Issue Brief

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Key Points

- CMS projects a payment increase of $3.1 billion or 2.9 percent (1.7 percent marketbasket and an additional 1.2 percent for uncompensated care payments)
- Changes to the LTCH quality reporting program
- Proposed changes to the Medicare code editor
- Revisions to quality reporting requirements
- Changes to instructions for the review of critical access hospital 96-hour certification requirements

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MISSOURI HOSPITAL ASSOCIATION

CMS Releases Proposed FY 2018 Medicare IPPS and LTCH Update

The Centers for Medicare and Medicaid Services has released a proposed rule to update both the Hospital Inpatient Prospective Payment System and the Long-Term Care Hospital Prospective Payment System for fiscal year 2018.

The rule is some 1,832 pages and the rule doesn't include tables that are available on CMS' website.

The document is currently on public display at the *Federal Register* office and is scheduled for publication April 28. A copy is available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-07800.pdf. This link will, of course, change upon publication.

The IPPS tables are at: http://www.cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html. Click on the link on the left side of the screen titled, "FY 2018 IPPS Proposed Rule Home Page" or "Acute Inpatient—Files for Download." The LTCH PPS tables are available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/index.html under the list item for Regulation Number CMS-1677-P.

COMMENT

Once again, CMS outdoes itself. The sheer size of this rule is unbelievable. Last year's proposed rule was "only" 1,579 pages. This year's proposal is 16 percent longer.

Something is very wrong that CMS finds it so necessary to repeat so much history which clouds the issues at hand from being more easily identified, digested and understood. The table of contents is more than 40 pages, and CMS still has not adapted to the concept of page numbering. If you find an item in the table of contents, there is no page number to easily find it. One must scroll through the entire document looking for the item.

It appears that CMS simply continues to add new material to old rules. It's time for CMS to simply start again and throw old versions of their updates away. A new clean approach is needed or in a few years, proposed rules may exceed 3,000 pages. No doubt, this year's final will approach, if not exceed, 3,000 pages.

CMS is reversing itself. Last year, CMS said it was backing off plans to begin using hospital S-10 data for purposes of the disproportionate share hospital adjustment, and delaying these efforts from FY 2018 to FY 2021. CMS now says it will adopt S-10 data beginning in FY 2018.

CMS says the changes it is making will increase Medicare payments by $3.1 billion in FY 2018. However, one needs to look deeper to assess payment changes.

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The following material is from CMS' fact sheet which is based on material in the rule's executive summary concerning major provisions.

COMMENT

The fact sheet provides a short summary of changes being proposed, but it leaves many important changes to the reader to find and sort through.

To assist those with a particular subject interest page numbers corresponding to the material in the display copy are provided. Note: these numbers will change upon the rule's publication in the Federal Register. It is highly recommended that you download the display version before it is removed on April 28th. Also, there are instances in which a particular item can be discussed in more than one area. Not all such area page listings are identified.

For many payment issues, the rule's Addendum (beginning on page 1,530) contains much concise and helpful information.

PROPOSED CHANGES TO PAYMENT RATES UNDER IPPS

The proposed increase in operating payment rates for general acute care hospitals paid under the IPPS that successfully participate in the Hospital Inpatient Quality Reporting Program and are meaningful electronic health record users is approximately 1.6 percent.

This reflects (1) a projected hospital market basket update of 2.9 percent adjusted by a -0.4 percentage point required for productivity; (2) a -0.6 percent adjustment to remove the one-time adjustment of 0.6 percent made in FY 2017 for the FYs 2014–2016 effect of the adjustment to offset the estimated costs of the two midnight policy, (3) a proposed +0.4588 percentage point adjustment restoring the $11 billion reduction for documentation and coding, required by the statute, as recently amended by the 21st Century Cures Act (Cures Act), and (6) a -0.75 percentage point adjustment to the update required by the Affordable Care Act.

CMS projects that the rate increase, together with other proposed changes to IPPS payment policies, will increase IPPS operating payments by approximately 1.7 percent, and that proposed changes in uncompensated care payments will increase IPPS operating payments by an additional 1.2 percent for a total increase in IPPS operating payments of 2.9 percent.

Other additional payment adjustments will include continued penalties for excess readmissions, a continued 1.0 percent penalty for hospitals in the worst performing quartile under the Hospital Acquired Condition Reduction Program, and continued upward and downward adjustments under the Hospital Value-Based Purchasing Program.

In sum, CMS projects that total Medicare spending on inpatient hospital services, including capital, will increase by about $3.1 billion in FY 2018.

MEDICARE UNCOMPENSATED CARE PAYMENTS (PAGE 604)

CMS is proposing to distribute roughly $7.0 billion in uncompensated care payments in FY 2018, an increase of approximately $1.0 billion from the FY 2017 amount. This change reflects CMS' proposal to incorporate data from its National Health Expenditure Accounts into estimate the percent change in the rate of uninsurance, which is used in calculating the total amount of uncompensated care payments available to be distributed.

For FY 2018, CMS proposes to begin incorporating uncompensated care cost data from Worksheet S-10 of the Medicare cost report in the methodology for distributing these funds. Specifically,

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for FY 2018, CMS proposes to use Worksheet S-10 data from FY 2014 cost reports in combination with insured low income days data from the two preceding cost reporting periods to determine the distribution of uncompensated care payments.

HOSPITAL READMISSIONS REDUCTION PROGRAM (PAGE 673)

The HRRP requires a reduction to a hospital's base operating DRG payment to account for excess readmissions associated with selected applicable conditions. CMS is proposing to implement changes to the payment adjustment factor in accordance with the Cures Act. CMS is proposing to assess penalties based on a hospital's performance relative to other hospitals with a similar proportion of patients who are dually eligible for Medicare and full-benefit Medicaid. Specifically, CMS is proposing the following:

- A methodology for calculating the proportion of dual-eligible patients;
- A methodology for assigning hospitals to peer groups; and
- A payment adjustment formula calculation methodology.

In addition, CMS is proposing to specify the applicable time period and the methodology for the calculation of aggregate payments for excess readmissions for FY 2018 and to update the program's Extraordinary Circumstance Exception policy.

