vaginal, among others) and involves resection of pelvic structures.

  CMS finalized its proposal to remove the ICD-10-PCS procedure code cluster for pelvic evisceration procedures from MDC 6 (Diseases and Disorders of the Digestive System) under the ICD-10 MS-DRGs Version 34. The cluster will remain in ICD-10 MDC 13 under MS-DRGs 734 and 735 (Pelvic Evisceration, Radical Hysterectomy and Radical Vulvectomy with CC/MCC and without CC/MCC, respectively) only.

- **Major Diagnostic Category (MDC) 19 (Mental Diseases and Disorders): Organic Disturbances and Mental Retardation.** CMS finalizes its proposal to change the title of MS-DRG 884 (Organic Disturbances and Mental Retardation) to “Organic Disturbances and Intellectual Disability” to reflect more recent terminology.

- **Major Diagnostic Category (MDC) 23 (Factors Influencing Health Status and Other Contacts with Health Services): Rehabilitation with and without CC/MCC, Respectively.** 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). The logic does not replicate the ICD-9-CM MS-DRGs because of changes in the ICD-10-CM codes and the corresponding guidelines for admissions/encounters for rehabilitation. CMS acknowledges that ICD-10-CM does not have clear diagnosis codes that indicate the reason for the encounter was for rehabilitation services. For that reason, CMS had to modify the MS-DRG logic using ICD-10-PCS procedure codes to assign these cases to MS-DRGs 945 and 946. In order to replicate the ICD-9-CM MS-DRG logic, 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.

  CMS received comments offering several different options to replicate the ICD-9-CM MS-DRG logic. The suggestions varied from the creation of a guideline that limits the use of the ICD-10-PCS rehabilitation codes to rehabilitation admissions, to the creation of a unique ICD-10-CM diagnosis code that would replicate the ICD-9-CM

diagnosis code for encounters for rehabilitation. CMS finalizes its proposal to maintain the current structure of MS-DRGs 945 and 946 and reconsider the issue when ICD-10 claims data become available prior to proposing any updates. The AHA has submitted a request 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 to replicate the ICD-9-CM code category V57, Care involving use of rehabilitation procedures.

Medicare Code Editor (MCE) Changes. After implementation of the ICD-10 MCE Version 33, CMS received several requests to examine specific code edit lists that the requestors believed were incorrect and that affected claims processing functions.

- **Age Conflict Edit.** Currently, in the MCE, there are four age diagnosis categories that appear under the Age conflict edit and are listed in the manual and written in the software program.

  Newborn Diagnosis Category. CMS finalized its proposal to remove all the ICD-10-CM diagnoses in the code range of P00 through P96 from the newborn diagnosis category in the Age conflict code edit list for the ICD-10 MCE for FY 2017. CMS also will revise the description of the newborn diagnosis category under the ICD-10 MCE from "Newborn. Age of 0 years; a subset of diagnoses intended only for newborns and neonates (e.g., fetal distress, perinatal jaundice)" to "Perinatal/ Newborn. Age 0 years only; a subset of diagnoses which will only occur during the perinatal or newborn period of age 0 (e.g., tetanus neonatorum, health examination for newborn under 8 days old)" in the ICD-10 MCE.

  - *Pediatric Diagnosis Category.* Under the ICD-10 MCE Version 33, the pediatric diagnosis category for the Age conflict edit considers the age range of 0 to 17 years inclusive. CMS finalized its proposal to remove the following pediatric age conflict edits:

    - *Behavioral and Emotional Disorders with Onset Usually Occurring in Childhood and Adolescence.* Twelve diagnosis codes within the F90-F98 code range removed because the edit conflicts with guidance in the ICD-10-CM classification that indicates that these codes may be used regardless of the age of the patient.
    - *Pediatric Body Mass Index (BMI)*. Four diagnosis codes (Z68.51, Z68.52, Z68.53 and Z68.54) removed describing the BMI for pediatric patients because there is an age discrepancy between the MCE age conflict edits (ages 0 through 17) and the ICD-10-CM guidance for the codes (ages 2 through 20).
    - *ICD-10-CM Subcategory R62.5 (Lack of expected normal physiological development in childhood and adults)*. Codes R62.50, R62.52 and R62.59 removed because the codes are appropriate to report for adult patients as the diagnoses can carry over into adulthood.

- *ICD-10-CM code Y93.6A (Activity, physical games generally associated with school recess, summer camp and children).* ICD-10-CM external cause code Y93.6A removed from the edit code list because the code is applicable for adults as well as children.