HOSPITAL VALUE-BASED PURCHASING PROGRAM (PAGE 717)

The Hospital VBP Program adjusts payments to hospitals for inpatient services based on their performance on an announced set of measures. CMS is proposing to implement updates to the Hospital VBP Program, including the removal of one measure and adoption of two measures. Specifically, the rule proposes to:

- Remove the current 8-indicator Patient Safety for Selected Indicators (PSI 90) measure from the Safety domain beginning with the FY 2019 program year;
- Adopt the 10-indicator modified Patient Safety and Adverse Events Composite PSI 90 measure beginning in the FY 2023 program year;
- Adopt the Hospital-Level, Risk-Standardized Payment Associated with a 30-day Episode of Care for Pneumonia measure for the Efficiency and Cost Reduction domain beginning with the FY 2022 program year; and
- Revise the Efficiency and Cost Reduction domain weighting beginning with the FY 2021 program year to reflect the implementation of condition-specific payment measures in the Hospital VBP Program.

Furthermore, CMS is inviting public comment on accounting for social risk factors in the Hospital VBP Program.

HOSPITAL-ACQUIRED CONDITIONS REDUCTION PROGRAM (PAGE 780)

CMS is proposing to make five changes to existing HAC Reduction Program policies:

- Specify the dates of the time period used to calculate hospital performance for the FY 2020 HAC Reduction Program;
- Request comments on additional measures for potential future adoption;
- Request comments on accounting for social risk factors;
- Request comments on accounting for disability and medical complexity in the CDC NHSN measures in Domain 2; and

continued

- Update the Extraordinary Circumstance Exception policy.

LONG-TERM CARE HOSPITAL (LTCH) PROSPECTIVE PAYMENT SYSTEM CHANGES (PAGE 872)

CMS is proposing to update the LTCH PPS standard Federal payment rate by 1.0 percent, consistent with the provisions of the Medicare Access and CHIP Reauthorization Act of 2015. This is the payment rate applicable to LTCH patients that meet certain clinical criteria under the dual rate LTCH PPS payment system required by the Pathway for SGR Reform Act of 2013. Overall, based on the changes included in this proposed rule, CMS projects that LTCH PPS payments would decrease by approximately 3.75 percent, or $173 million in FY 2018, which is due in large part to the continued phase in of the dual payment rate system.

In addition, CMS is evaluating if its 25-percent threshold policy is still needed. For FY 2018, CMS is proposing a regulatory moratorium on the implementation of the 25-percent threshold policy for FY 2018 while it conducts the evaluation. CMS is also proposing to revise its short-stay outlier payment adjustment and implementing various provisions of the Cures Act that affect LTCHs.

NOTICE REGARDING CHANGES TO INSTRUCTIONS FOR THE REVIEW OF THE CRITICAL ACCESS HOSPITAL 96-HOUR CERTIFICATION REQUIREMENT (PAGE 868)

For inpatient CAH services to be payable under Medicare Part A, the statute requires that a physician certify that the individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH. Based on feedback from stakeholders CMS has reviewed the CAH 96-hour certification requirement to determine if there are ways to reduce its burden on providers. CMS is providing notice that it will direct Quality Improvement Organizations, Medicare Administrative Contractors, the Supplemental Medical Review Contractor, and Recovery Audit Contractors to make the CAH 96-hour certification requirement a low priority for medical record reviews conducted on or after October 1, 2017. This means that absent concerns of probable fraud, waste or abuse of the coverage requirement, these contractors will not conduct medical record reviews.

HOSPITAL INPATIENT QUALITY REPORTING PROGRAM (PAGE 972)

The Hospital IQR Program is a quality reporting program established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. In the FY 2018 IPPS/LTCH PPS proposed rule, CMS is proposing to refine two previously adopted measures as follows:

- Re-wording the current pain management questions in the Hospital Consumer Assessment of Healthcare Providers and Systems survey to focus on the hospital's communications with patients about the patients' pain during the hospital stay beginning with surveys in January 2018; and
- Changing the risk adjustment methodology used in the Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate following Acute Ischemic Stroke Hospitalization (Stroke 30-Day Mortality Rate) measure to include stroke severity codes (based on the NIH Stroke Scale), beginning with the FY 2023 payment determination.

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CMS is also proposing voluntary reporting of one new measure, the Hybrid Hospital-Wide Readmission Measure with Claims and Electronic Health Record Data, for the CY 2018 reporting period.

Furthermore, CMS is inviting public comment on potential new quality measures for future inclusion in the Hospital IQR Program, accounting for social risk factors in the Hospital IQR Program, and providing confidential feedback reports to hospitals with measure rates for certain measures stratified by patients' dual eligibility status.

PROPOSED CHANGES TO CLINICAL QUALITY MEASURES (PAGE 1,039)

CMS is proposing the following changes:

For Calendar Year 2017;

- Reporting period: For eligible hospitals and CAHs demonstrating meaningful use for the first time in 2017 or that have demonstrated meaningful use in any year prior to 2017, the reporting period would be two self-selected quarters of CQM data in CY 2017.
- CQMs: If an eligible hospital or CAH is only participating in the EHR Incentive Program, or is participating in both the EHR Incentive Program and the Hospital IQR Program, the eligible hospital or CAH would report on at least six (self-selected) of the available CQMs.

For CY 2018;

- Reporting period: For eligible hospitals and CAHs reporting CQMs electronically that demonstrate meaningful use for the first time in 2018 or that have demonstrated meaningful use in any year prior to 2018, the reporting period would be the first 3 quarters of CY 2018. For the Medicare EHR Incentive Program only, the submission period for reporting CQMs electronically would be the 2 months following the close of the calendar year, ending February 28, 2019.
- CQMs: For eligible hospitals and CAHs participating only in the EHR Incentive Program, or is participating in both the EHR Incentive Program and the Hospital IQR Program, the eligible hospital or CAH would report on at least 6 (self-selected) of the available CQMs.

Additionally, for the Eligible Professionals in the EHR Incentive Program, CMS is proposing the following changes:

- Reporting Periods: For 2017, CMS is proposing to modify the CQM reporting period for EPs electronically reporting CQMs under the Medicaid EHR Incentive Program to a minimum of a continuous 90-day period during the calendar year.
- CQMs: Align the specific CQMs available to EPs participating in the Medicaid EHR Incentive Program with those available to professionals participating in the Merit-based Incentive Payment System.

In addition, CMS is proposing a number of changes in relation to the reporting of electronic clinical quality measures as follows:

- Modifying the previously finalized eCQM reporting requirements for the CY 2017 reporting period/FY 2019 payment determination, such that hospitals would be required to select and submit six of the available eCQMs included in the Hospital IQR Program measure set and provide two, self-selected, calendar year quarters of data, in alignment with the electronic reporting requirements for CQMs in the Medicare EHR Incentive Program for hospitals;

continued

- Modifying the previously finalized eCQM reporting requirements for the CY 2018 reporting period/FY 2020 payment determination, such that hospitals would be required to select and submit six of the available eCQMs, and provide data for the first three calendar quarters (Q1-Q3) of CY 2018, in alignment with the electronic reporting requirements for CQMs in the Medicare EHR Incentive Program for hospitals;
- Making changes to several related technical eCQM submission requirements beginning with the FY 2019 payment determination, including which Edition of certified EHR technology hospitals should use for eCQM reporting, in alignment with the Medicare EHR Incentive Program for hospitals;
- Modifying the previously finalized validation process for eCQM data to reduce the number of cases required to be submitted and to include additional exclusion criteria beginning with the FY 2020 payment determination and subsequent years; and
- Continuing the medical record submission requirements for validation of eCQM data that were finalized in the FY 2017 IPPS/LTCH PPS final rule for the FY 2021 payment determination and subsequent years.

PPS-EXEMPT CANCER HOSPITAL QUALITY REPORTING PROGRAM (PAGE 1,149)

The PCHQR Program collects and publishes data on an announced set of quality measures. CMS is proposing to collect four new measures, remove three previously-adopted measures, and implement revisions to the PCHQR Extraordinary Circumstances Exceptions Policy.

Specifically, CMS is proposing to add four measures that assess end-of-life care:

- Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (NQF #0210);
- Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life (NQF #0213);
- Proportion of Patients Who Died from Cancer Not Admitted to Hospice (NQF #0215); and
- Proportion of Patients Who Died from Cancer Admitted to Hospice for Less than Three Days (NQF #0216).

CMS is proposing to remove three cancer-specific, chart-abstracted process measures:

- Adjuvant Chemotherapy is Considered or Administered Within four Months (120 Days) of Diagnosis to Patients Under the Age of 80 with AJCC III (Lymph Node Positive) Colon Cancer (NQF #0223);
- Combination Chemotherapy is Considered or Administered Within four Months (120 Days) of Diagnosis for Women Under 70 with AJCC T1c, or Stage II or III Hormone Receptor Negative Breast Cancer (NQF #0559); and
- Adjuvant Hormonal Therapy (NQF #0220).

LONG TERM CARE HOSPITAL QUALITY REPORTING PROGRAM (PAGE 1,188)

Under the LTCH QRP, the applicable annual update to the LTCH PPS standard Federal payment rate for discharges applicable to an LTCH is reduced by two percentage points if the LTCH does not submit to CMS data on specified quality measures. Beginning with the FY 2020 program year, LTCHs must also report standardized patient assessment data

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related to five specified patient assessment categories.

CMS is proposing to replace the current pressure ulcer measure with an updated version of that measure, as well as adopt two new companion measures (one process and one outcome) related to ventilator weaning, beginning with the FY 2020 LTCH QRP. These proposed measures are:

- Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury
- Compliance with Spontaneous Breathing Trial by Day 2 of the LTCH Stay
- Ventilator Liberation Rate

Further, CMS is proposing to remove two currently adopted measures Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) and All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from LTCHs. CMS is also proposing to begin publicly reporting new measures to display on the LTCH Compare website by fall 2018 and two new measures to display on the LTCH Compare website by fall 2020.

In addition, CMS is also proposing that, beginning with the FY 2020 program year, LTCHs begin reporting standardized patient assessment data, and that beginning with the FY 2020 program year, LTCHs begin reporting additional standardized patient assessment data with respect to five specified patient assessment categories required by law, including:

1. functional status;
2. cognitive function;
3. special services, treatments and interventions;
4. medical conditions and co-morbidities; and
5. impairments.

INPATIENT PSYCHIATRIC FACILITY QUALITY REPORTING QUALITY REPORTING PROGRAM (PAGE 1,324)

CMS is proposing one additional measure for the program. Specifically, beginning with FY 2020 payment determination, and continuing for subsequent years, CMS is proposing to add one measure, Medication Continuation following Inpatient Psychiatric Discharge, which is calculated from claims data. Second, CMS is proposing to update the IPFQR Program's extraordinary circumstances exception policy to align with other programs' ECE provisions. Third, CMS is proposing to change how the annual data submission period is specified in order to align the end of this period with the deadline for submitting a Notice of Participation or withdrawing from the program. Finally, CMS is proposing factors by which it would evaluate measures to be removed from or retained in the IPFQR Program.

PROPOSED CHANGES FOR THE MEDICARE AND MEDICAID EHR INCENTIVE PROGRAMS (PAGE 1,364)

For 2018, CMS is proposing to modify the EHR reporting periods for new and returning participants attesting to CMS or their state Medicaid agency from the full year to a minimum of any continuous 90-day period during the calendar year.

As mandated by the Cures Act, CMS is proposing to add a new exception from the Medicare payment adjustments for EPs, eligible hospitals, and CAHs that demonstrate through an application process that compliance with the requirement for being a meaningful EHR user is not possible because their certified EHR technology has been decertified under ONC's Health IT Certification Program.

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CMS is also proposing, as mandated by the Cures Act, to implement a policy to provide that no payment adjustments will be made for eligible professionals who furnish "substantially all" of their services in an ambulatory surgical center. In addition, CMS is proposing to exempt ambulatory surgical center ASC-based EPs from the 2017 and 2018 Medicare payment adjustments if they furnish substantially all of their covered professional services in an ASC CMS is requesting public comment on two proposed alternative definitions to determine the final definition:

- An EP who furnishes 75 percent or more of his or her covered professional services in sites of service identified by the codes used in the HIPAA standard transaction as an ASC setting in the calendar year that is two years before the payment adjustment year; and
- An EP who furnishes 90 percent or more of his or her covered professional services in sites of service identified by the codes used in the HIPAA standard transaction as an ASC setting in the calendar year that is two years before the payment adjustment year.

Additionally, CMS proposes to use Place of Service code 24 to identify services furnished in an ASC and requesting public comment on whether other POS codes or mechanisms should be used to identify sites of service in addition to or in lieu of POS code 24.

The material that follows is a section-by-section analysis of major components based on the proposed rule. The material does not follow the order in the regulation.

Please note that the printed pages of the pdf file are "5" less than the pdf count starting at page 1,523.