- **Sex Conflict Edit.** This edit detects inconsistencies between a patient's sex and any diagnosis or procedure on the patient's record. CMS finalizes its proposal to remove the following diagnosis codes from the "Diagnosis for females only" list because they are appropriate to report for male patients should not be restricted to females only:

  - Z79.890 Hormone replacement therapy (postmenopausal). The term "postmenopausal" is a nonessential modifier and there does not need to be a diagnostic statement that the patient is postmenopausal to assign the code.
  - Three ICD-10-CM diagnosis codes (Z44.30. Z44.31, and Z44.32) for encounters for fitting and adjustment of external breast prosthesis.
  - Three ICD-10-CM diagnosis codes (Z45.811, Z45.812, and Z45.819) for encounters for adjustment or removal of breast implant.

- **Non-covered Procedure Edit.** In the MCE, the Non-covered Procedure edit identifies procedures for which Medicare does not provide payment due to specific criteria established in the National Coverage Determination (NCD) process. CMS finalizes its proposal to remove four codes for removal of clot from intracranial artery from the Non-covered Procedure edit code list to address replication issues. CMS notes that it has instructed the Medicare Administrative Contractors (MACs) to reprocess any affected claims retroactively and noted that contractors began reprocessing affected claims at providers' request in March 2016. CMS recommends that providers who have experienced claims processing issues work with their local MACs to resolve any outstanding claims. Instructions with updated changes to the NCD for Intracranial Percutaneous Angioplasty with Stenting, were issued on June 3, 2016 as a One-Time Notification, Pub. No. 100-20, Transmittal 1672, Change Request 9631, effective October 1, 2016.

  In addition, CMS finalizes its proposal to create a new ICD-10 MCE Version 34 Non-covered Procedure edit to reflect that procedures performed on males involving the unilateral or bilateral vas deferens and procedures performed on females involving the fallopian tubes are not covered procedures for sterilization purposes. The procedure codes would be identified as non-covered procedures **only** when ICD-10-CM diagnosis code Z30.2 (Encounter for sterilization) is listed as the principal diagnosis or secondary diagnosis. The new edit will address issues when the edit is triggered for removal of the vas deferens being performed as part of a radical prostatectomy for reasons other than sterilization.

- **Unacceptable Principal Diagnosis Edit.** In the MCE, there are select codes that describe a circumstance which influences an individual's health status but does not actually describe a current illness or injury. There also are codes that are not specific

manifestations but may be due to an underlying cause. These codes are considered unacceptable as a principal diagnosis.

For FY 2017, CMS finalizes its proposal to remove the following ICD-10-CM diagnosis codes from the Unacceptable Principal Diagnosis edit:

- Three ICD-10-CM codes (Z38.1, Z38.4 and Z38.7) for liveborn infants born outside the hospital.
- Fifty-six ICD-10-CM diagnosis codes (Category O30) that describe multiple gestation and contain information pertaining to the placenta. The codes are listed in Table 6P.1.c. of the final rule.

CMS does not finalize its proposal to remove 52 ICD-10-CM diagnosis codes (Category O09) related to high-risk pregnancy listed on Table 6P.1.d. of the proposed rule. The ICD-10-CM Guidelines have been updated for FY 2017 to explain the appropriate reporting of Category O09 codes. The ICD-10-CM diagnosis codes listed in Table 6P.1d. will continue to be subject to the Unacceptable Principal Diagnosis edit.

Other MCE Issues. CMS finalizes its proposal to make the following additional changes to the MCE: Change the edit description for "Procedure inconsistent with length of stay" with regard to ICD-10-PCS procedure code 5A1955Z (Respiratory ventilation, greater than 96 consecutive hours). The edit description is changed from "The following procedure code should only be coded on claims with a length of stay greater than four days" to "The following procedure code should only be coded on claims when the respiratory ventilation is provided for greater than four **consecutive** days during the length of stay." The modification is intended to further clarify the appropriate circumstances in which code 5A1955Z may be reported. CMS is also revising the title of MS-DRG 208 by adding an "equal" sign (=) after the "less than" (<) sign to better reflect the GROUPER logic. The finalized title for MS-DRG 208 is Respiratory System Diagnosis with Ventilator Support < = 96 Hours.

- Add three ICD-10-CM diagnosis codes (C58, D39.2, and F53) that describe conditions related to pregnancy or the puerperium to the Age Conflict edit code list for maternity diagnoses.
- Add 22 ICD-10-CM codes at Subcategory M02,8 (Other reactive arthropathies), to the "Manifestation codes not allowed as principal diagnosis" edit code list.
- Remove five ICD-10-CM codes (T81.81XA, T88.4XXA, T88.7XXA, T88.8XXA, and T88.9XXA) listed under the Questionable Admission edit.
- Remove from the MCE Version 33 manual file two discontinued edits (open biopsy check and the bilateral procedure) that are no longer valid.

Surgical Hierarchies. The surgical hierarchy is a decision rule within the GROUPER that orders surgical classes from most resource intensive to least resource intensive. This rule is used to assign a single DRG when an inpatient stay entails multiple surgical procedures, each one of which, occurring by itself, could result in assignment of the case to a different DRG within the MDC to which the principal diagnosis is assigned. Application of this hierarchy ensures that cases involving multiple surgical procedures are assigned to the DRG associated with the most resource intensive surgical class.