I. STANDARDIZED PAYMENT RATES (PAGES 1,530)

The following are the current FY 2017 standardized payment amounts. (Note: these rates were promulgated in the October 5, 2016 *Federal Register* as a correction to the amounts published in the August 22 *Federal Register.*)

Hospital Submitted Quality Data and is a Meaningful EHR User		Hospital Submitted Quality Data and is NOT a Meaningful EHR User		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User	
Wage Index Greater Than 1.0000							
Labor	**Nonlabor**	**Labor**	**Nonlabor**	**Labor**	**Nonlabor**	**Labor**	**Nonlabor**
$3,839.23	$1,676.91	$3,762.75	$1,643.50	$3,813.74	$1,665.77	$3,737.25	$1,632.37
Wage Index Equal to or Less Than 1.0000							
Labor	**Nonlabor**	**Labor**	**Nonlabor**	**Labor**	**Nonlabor**	**Labor**	**Nonlabor**
$3,420.01	$2,096.13	$3,351.88	$2,054.37	$3,397.30	$2,082.21	$3,329.16	$2,040.46

The total labor/nonlabor amount for the full update (2 left columns) is $5,516.14.

There are four possible applicable percentage increases that can be applied to the national standardized amount. The table below reflects these four options. (Page 1,534 and Page 567)

Proposed FY 2018	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
Proposed Market Basket Rate-of-Increase	2.9	2.9	2.9	2.9
Proposed Adjustment for Failure to Submit Quality Data under Section 1886(b)(3)(B)(viii) of the Act (1/4 of MB Update)	0.0	0.0	-0.725	-0.725
Proposed Adjustment for Failure to be a Meaningful EHR User under Section 1886(b)(3)(B)(ix) of the Act (3/4 of MB Update)	0.0	-2.175	0.0	-2.175
Proposed MFP Adjustment under Section 1886(b)(3)(B)(xi) of the Act	-0.4	-0.4	-0.4	-0.4
Statutory Adjustment under Section 1886(b)(3)(B)(xii) of the Act	-0.75	-0.75	-0.75	-0.75
Proposed Applicable Percentage Increase Applied to Standardized Amount	**1.75**	**-0.425**	**1.025**	**-1.15**

The labor-related portion for areas with wage indexes greater than 1.0000 is being proposed at 68.3 percent, a decrease from the current amount of 69.6 percent. Areas with wage index values equal to or less than 1.000 would remain at 62.0 percent, as required by statute.

The proposed FY 2018 standardized amounts for operating and capital costs appear in Tables 1A, 1B, and 1C that are listed and published in section VI of the Addendum to this rule. (see Page 1,667)

The following table (pages 1,574-1,575) illustrates the changes from the FY 2017 national standardized amount. The unadjusted FY 2017 total rates are $5,847.32 for all columns.

	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
FY 2018 Base Rate after removing: 1. FY 2017 Geographic Reclassification Budget Neutrality (0.988136) 2. FY 2017 Operating Outlier Offset (0.948998) 3. FY 2017 2-Midnight Rule One-Time Prospective Increase (1.006) 4. FY 2017 Labor Market Delineation Wage Index Transition Budget Neutrality Factor (0.999997)	If Wage Index is Greater Than 1.0000: Labor (68.3%): $3,993.72 Nonlabor (31.7%): $1,853.60 (Combined labor and nonlabor = $5,847.32) If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,625.34 Nonlabor (38%): $2,221.98 (Combined labor and nonlabor = $5,847.32)	If Wage Index is Greater Than 1.0000: Labor (68.3%): $3,993.72 Nonlabor (31.7%): $1,853.60 (Combined labor and nonlabor = $5,847.32) If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,625.34 Nonlabor (38%): $2,221.98 (Combined labor and nonlabor = $5,847.32)	If Wage Index is Greater Than 1.0000: Labor (68.3%): $3,993.72 Nonlabor (31.7%): $1,853.60 (Combined labor and nonlabor = $5,847.32) If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,625.34 Nonlabor (38%): $2,221.98 (Combined labor and nonlabor = $5,847.32)	If Wage Index is Greater Than 1.0000: Labor (68.3%): $3,993.72 Nonlabor (31.7%): $1,853.60 (Combined labor and nonlabor = $5,847.32) If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,625.34 Nonlabor (38%): $2,221.98 (Combined labor and nonlabor = $5,847.32)
Proposed FY 2018 Update Factor (refer table above)	1.01750	0.99575	1.01025	0.98950
Proposed FY 2018 MS-DRG Recalibration Budget Neutrality Factor	0.997573	0.997573	0.997573	0.997573
Proposed FY 2018 Wage Index Budget Neutrality Factor	1.000465	1.000465	1.000465	1.000465
Proposed FY 2018 Reclassification Budget Neutrality Factor	0.988522	0.988522	0.988522	0.988522
Proposed FY 2018 Operating Outlier Factor	0.948999	0.948999	0.948999	0.948999
Proposed Adjustment for FY 2018 Required under Section 414 of Pub. L. 114-10 (MACRA) and Section 15005 of Pub. L. 114-255	1.004588	1.004588	1.004588	1.004588

	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
Proposed National Standardized Amount for FY 2017 if Wage Index is Greater Than 1.0000; Labor/Non-Labor Share Percentage (68.3/31.7)	Labor: $3,822.07 Nonlabor: $1,773.93	Labor: $3,740.37 Nonlabor: $1,736.01	Labor: $3,794.84 Nonlabor: $1,761.29	Labor: $3,713.14 Nonlabor: $1,723.37
National Standardized Amount for FY 2017 if Wage Index is less Than or Equal to 1.0000; Labor/Non-Labor Share Percentage (62.0/38.0)	Labor: $3,469.52 Nonlabor: $2,126.48	Labor: $3,395.36 Nonlabor: $2,081.02	Labor: $3,444.80 Nonlabor: $2,111.33	Labor: $3,370.64 Nonlabor: $2,065.87

The combined proposed FY 2018 labor and nonlabor amounts for a full update is $5,596.00. The current amount is $5,516.14 for a net increase of $79.86.

These amounts are before other adjustments such as the hospital value-based purchasing program, readmission program, and hospital acquired conditions program.

COMMENT

CMS says that 82 hospitals are estimated to not receive the full market basket rate-of-increase for FY 2018 because they failed the quality data submission process or did not choose to participate, but are meaningful EHR users. CMS says that 103 hospitals are estimated to not receive the full market basket rate-of-increase for FY 2018 because they are identified as not meaningful EHR users. CMS says that 21 hospitals are estimated to not receive the full market basket rate-of-increase for FY 2018 because they are identified as both not meaningful EHR users and do not submit quality data.

PROPOSED CHANGES TO PAYMENT RATES FOR ACUTE CARE HOSPITAL INPATIENT CAPITAL-RELATED COSTS FOR FY 2018 (PAGE 1,604)

The proposed FY 2018 capital rate would be $451.37. The current amount is $446.79.

Comparison of Factors and Adjustments: FY 2017 Capital Federal Rate and Proposed FY 2018 Capital Federal Rate				
	FY 2016	FY 2017	Change	Percent Change
Update Factor[1]	1.009	1.0120	1.0120	1.20
GAF/DRG Adjustment Factor[1]	0.9990	0.9992	0.9992	-0.08
Outlier Adjustment Factor[2]	0.9386	0.9434	1.0051	0.51
Removal of One-Time 2-midnight Policy Adjustment Factor	1.0060	1/1.006	0.9940	-0.61
Capital Federal Rate	$446.79	$451.37	1.0103	1.03[3]

[1] The update factor and the GAF/DRG budget neutrality adjustment factors are built permanently into the capital Federal rates. Thus, for example, the proposed incremental change from FY 2017 to FY 2018 resulting from the application of the proposed 0.9992 GAF/DRG budget neutrality adjustment factor for FY 2018 is a proposed net change of 0.9992 (or -0.08 percent).

[2] The outlier reduction factor is not built permanently into the capital Federal rate; that is, the factor is not applied cumulatively in determining the capital Federal rate. Thus, for example, the proposed net change resulting from the application of the proposed FY 2018 outlier adjustment factor is 0.9434/0.9386 or 1.0051 (or 0.51 percent).

[3] Proposed percent change may not sum due to rounding.

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OUTLIER PAYMENTS (PAGE 1,563)

CMS is establishing a proposed outlier fixed-loss cost threshold for FY 2018 equal to the prospective payment rate for the MS-DRG, plus any IME, empirically justified Medicare DSH payments, estimated uncompensated care payment, and any add-on payments for new technology, plus $26,713.

The current amount is $23,573.

CMS says that its current estimate, using available FY 2016 claims data, is that actual outlier payments for FY 2016 were approximately 5.37 percent of actual total MS-DRG payments.

SOLE COMMUNITY HOSPITALS (PAGE 1,581)

The prospective payment rate for SCHs for FY 2018 equals the higher of the applicable Federal rate, or the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; the updated hospital-specific rate based on FY 1996 costs per discharge; or the updated hospital-specific rate based on FY 2006 costs per discharge.

Proposed Change to Volume Decrease Adjustment for Sole Community Hospitals and Medicare-Dependent, Small Rural Hospitals (§ 412.92) (page 575)

The MDH program is not authorized by statute beyond September 30, 2017. Therefore, beginning October 1, 2017, all hospitals that previously qualified for MDH status under section 1886(d)(5)(G) of the Act will no longer have MDH status and will be paid based on the IPPS Federal rate.

To qualify for a volume decrease adjustment, the SCH must: (a) submit documentation demonstrating the size of the decrease in discharges and the resulting effect on per discharge costs; and (b) show that the decrease is due to circumstances beyond the hospital's control. If an SCH demonstrates to the MAC's satisfaction that it has suffered a qualifying decrease in total inpatient discharges, the MAC determines the appropriate amount, if any, due to the SCH as an adjustment.

CMS is proposing to prospectively change how the MACs calculate the volume decrease adjustments and require that the MACs compare estimated Medicare revenue for fixed costs to the hospital's fixed costs to remove any conceivable possibility that a hospital that qualifies for the volume decrease adjustment could ever be less than fully compensated for fixed costs as a result of the application of the adjustment.

COMMENT

CMS says that there are 243 RRCs (see more below), 317 SCHs, and 129 hospitals that are both SCHs and RRCs. CMS identifies 96 MDHs will no longer receive the blended payment and will be paid only under the Federal rate in FY 2018, it is estimated that those hospitals would experience an overall decrease in payments of approximately $119 million.

PROPOSED CHANGES TO PAYMENT RATES FOR EXCLUDED HOSPITALS: RATE-OF-INCREASE PERCENTAGES FOR FY 2018 (PAGE 1,608)

Payments for services furnished in children's hospitals, 11 cancer hospitals, and hospitals located outside the 50 States, the District of Columbia and Puerto Rico (that is, short-term acute care hospitals located in the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa) that are excluded from the IPPS are made on the basis of reasonable costs based on the hospital's

continued

own historical cost experience, subject to a rate-of-increase ceiling.

The proposed rate of increase update for FY 2018 would be 2.9 percent.

As of March 2017, there were 98 children's hospitals, 11 cancer hospitals, 5 short-term acute care hospitals located in the Virgin Islands, Guam, the Northern Mariana Islands and American Samoa, and 18 RNHCIs being paid on a reasonable cost basis subject to the rate-of-increase ceiling under § 413.40.

II. CHANGES TO THE HOSPITAL WAGE INDEX FOR ACUTE CARE HOSPITALS (PAGE 435)

Core-Based Statistical Areas (Page 436)

The current statistical areas (which were implemented beginning with FY 2015) are based on revised OMB delineations issued on February 28, 2013, in OMB Bulletin No. 13-01.

For the purposes of cross-walking counties to CBSAs, CMS is proposing to discontinue the use of Social Security Administration codes and to begin using only Federal Information Processing Standard codes.

CMS notes that OMB has issued a revised bulletin – OMB Bulletin 15-01 that makes the following adjustments to CBSAs:

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

Worksheet S-3 Wage Data for the Proposed FY 2018 Wage Index (Page 440)

The proposed FY 2018 wage index values are based on the data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY 2014 (the FY 2017 wage indexes were based on data from cost reporting periods beginning during FY 2013).

Clarification of Other Wage Related Costs in the Wage Index (Page 446)

CMS is clarifying that, under current policy, an "other" wage-related cost (which CMS defines as the value of a benefit) must be a fringe benefit as described by the IRS (refer to IRS Publication 15-B) and must be reported to the IRS on employees' or contractors' W-2 or 1099 forms as taxable income in order to be considered a wage-related cost on Line 18 of Worksheet S-3 and for the wage index. That is, other wage-related costs that are not reported to the IRS on employees' or contractors' W-2 or 1099 forms as taxable income, even if not required to be reported to the IRS according to IRS requirements, will not be included in the wage index.

Proposed Occupational Mix Adjustment to the FY 2017 Wage Index (Page 455)

For the proposed FY 2018 wage index, CMS used the occupational mix data collected using the 2013 survey.

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Using the occupational mix survey data and applying the occupational mix adjustment to 100 percent of the proposed FY 2018 wage index results in a national average hourly wage of $41.9599.