CMS finalizes its proposal to maintain the existing surgical hierarchy in MDC 5 (Diseases and Disorders of the Circulatory System) for revised MS-DRGs 228 and 229 (Other Cardiothoracic Procedures with MCC and without MCC, respectively).

Changes to the MS-DRG Diagnosis Codes for FY 2017. CMS finalizes the proposed additions and deletions to the Major Complications or Comorbidities (MCC) and Complications or Comorbidities (CC) severity levels list. The complete MCC and CC list, as well as the finalized additions and deletions to the MCC and CC list and other MCC/CC list changes for FY 2017 are available on the CMS website.

CC Exclusion List. For FY 2017, CMS finalized changes to the CC Exclusion List. The changes are available via the Internet on the CMS website.

Changes to the ICD-10-CM and ICD-10-PCS Coding System. For FY 2017, new and deleted diagnosis and procedure codes are available via the Internet on the CMS website.

Of note is that there are 1,974 new diagnosis codes and 3,827 new procedure codes due to the lifting of the 5-year partial code set freeze in preparation for the implementation of ICD-10. The tables include codes that were discussed at the March 2016 ICD-10 Coordination and Maintenance Committee meeting but were not finalized in time to include in the proposed rule.

Reassignment of Procedures among MS-DRGs 981 through 983, 984 through 986, and 987 through 989. Each year, CMS reviews cases assigned to MS-DRGs 981, 982 and 983 (Extensive O.R. Procedure Unrelated to Principal Diagnosis with MCC, with CC and without CC/MCC, respectively); MS-DRGs 984, 985 and 986 (Prostatic O.R. Procedure Unrelated to Principal Diagnosis with MCC, with CC and without CC/MCC, respectively); and MS-DRGs 987, 988,and 989 (Nonextensive O.R. Procedure Unrelated to Principal Diagnosis with MCC, with CC, and without CC/MCC, respectively) to determine whether it would be appropriate to change the procedures assigned among these MS-DRGs. MS-DRGs 981 through 983, 984 through 986, and 987 through 989 are reserved for those cases in which none of the O.R. procedures performed are related to the principal diagnosis. These MS-DRGs are intended to capture atypical cases that is, those cases not occurring with sufficient frequency to represent a distinct, recognizable clinical group.

CMS finalizes its proposal to add multiple codes to MDCs for FY 2017 to address replication issues for the following procedures:

- Angioplasty of extracranial vessel—Add 41 procedure codes to ICD-10 MS-DRGs 037, 038, and 039 (Extracranial Procedures with MCC, with CC, or without CC/MCC, respectively) under MDC 1)
- Excision of abdominal arteries—Add 34 procedure codes describing aneurysmectomy procedures with the open and percutaneous endoscopic approach to the following MS-DRGS:

- MDC 6 (Diseases and Disorders of the Digestive System): MS-DRGs 356 through 358 (Other Digestive System O.R. Procedures with MCC, with CC and without CC/MCC, respectively);
- MDC 11 (Diseases and Disorders of the Kidney and Urinary Tract): MS-DRGs 673 through 675 (Other Kidney and Urinary Tract Procedures with MCC, with CC and without CC/MCC, respectively);
- MDC 21 (Injuries, Poisonings and Toxic Effects of Drugs): MS-DRGs 907 through 909 (Other O.R. Procedures for Injuries with MCC, with CC, and without CC/MCC, respectively); and
- MDC 24 (Multiple Significant Trauma): MS-DRG 957 through 959 (Other O.R. Procedures for Multiple Significant Trauma with MCC, with CC and without CC/MCC, respectively).

- Excision of retroperitoneal tissue—Add three procedure codes to MDC 6 in MS-DRGs 356 through 358 (Other Digestive System O.R. Procedures with MCC, with CC, and without CC/MCC, respectively)
- Occlusion of vessels: esophageal varices—Add two procedure codes to MDC 7 under MS-DRGs 423 through 425 (Other Hepatobiliary or Pancreas O.R. procedures with MCC, with CC, and without CC/MCC, respectively)
- Excision of vulva—Add one procedure code to MDC 13 under MS-DRG 746 (Vagina, cervix and vulva procedures with CC/MCC) and MS-DRG 747 (Vagina, Cervix and Vulva procedures without CC/MCC)
- Lymph node biopsy—Add three procedure codes to MDC 4 under MS-DRGs 166 through 168 (Other Respiratory System O.R. Procedures with MCC, with CC, and without CC/MCC, respectively)
- Obstetrical laceration repair—Add 11 procedure codes to MS-DRG 774 (Vaginal Delivery with Complicating Diagnoses)

Other Policy Changes. CMS finalized additional changes to the MS-DRG GROUPER logic to address replication issues for several different procedures. Listed below are the procedures, the corresponding number of ICD-10-PCS that were inadvertently omitted, as well as the finalized changes.

Table 7: Procedures Inadvertently Omitted and Finalized MS-DRG Changes

Procedure	Number of Procedure Codes Affected	MS-DRG Changes
Operations on Products of Conception	208	Add to MDC 14 in MS-DRG 768
Other Heart Revascularization	16	Add to MDC 5 in MS-DRG 228 and MS-DRG 229
Procedures on Vascular Bodies: Chemoreceptors	234	Add to MDC 5 in MS-DRGs 252, 253 and 254

Repair of the Intestine	4	Add to MDC 6 in MS-DRGs 329, 330 and 331
Insertion of Infusion Pump	16	Designate as O.R. procedure (MS-DRG Definitions Manual Appendix E)
Procedures on the Bursa	6	Add to MDC 8 in MS-DRGs 500, 501 and 502
Procedures on the Breast	2	Remove from MS-DRG 981, 982 and 983 and designate them as non-operating room (non-O.R.) procedures
Excision of Subcutaneous Tissue and Fascia	19	Add to MDC 9 in MS-DRGs 579, 580 and 581.
Shoulder Replacement	2	Add to MDC 8 in MS-DRGs 492, 493 and 494
Reposition of Vertebra	4	Add to MDC 8 in MS-DRGs 515, 516 and 517
Bladder Neck Repair	5	Add to MDC 11 in MS-DRGs 653, 654 and 655 and MDC 13 in MS-DRGs 749 and 750.

CMS does not finalize its proposal to add 49 Insertion of Infusion Device codes to MDC 8 in MS-DRGs 515, 516 and 517. In view of the different types of pumps used for short-term and long-term treatment purposes and the different interpretations of the infusion device codes, CMS will continue to analyze if further revisions to these codes are needed in ICD-10-PCS to ensure accurate assignment under the ICD-10-MS-DRGs. CMS also notes that it will continue to work with the AHA through the *Coding Clinic for ICD-10-CM and ICD-10-PCS* to promote proper coding.

Issues Relating to MS-DRG 999 (Ungroupable). CMS discovered that cases where a patient has been readmitted to the hospital after a delivery and ICD-10-CM diagnosis code O90.2 (Hematoma of obstetric wound) is reported as the principal diagnosis are resulting in assignment to MS-DRG 999 (Ungroupable). To resolve this replication issue, CMS finalizes its proposal to add ICD-10-CM diagnosis code O90.2 to MDC 14 under MS-DRGs 769 (Postpartum and Post Abortion Diagnoses with O.R. Procedure) or MS-DRG 776 (Postpartum and Post Abortion Diagnoses without O.R. Procedure).

Other Operating Room (O.R.) and Non-O.R. Issues. As noted above, CMS has continued to address the MS-DRG replication issues between ICD-9-CM logic and ICD-10. As a result, it has identified areas where additional refinements could further support replication efforts.

- **O.R. Procedures to Non-O.R. Procedures.** CMS evaluated specific groups of ICD-10-PCS procedure codes with respect to their current O.R. designation that were determined to be inconsistent with the ICD-9-CM procedure codes from which the designation was initially derived. CMS finalizes its proposal to change the status of

the ICD-10-PCS codes for the categories of procedures listed below from being O.R. procedures to non-O.R. procedures. For each group summarized below, the detailed code lists are shown in Tables 6P.4a. through 6P.4k. (FY 2017 ICD-10-CM and ICD-10-PCS Codes for MCE and MS-DRG Changes) are available on the CMS website.

Table 8: Procedures Changed from O.R. Procedure to Non-O.R. Procedure

Procedure	Number of ICD-10-PCS Procedure Codes Affected
Endoscopic/Transorifice Insertion (includes insertion of infusion and monitoring devices)	72
Endoscopic/Transorifice Removal (includes removal of common devices such as drainage device, infusion device, intraluminal device or monitoring device)	155
Tracheostomy Device Removal	5
Endoscopic/Percutaneous Insertion (includes insertion of infusion and monitoring devices into vascular and musculoskeletal areas)	117
Percutaneous Removal (includes removal of drainage, infusion and monitoring devices from vascular and musculoskeletal areas)	124
Percutaneous Drainage (includes percutaneous therapeutic drainage of all body sites, with the exception of cranial, intracranial and eye)	519
Percutaneous Inspection (percutaneous inspection of different areas of the body, with the exception of cranial cavity and brain)	131
Inspection without Incision (includes inspection of various body sites with endoscopic/transorifice and external approaches	40
Dilation of Stomach	6
Endoscopic/Percutaneous Occlusion (Includes percutaneous occlusion of esophageal vein with and without a device)	6
Infusion Device (includes insertion of infusion device into various parts of the body)	82

- **Non-O.R. Procedures to O.R. procedures.** CMS finalizes its proposal to change the status of four ICD-10-PCS codes for Percutaneous Endoscopic Drainage of Pleural Cavity With or Without a Drainage Device and 18 ICD-10-PCS codes for Endoscopic/Percutaneous Drainage of Intracranial Sites With or Without a Drainage Device from being non-O.R. procedures to O.R. procedures to address replication issues.