The proposed FY 2018 national average hourly wages for each occupational mix nursing subcategory are as follows:

Occupational Mix Nursing Subcategory	Average Hourly Wage
National RN	$38.84760578
National LPN and Surgical Technician	$22.72715122
National Nurse Aide, Orderly, and Attendant	$15.94890269
National Medical Assistant	$17.97139786
National Nurse Category	$32.84544016

Use of the 2016 Medicare Wage Index Occupational Mix Survey for the FY 2019 Wage Index (Page 457)

A new measurement of occupational mix is required for FY 2019. The FY 2019 occupational mix adjustment will be based on a new calendar year 2016 survey. The CY 2016 survey (CMS Form CMS-10079) received OMB approval on September 27, 2016. The final CY 2016 Occupational Mix Survey Hospital Reporting Form is available on CMS' website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files-Items/2016-Occupational-Mix-Survey-Hospital-Reporting-Form-CMS-10079-for-the-Wage-Index-Beginning-FY-2019.html.

Hospitals are required to submit their completed 2016 surveys to their MACs by July 3, 2017. The preliminary, unaudited CY 2016 survey data will be posted on the CMS website in mid-July 2017. As with the Worksheet S–3, Parts II and III cost report wage data, as part of the FY 2019 desk review process, the MACs will revise or verify data elements in hospitals' occupational mix surveys that result in certain edit failures.

Proposed Application of the Rural, Imputed, and Frontier Floors

Rural Floor Section (Page 461)

The area wage index applicable to any hospital that is located in an urban area of a State may not be less than the area wage index applicable to hospitals located in rural areas in that State. CMS estimates that 366 hospitals will receive an increase in their proposed FY 2018 wage index due to the application of the rural floor.

Proposed Expiration of the Imputed Floor Policy (Page 461)

Currently, there are three all-urban States: Delaware, New Jersey, and Rhode Island. The imputed floor is set to expire effective October 1, 2017, and CMS is not proposing to extend the imputed floor policy.

Proposed State Frontier Floor (page 466)

Forty-eight hospitals would receive the frontier floor value of 1.0000 for their FY 2018 wage index. These hospitals are located in Montana, Nevada, North Dakota, South Dakota, and Wyoming.

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FY 2018 Reclassification Requirements and Approvals (Page 467)

At the time this proposed rule was constructed, CMS says the MGCRB had completed its review of FY 2018 reclassification requests. Based on such reviews, there are 375 hospitals approved for wage index reclassifications by the MGCRB starting in FY 2018. Because MGCRB wage index reclassifications are effective for 3 years, for FY 2018, hospitals reclassified beginning in FY 2016 or FY 2017 are eligible to continue to be reclassified to a particular labor market area based on such prior reclassifications for the remainder of their 3-year period. There were 257 hospitals approved for wage index reclassifications in FY 2016 that will continue for FY 2018, and 274 hospitals approved for wage index reclassifications in FY 2017 that will continue for FY 2018. Of all the hospitals approved for reclassification for FY 2016, FY 2017, and FY 2018, based upon the review at the time of this proposed rule, 906 hospitals are in a MGCRB reclassification status for FY 2018.

Applications for FY 2019 reclassifications are due to the MGCRB by September 1, 2017 (the first working day of September 2017). CMS notes that this is also the deadline for canceling a previous wage index reclassification, withdrawal, or termination under 42 CFR 412.273(d). Applications and other information about MGCRB reclassifications may be obtained, beginning in mid-July 2017, via the Internet on CMS' website: https://www.cms.gov/Regulations-and-Guidance/Review-Boards/MGCRB/index.html, or by calling the MGCRB at (410) 786-1174. The mailing address of the MGCRB is: 2520 Lord Baltimore Drive, Suite L, Baltimore, MD 21244-2670.

Proposed Deadline for Submittal of Documentation of Sole Community Hospital and Rural Referral Center Classification Status to the MGCRB (Page 474)

The regulations at 42 CFR 412.230(a)(3), consistent with section 1886(d)(10)(D)(i)(III) of the Act, set special rules for sole community hospitals and rural referral centers that are reclassifying under the MGCRB. Specifically, a hospital that is an RRC or an SCH, or both, does not have to demonstrate a close proximity to the area to which it seeks redesignation. If a hospital that is an RRC or an SCH, or both, qualifies for urban redesignation, it is redesignated to the urban area that is closest to the hospital. If the hospital is closer to another rural area than to any urban area, it may seek redesignation to either the closest rural or the closest urban area.

The MGCRB currently accepts supporting documentation of SCH and RRC classification (the CMS approval letter) up until the date of MGCRB's review, which varies annually. CMS is proposing to establish a deadline of the first business day after January 1 for hospitals to submit to the MGCRB documentation of SCH or RRC status approval (the CMS approval letter) in order to take advantage of the special rules under § 412.230(a)(3) when reclassifying under the MGCRB.

Clarification of Special Rules for SCHs and RRCs Reclassifying to Geographic Home Area (Page 481)

Hospitals may simultaneously be redesignated as rural under § 412.103 and reclassified under the MGCRB. An urban hospital seeking benefits of rural status, such as rural payments for disproportionate share hospitals and eligibility for the 340B Drug Pricing Program administered by HRSA, without the associated rural wage index may

continued

be redesignated as rural under § 412.103 (if it meets the applicable requirements) and also reclassify under the MGCRB to an urban area (again, if it meets the applicable requirements).

CMS is proposing to revise § 412.230(a)(3)(ii) to state that if a hospital that is approved as an RRC or an SCH, or both, qualifies for urban redesignation, it is redesignated to the urban area that is closest to the hospital or to the hospital's geographic home area. If the hospital is closer to another rural area than to any urban area, it may seek redesignation to either the closest rural or the closest urban area.

Redesignations under Section 1886(d)(8)(B) of the Act (Page 484)

Section 1886(d)(8)(B)(i) of the Act requires the Secretary to treat a hospital located in a rural county adjacent to one or more urban areas as being located in the urban metropolitan statistical area to which the greatest number of workers in the county commute if certain adjacency and commuting criteria are met.

Hospitals located in these counties are referred to as "Lugar" hospitals and the counties themselves are often referred to as "Lugar" counties. The chart with the listing of the rural counties containing the hospitals designated as urban under section 1886(d)(8)(B) of the Act is available on CMS' website.

An eligible hospital that waives its "Lugar" status in order to receive the out-migration adjustment has effectively waived its deemed urban status and, thus, is rural for all purposes under the IPPS effective for the fiscal year in which the hospital receives the out-migration adjustment.

CMS is proposing to revise this policy to require a Lugar hospital that qualifies for and accepts the out-migration adjustment, or that no longer wishes to accept the out-migration adjustment and instead elects to return to its deemed urban status, to notify CMS within 45 days from the date of public display of the proposed rule at the Office of the Federal Register.