New Technology Payments

The inpatient PPS provides additional payments for cases with relatively high costs involving eligible new medical services or technologies. New technology add-on payments are not subject to budget neutrality and, therefore, do not reduce payments for all other inpatient services. To gain approval for such payments, a technology must be considered new, be inadequately paid otherwise and represent a substantial clinical improvement over previously available technologies. The cost threshold for new technologies to qualify for add-on payments is the lesser of either 75 percent of the standardized amount (increased to reflect the difference between costs and charges) or 75 percent of one standard deviation above mean charges for the MS-DRG involved For a full discussion of the status of technologies approved for add-on payments in FY 2017, please see the discussion beginning on page 481 of the display version of the final rule.

Rural Referral Centers (RRC)

If a hospital wants to become a RRC, but does not have 275 or more beds, it must meet two mandatory criteria – a minimum case-mix index and a minimum number of discharges – and one of three additional criteria relating to specialty composition of medical staff, source of inpatients or referral volume. CMS updates the alternative criteria for RRC designation in FY 2017 to include:

- A case-mix index that is at least equal to either the median case-mix index for urban hospitals in its Census region (excluding hospitals with approved teaching programs) or the median case-mix index for urban hospitals nationally (1.6125), whichever is lower; or
- At least 5,000 discharges per year (at least 3,000 for osteopathic hospitals) or, if fewer, the median number of discharges for urban hospitals in its Census region.

The median case-mix index values and number of discharges can be found on pp. 747-748 of the display copy of the final rule.

RCH Demonstration Program

The Medicare Modernization Act of 2003 required CMS to conduct a demonstration program in rural areas under which up to 15 qualifying hospitals with fewer than 51 beds receive cost-based reimbursement (rather than PPS payment) for inpatient acute-care and swing-bed services for a five-year period. Hospitals located in rural areas in 10 states with low-population densities were eligible, but they could not be CAHs. The ACA extended the demonstration for five additional years. It also increased the maximum number of participating hospitals from 15 to 30 and expanded the eligible sites from rural areas in 10 states to those in 20 states with low-population densities. For hospitals that were in the original demonstration, their payment amounts were rebased. CMS implements this program in a budget-neutral manner, as required by law.

Given that this program will end on Dec. 31, 2016, CMS does not finalize an offset to inpatient PPS payments to all hospitals for FY 2017 to account for the additional spending by participating hospitals. The agency indicates that it calculate the costs of

the demonstration and resulting budget-neutrality adjustment factor for FY 2017 once the finalized cost reports for cost-reporting periods beginning in FY 2016 become available.

Hospitals and Hospital Units Excluded from the Inpatient PPS

Only cancer hospitals, children's hospitals and religious, non-medical health care institutions remain subject to the historical limits set by the Tax Equity and Fiscal Responsibility Act of 1982, with payments based on reasonable costs subject to rate-of-increase limits. CMS finalizes a 2.7 percent increase in the rate-of-increase limits for FY 2017, which is based on the inpatient PPS operating market basket, excluding the ACA-mandated market-basket cuts (which do not apply to these hospitals).

Inpatient Psychiatric Facility (IPF) Quality Reporting Program (IPFQR)

CMS finalized several measure changes for the IPFQR, and modified how the agency specifies the timeframes for public display of data and related IPF preview periods.

Measure Changes. CMS finalizes a technical change to the Screening for Metabolic Disorders measure in order to promote consistency with other measures included in the global sampling methodology. Specifically, CMS altered the "length of stay" denominator exclusion for the measure. Currently, patients with a length of stay equal to or greater than 365 days or less than three days are excluded. In the final rule, CMS excludes patients with a length of stay equal to or greater than 365 days, or less than *or equal to* three days. Note that CMS has delayed implementation of this measure until Jan. 1, 2017 (for the FY 2019 payment determination and beyond).

CMS finalizes two new measures for the FY 2019 payment determination and beyond:

- *SUB-3: Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge* and the subset measure *SUB-3a: Alcohol & Other Drug Use Disorder Treatment at Discharge* (NQF #1664). The measure calculates an overall rate for hospitalized patients 18 years of age and older to whom alcohol or drug use disorder treatment was provided, or offered and refused, at discharge. CMS believes that adding SUB-3 and SUB-3a to the IPFQR measure set would encourage IPFs to offer and provide medication or a referral for addiction treatment to patients with co-occurring drug or alcohol use disorders at discharge.

- *Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an IPF*. This measure estimates the incidence of all-cause, unplanned, 30-day readmissions to IPFs or acute care hospitals for adult Medicare fee-for-service patients with a principal discharge diagnosis of a psychiatric disorder or dementia. NQF is currently reviewing a version of this measure for endorsement that is not adjusted for sociodemographic factors. AHA is concerned that this measure fails to take several important factors into account, such as patients' access to post-hospital care.