Proposed Out-Migration Adjustment Based on Commuting Patterns of Hospital Employees (Page 487)

Table 2 associated with this proposed rule (which is available via the Internet on the CMS website) includes the proposed out-migration adjustments for the FY 2018 wage index. CMS notes that the out-migration wage adjustment is not budget neutral, and estimates the impact of these providers receiving the out-migration increase would be approximately $39 million.

Proposed Labor Market Share for the Proposed FY 2018 Wage Index (Page 508)

CMS is proposing to rebase and revise the IPPS market basket reflecting 2014 data. For all hospitals whose wage indexes are greater than 1.0000 CMS is proposing to use a labor-related share of 68.3 percent for discharges occurring on or after October 1, 2017.

COMMENT

CMS spends 50 pages discussing its rebasing and revisions to the hospital market basket. Bottom line, is they are proposing, as noted above, a labor share of 68.3 percent for areas with wage index values greater than 1.0000.

III. PROPOSED CHANGES TO MEDICARE SEVERITY DIAGNOSIS-RELATED GROUP CLASSIFICATIONS AND RELATIVE WEIGHTS (PAGES BEGINNING ON 103)

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Proposed FY 2018 MS-DRG Documentation and Coding Adjustment (Page 106)

With the end of payment reductions for documentation and coding beginning in FY 2018, CMS says it planned on making a full positive adjustment to return IPPS rates to their appropriate payment amounts.

CMS notes that section 414 of MACRA replaced the single positive adjustment the agency intended to make in 2018 with a 0.5 percent positive adjustment for each of FYs 2018 through 2023. Further, section 15005 of the Cures Act reduced the adjustment for FY 2018 from 0.5 percentage points to 0.4588 percentage points.

COMMENT

CMS is required by statute to reinstate the IPPS rates to the amounts that would be have been made had no reduction offsets been made. In other words, if CMS was paying hospitals $1,100 but reduced payment to recapture previous over payments to say $1,000 by $100, CMS needs to reset the amounts back to $1,100. It cannot go forward using the $1,000 rate.

As noted above, MACRA and the Cures Act are going to limit the return to "proper/normal" amounts. MACRA appears to never allow the full recapture. CMS has withheld 0.8 percent for 3 years (2.4 in aggregate) plus 1.5 percent for FY 2017 (2.4 + 1.5 =3.9). Yet, MACRA would only permit 3.0 percent (6 X 0.5) to be returned. And, this amount has now been reduced by the Cures Act to 2.9558 (5 x .05 + 0.4588).

It seems that the documentation and coding issue is a long way from being solved, if ever.

PROPOSED CHANGES TO THE MS-DRGS FOR FY 2018

The following items are some of the major MS-DRG proposed changes for FY 2018.

Functional Quadriplegia (Page 115)

CMS is proposing to reassign cases identified by diagnosis code R53.2 from MS-DRGs 052 and 053 to MS-DRGs 091, 092, and 093 for FY 2018.

Responsive Neurostimulator System (Page 120)

CMS is proposing to reassign all cases with a principal diagnosis of epilepsy and one of the following ICD-10-PCS code combinations capturing cases with the neurostimulator generators inserted into the skull (including cases involving the use of the RNS© neurostimulator), to MS-DRG 023, even if there is no MCC reported:

- 0NH00NZ (Insertion of neurostimulator generator into skull, open approach), in combination with 00H00MZ (Insertion of neurostimulator lead into brain, open approach);
- 0NH00NZ (Insertion of neurostimulator generator into skull, open approach), in combination with 00H03MZ (Insertion of neurostimulator lead into brain, percutaneous approach); and
- 0NH00NZ (Insertion of neurostimulator generator into skull, open approach), in combination with 00H04MZ (Insertion of neurostimulator lead into brain, percutaneous endoscopic approach).

CMS is also proposing to change the title of MS-DRG 023 from "Craniotomy with Major Device Implant or Acute Complex Central Nervous System Principal Diagnosis with MCC or Chemo Implant" to "Craniotomy with Major Device Implant or Acute Complex Central Nervous System Principal Diagnosis with MCC or Chemotherapy Implant or Epilepsy with Neurostimulator" to reflect the proposed modifications to MS-DRG assignments.

continued

Precerebral Occlusion or Transient Ischemic Attack with Thrombolytic (Page 132)

CMS is proposing to add ICD-10-CM diagnosis codes that are currently assigned to MS-DRGs 067 and 068 and the ICD-10-CM diagnosis codes currently assigned to MS-DRG 069 to the GROUPER logic for MS-DRGs 061, 062, and 063 when those conditions are sequenced as the principal diagnosis and reported with an ICD-10-PCS procedure code describing use of a thrombolytic agent (for example, tPA).

CMS also is proposing to retitle MS-DRGs 061, 062, and 063 as "Ischemic Stroke, Precerebral Occlusion or Transient Ischemia with Thrombolytic Agent with MCC, with CC and without CC/MCC", respectively, and to retitle MS-DRG 069 as "Transient Ischemia without Thrombolytic".

Swallowing Eye Drops (Tetrahydrozoline) (Page 138)

CMS is proposing to reassign the following ICD-10-CM diagnosis codes from MS-DRGs 124 and 125 to MS-DRGs 917 and 918 for FY 2018: T49.5X1A; T49.5X2A; T49.5X3A; and T49.5X4A.

Percutaneous Cardiovascular Procedures and Insertion of a Radioactive Element (Page 141)

CMS is proposing to remove ICD-10-PCS procedure codes 0WHC01Z, 0WHC31Z, 0WHC41Z, 0WHD01Z, 0WHD31Z, and 0WHD41Z from MS-DRGs 246 through 249, but maintain their current assignment in MS-DRG 264.

Proposed Modification of the Titles for MS-DRG 246 (Percutaneous Cardiovascular Procedures with Drug-Eluting Stent with MCC or 4+ Vessels or Stents) and MS-DRG 248 (Percutaneous Cardiovascular Procedures with Non-Drug-Eluting Stent with MCC or 4+ Vessels or Stents) (Page 144)

CMS is proposing to revise the titles for MS-DRGs 246 (Percutaneous Cardiovascular Procedures with Drug-Eluting Stent with MCC or 4+ Vessels or Stents) and MS-DRG 248 (Percutaneous Cardiovascular Procedures with Non-Drug-Eluting Stent with MCC or 4+ Vessels or Stents) to better reflect the ICD-10-PCS terminology of "arteries" versus "vessels" as used in the procedure code titles within the classification.