Public Display and Review Requirements. IPFQR program data is available to the public. Under current policy, CMS displays the data in April of each calendar year following the start of the respective payment determination year. However, CMS finalized a policy to make the data available as soon as feasible, on at least a yearly basis. As a consequence, CMS will:

- No longer specify the preview period or publication dates in rulemaking;
- Announce exact timeframes through a sub-regulatory process; and
- Maintain its policy that IPFs will have a 30-day preview period.

For the FY 2017 payment determination, CMS may display the data in December 2016 if it is technically feasible to do so. If so, CMS anticipates providing IPFs with their data in mid-September.

PPS-Exempt Cancer Hospital (PCH) Quality Reporting (PCHQR) Program

The ACA mandated a quality reporting program for PCHs, beginning in FY 2014. CMS proposes to adopt specific criteria for measure retention and removal for the PCHQR. CMS also proposes one new measure for the FY 2019 PCHQR program, and to publicly report several additional PCHQR measures. CMS proposes no other substantive changes to the program.

PCHQR Measure Removal and Retention Criteria. CMS adopts measure removal and retention criteria that are very similar to those used in the IQR program. Specifically, CMS will use the following criteria in considering whether a measure should be removed from the PCHQR:

- Measure performance among PCHs is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made ("topped-out" measures);
- A measure does not align with current clinical guidelines or practice;
- The availability of a more broadly applicable measure (across settings or populations) or the availability of a measure that is more proximal in time to desired patient outcomes for the particular topic;
- Performance or improvement on a measure does not result in better patient outcomes;
- The availability of a measure that is more strongly associated with desired patient outcomes for the particular topic;
- Collection or public reporting of a measure leads to negative unintended consequences other than patient harm; and
- It is not feasible to implement the measure specifications.

In addition, CMS finalizes criteria it will consider in deciding to retain PCHQR measures:

- The measure aligns with CMS and HHS goals;
- The measure aligns with other CMS programs, including other quality reporting programs; and

- The measure supports efforts to move PCHs towards reporting electronic measures.

New Measure for FY 2019. CMS adopts a measure that assesses the percentage of PCH patients receiving outpatient chemotherapy who have had either an admission to an inpatient hospital or a visit to the ED for a number of cancer-related complications (e.g., pain, nausea, neutropenic fever, dehydration, etc.) within 30 days of an outpatient chemotherapy treatment encounter. CMS will calculate the measure using Medicare claims data.

Public Reporting. The ACA requires that measures from the PCHQR program be publicly reported. CMS finalizes its proposal to report publicly one additional PCHQR measure during 2017 – external beam radiotherapy for bone metastases. CMS also will postpone the public reporting of CAUTI and CLABSI that was schedule for 2017, and intends to work with the CDC to identify an appropriate timeframe for public reporting.

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 for hospitals to assess the impact of these policies on their organizations.** They are available at:

- 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 note: AHA is still awaiting updated and final FY 2017 public use files (PUF) from CMS; hence these calculators still reflect the proposed rule parameters and will be updated once the final PUFs are released.

The AHA also encourages hospitals to verify CMS's table listing the factor used to calculate uncompensated care payments in FY 2017 for DSH hospitals. Hospitals have until Aug. 31 to review this table and notify CMS in writing of any inaccuracies.

Determine whether your hospital will submit revisions to your Worksheet S-10 for FY 2014. The deadline for such revisions is Sept. 30.

In addition, hospitals should verify whether they have attested to meaningful use. Attestation status can be determined through CMS's EHR Incentive Program registration and attestation website.

FURTHER QUESTIONS

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

Appendix A: Hospital Value-Based Purchasing (VBP) Program Measures and Domains, FYs 2018 – 2022

Measure	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
Domain: Safety					
Central-Line Associated Bloodstream Infection (CLABSI)	X	X	X	X	X
PSI 90: Complication/patient safety for selected indicators (composite)	X	X	X	X	X
Surgical Site Infection (SSI)	X	X	X	X	X
Catheter-Associated Urinary Tract Infection (CAUTI)	X	X	X	X	X
Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia	X	X	X	X	X
Clostridium Difficile (C Difficile)	X	X	X	X	X
PC-01: Elective Delivery Prior to 39 Completed Weeks Gestation	X	X	X	X	X
Domain: Clinical Care					
Acute myocardial infarction (AMI) 30-day mortality rate	X	X	X	X	X
Heart failure (HF) 30-day mortality rate	X	X	X	X	X
Pneumonia (PN) 30-day mortality rate	X	X	X	X	X
Hospital-Level Risk Standardized Complication Rate following Elective Primary Total Hip Arthroplasty and Total Knee Arthroplasty (THA/TKA)		X	X	X	X
Chronic obstructive pulmonary disease (COPD) 30-day mortality rate				X	X
Coronary artery bypass graft (CABG) 30-day mortality rate					X^F
Domain: Patient and Caregiver Centered Experience of Care / Care Coordination**					
HCAHPS survey	X	X	X	X	X
Three-item Care Transition Measure (CTM-3)	X	X	X	X	X
Domain: Efficiency and Cost Reduction					
Medicare spending per beneficiary (MSPB)	X	X	X	X	X
AMI payment per episode of care					X^F
HF payment per episode of care					X^F

X^F**=** *Finalized in the FY 2017 inpatient PPS final rule*
*** = CMS will change the name of this domain to "Person and Community Engagement" starting with the FY 2019 VBP program year*

Appendix B: Inpatient Quality Reporting (IQR) Program Measures for FYs 2016 through 2019

Key:

F	Finalized in the FY 2017 inpatient PPS final rule
X[eCQM]	Chart-abstracted IQR measure, but has an eCQM version available for hospitals to use in the IQR voluntary electronic data reporting option (through FY 2017), or the mandatory IQR eCQM reporting (FY 2018 onward)
eCQM only	Measure is available **only** as an eCQM. Can be used in the IQR voluntary electronic data reporting option (through FY 2017), or the mandatory IQR eCQM reporting (FY 2018 onward)

Measure	FY 2016	FY 2017	FY 2018	FY 2019
Acute Myocardial Infarction (AMI) Measures				
AMI-2 Aspirin prescribed at discharge		eCQM only	eCQM only	Removal[F]
AMI-7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival	X	X[eCQM]	eCQM only	Removal[F]
AMI-8a Timing of receipt of primary percutaneous coronary intervention (PCI)	X	eCQM only	eCQM only	eCQM only
AMI-10 Statin prescribed at discharge		eCQM only	eCQM only	Removal[F]
Heart Failure (HF) Measures				
HF-2 Evaluation of left ventricular systolic function	X			
Stroke (STK) Measures				
STK-1 VTE prophylaxis	X	X		
STK-2 Antithrombotic therapy for ischemic stroke	X[eCQM]	eCQM only	eCQM only	eCQM only
STK-3 Anticoagulation therapy for Afib/flutter	X[eCQM]	eCQM only	eCQM only	eCQM only
STK-4 Thrombolytic therapy for acute ischemic stroke	X[eCQM]	X[eCQM]	eCQM only	Removal[F]
STK-5 Antithrombotic therapy by the end of hospital day 2	X[eCQM]	eCQM only	eCQM only	eCQM only
STK-6 Discharged on Statin	X[eCQM]	X[eCQM]	eCQM only	eCQM only
STK-8 Stroke education	X[eCQM]	X[eCQM]	eCQM only	eCQM only

Measure	FY 2016	FY 2017	FY 2018	FY 2019
STK-10 Assessed for rehabilitation services	X[eCQM]	eCQM only	eCQM only	eCQM only
Venous Thromboembolism (VTE) Measures				
VTE-1 VTE prophylaxis	X[eCQM]	X[eCQM]	eCQM only	eCQM only
VTE-2 ICU VTE prophylaxis	X[eCQM]	X[eCQM]	eCQM only	eCQM only
VTE-3 VTE patients with anticoagulation overlap therapy	X[eCQM]	X[eCQM]	eCQM only	Removal[F]
VTE-4 VTE patients receiving un-fractionated Heparin with doses/labs monitored by protocol	X[eCQM]	eCQM only	eCQM only	Removal[F]
VTE-5 VTE discharge instructions	X[eCQM]	X[eCQM]	X[eCQM]	Removal[F]
VTE-6 Incidence of potentially preventable VTE	X[eCQM]	X[eCQM]	X[eCQM]	Removal as eCQM[F], retained as chart-abstracted measure
Pneumonia (PN) Measures				
PN-6 Appropriate initial antibiotic selection	X	eCQM only	eCQM only	eCQM only
Surgical Care Improvement Project (SCIP) Measures				
SCIP INF-1 Prophylactic antibiotic received within 1 hour prior to surgical incision	X	eCQM only	eCQM only	Removal[F]
SCIP-INF-2: Prophylactic antibiotic selection for surgical patients	X	eCQM only	eCQM only	Removal[F]
SCIP-INF 3 Prophylactic antibiotics discontinued within 24 hours after surgery end time (48 hours for cardiac surgery)	X			
SCIP-INF-4: Cardiac surgery patients with controlled 6AM postoperative serum glucose	X	X		
SCIP–INF-9: Postoperative urinary catheter removal on postoperative day 1 or 2 with day of surgery being day zero	X	eCQM only	eCQM only	Removal[F]
SCIP-Cardiovascular-2: Surgery patients on a beta blocker prior to arrival who received a beta blocker during the perioperative period	X			

Measure	FY 2016	FY 2017	FY 2018	FY 2019
SCIP-VTE-2: Surgery patients who received appropriate VTE prophylaxis within 24 hours pre/ post surgery	X			
Mortality Measures				
AMI 30-day mortality rate	X	X	X	X
Heart Failure 30-day mortality rate	X	X	X	X
Pneumonia 30-day mortality rate	X	X	X	X
Chronic Obstructive Pulmonary Disease 30-day mortality rate	X	X	X	X
Acute Ischemic Stroke 30-day mortality	X	X	X	X
CABG surgery 30-day mortality		X	X	X
HCAHPS Patients' Experience of Care Measures				
HCAHPS survey	X	X	X	X
Readmission and Excess Acute Care Day Measures				
Acute myocardial infarction (AMI) 30-day risk standardized readmission	X	X	X	X
Heart failure (HF) 30-day risk standardized readmission	X	X	X	X
Pneumonia (PN) 30-day risk standardized readmission	X	X	X	X
Total Hip/Total Knee Arthroplasty (THA/TKA) 30-day risk standardized readmission	X	X	X	X
Hospital-wide all cause unplanned readmission	X	X	X	X
Chronic obstructive pulmonary disease (COPD) 30-day risk standardized readmission	X	X	X	X
Acute ischemic stroke 30-Day risk standardized readmission	X	X	X	X
Coronary artery bypass graft (CABG) 30-day risk standardized readmission		X	X	X
Excess days in acute care after hospitalization for AMI			X	X
Excess days in acute care after hospitalization for HF			X	X
Excess days in acute care after hospitalization for PN				X[F]

Measure	FY 2016	FY 2017	FY 2018	FY 2019
AHRQ Patient Safety Indicators (PSIs), Inpatient Quality Indicators (IQIs) and Composite Measures				
PSI 90: Complication/patient safety for selected indicators (composite)	X	X	X	X
PSI 04 Death among surgical inpatients with serious, treatable complications	X	X	X	X
Structural Measures				
Participation in a systematic database for cardiac surgery	X			
Participation in a systematic clinical database registry for nursing sensitive care	X	X	X	Removal[F]
Participation in a systematic clinical database registry for general surgery	X	X	X	Removal[F]
Safe surgery checklist use	X	X	X	X
Hospital survey on patient safety culture			X	X
Healthcare-Associated Infection Measures				
Central-line associated bloodstream infection (CLABSI)	X	X	X	X
Surgical site infection	X	X	X	X
Catheter-associated urinary tract infection (CAUTI)	X	X	X	X
Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia	X	X	X	X
Clostridium Difficile (C Difficile)	X	X	X	X
Healthcare personnel influenza vaccination	X	X	X	X
Surgical Complications				
Hospital-Level risk standardized complication rate (RSCR) following elective primary total hip and/or total knee arthroplasty	X	X	X	X
Emergency Department (ED) Throughput Measures				
ED-1 Median time from ED arrival to departure from the emergency room for patients admitted to the hospital	X[eCQM]	X[eCQM]	X[eCQM]	X[eCQM]
ED-2 – Median time from admit decision to time of departure from	X[eCQM]	X[eCQM]	X[eCQM]	X[eCQM]

Measure	FY 2016	FY 2017	FY 2018	FY 2019
the ED for ED patients admitted to the inpatient status				
Prevention				
Global influenza immunization	X	X	X	X
Global pneumonia immunization	Suspended	Suspended		
Cost Efficiency				
Medicare spending per beneficiary	X	X	X	X
Acute Myocardial Infarction (AMI) payment per episode of care	X	X	X	X
Pneumonia (PN) payment per episode of care		X	X	X
Heart Failure (HF) payment per episode of care		X	X	X
Hospital level risk-standardized payment associated with an episode of care for Primary Elective THA / TKA			X	X
Kidney / urinary tract infection clinical episode-based payment measure				X
Cellulitis clinical episode-based payment measure				X
Gastrointestinal hemorrhage clinical episode-based payment measure				X
Aortic aneurysm clinical episode-based payment measure				X[F]
Cholecystectomy and common duct exploration clinical episode-based payment measure				X[F]
Spinal fusion clinical episode-based payment measure				X[F]
Perinatal Care				
PC-01: Elective delivery < 39 completed weeks gestation	X[eCQM]	X[eCQM]	X[eCQM]	X[eCQM]
PC-05: Exclusive Breast Milk Feeding and the subset measure PC-05a: Exclusive Breast Milk Feeding Considering Mother's Choice		eCQM only	eCQM only	eCQM only
Children's asthma care- Home Management Plan of Care (HMPC) document given to patient/ caregiver		eCQM only	eCQM only	eCQM only

Measure	FY 2016	FY 2017	FY 2018	FY 2019
Healthy term newborn		eCQM only	eCQM only	Removal[F]
Hearing screening prior to hospital discharge		eCQM only	eCQM only	eCQM only
Sepsis				
Severe sepsis and septic shock: Management bundle		X	X	X