Specifically, CMS is proposing to revise the title of MS-DRG 246 to "Percutaneous Cardiovascular Procedures with Drug-Eluting Stent with MCC or 4+ Arteries or Stents". CMS is proposing to revise the title of MS-DRG 248 to "Percutaneous Cardiovascular Procedures with Non-Drug-Eluting Stent with MCC or 4+ Arteries or Stents".

Percutaneous Mitral Valve Replacement Procedures (Page 148)

CMS is proposing to reassign the four percutaneous mitral valve replacement procedures from MS-DRGs 216 through 221 to MS-DRGs 266 and 267. In addition, CMS is proposing to assign eight new procedure codes that describe percutaneous and transapical, percutaneous tricuspid valve replacement procedures to MS-DRGs 266 and 267.

Total Ankle Replacement (TAR) Procedures (Page 155)

CMS is proposing to reassign the following TAR procedure codes from MS-DRG 470 to MS-DRG 469, even if there is no MCC reported: 0SRF0J9; 0SRF0JA; 0SRF0JZ; 0SRG0J9; 0SRG0JA; and 0SRG0JZ for FY 2018.

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CMS is proposing to change the titles of MS-DRGs 469 and 470 to the following to reflect these proposed MS-DRG reassignments:

- Proposed retitle of MS-DRG 469: "Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity with MCC or Total Ankle Replacement"; and
- Proposed retitle of MS-DRG 470: "Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity without MCC."

Combined Anterior/Posterior Spinal Fusion (Page 166)

CMS is proposing to move 149 ICD-10-PCS procedure codes listed in Table 6P.3a. associated with this proposed rule (which is available via the Internet on CMS' website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html) from the posterior spinal fusion list to the anterior spinal fusion list in MS-DRGs 453, 454, and 455.

CMS is proposing to delete 33 procedure codes from MS-DRGs 453, 454, and 455 for FY 2018 (refer to the rule for a list of the 33 codes-page 169).

MS-DRG 782 (Other Antepartum Diagnoses without Medical Complications) (Page 177)

CMS is proposing to remove three codes – 009.41, 009.42, and 009.43 – describing supervision of pregnancy from MS-DRG 782 and reassign them to MS-DRG 998 (Principal Diagnosis Invalid as Discharge Diagnosis) to reflect a more appropriate MS-DRG assignment.

Shock During or Following Labor and Delivery (Page 178)

CMS is proposing the following:

- Removing ICD-10-CM diagnosis code O75.1 from the list of principal or secondary diagnosis under the first condition-vaginal delivery GROUPER logic in MSDRGs 774, 767, and 768;
- Moving ICD-10-CM diagnosis code O75.1 from the list of principal or secondary diagnosis under the second condition-complicating diagnosis for MS-DRG 774 to the secondary diagnosis list only; and
- Adding ICD-10-CM diagnosis code O75.1 to the principal diagnosis list GROUPER logic in MS-DRGs 769 and 776.

MDC 15 (Newborns and Other Neonates with Conditions Originating in Perinatal Period): Observation and Evaluation of Newborn (Page 181)

CMS is proposing to add 14 diagnosis codes (listed on page 181) describing observation and evaluation of newborns for suspected conditions to the GROUPER logic for MS-DRG 795.

Proposed Changes to the Medicare Code Editor (Page 197)

The Medicare Code Editor is a software program that detects and reports errors in the coding of Medicare claims data. Patient diagnoses, procedure(s), and demographic information are entered into the Medicare claims processing systems and are subjected to a series of automated screens. The MCE screens are designed to identify cases that require further review before classification into an MS-DRG.

COMMENT

CMS discusses a number of issues regarding the MCE and proposes several changes. Please refer to the rule for specifics.

Proposed Changes to Surgical Hierarchies (Page 220)

Some inpatient stays entail multiple surgical procedures, each one of which,

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occurring by itself, could result in assignment of the case to a different MS-DRG within the MDC to which the principal diagnosis is assigned. CMS notes that it is necessary to have a decision rule within the GROUPER by which these cases are assigned to a single MS-DRG. The surgical hierarchy, an ordering of surgical classes from most resource-intensive to least resource-intensive, performs that function.

CMS is proposing to move MS-DRGs 614 and 615 above MS-DRGs 622, 623, and 624 in the surgical hierarchy to enable more appropriate MS-DRG assignment for these types of cases.

Proposed Additions and Deletions to the Diagnosis Code Severity Levels for FY 2018 (Page 224)

CMS provides the following tables identifying proposed additions and deletions to the MCC severity levels list and proposed additions and deletions to the CC severity levels list for FY 2018. The tables are available via the Internet on CMS' website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html.

- Table 6I.1--Proposed Additions to the MCC List--FY 2018;
- Table 6I.2--Proposed Deletions to the MCC List--FY 2018;
- Table 6J.1--Proposed Additions to the CC List--FY 2018; and
- Table 6J.2--Proposed Deletions to the CC List--FY 2018.

COMMENT

There is much more regarding the MCC and CC list of items. Please refer to the rule for additional specifics.

Replaced Devices Offered without Cost or with a Credit (Page 244)

For FY 2018, CMS is not proposing to add any MS-DRGs to the policy for replaced devices offered without cost or with a credit.

Other Operating Room and Non-O.R. Issues (Page 247)

This section addresses the recommendations for consideration received in response to some of the proposals set forth in the FY 2017 IPPS/LTCH PPS proposed rule pertaining to changing the designation of ICD-10-PCS procedure codes from O.R. procedures to non-O.R. procedures.

CMS has identified more than 800 code changes in 45 categories. Many are reflected in the rule's tables 6P4a through 6P4p. These tables are on the CMS web.

Proposed Add-On Payments for New Services and Technologies for FY 2018 (Page 311)

FY 2018 Status of Technologies Approved for FY 2017 Add-On Payments are as follows:

Discontinued

- CardioMEMS™ HF (Heart Failure) Monitoring System
- Lutonix® Drug Coated Balloon PTA Catheter and In.PACT™ Admiral™ Paclitaxel Coated Percutaneous Transluminal (PTA) Balloon Catheter
- MAGEC® Spinal Bracing and Distraction System (MAGEC® Spine)
- Blinatumomab (BLINCYTO®)

Continued

- Defitelio® (Defibrotide). The maximum payment will remain at $75,900.
- GORE® EXCLUDER® Iliac Branch Endoprosthesis. The maximum payment will remain at $5,250.
- Praxbind® Idarucizumab. The

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maximum payment for a case involving Idarucizumab will remain at $1,750

- Vistogard™ (Uridine Triacetate). The maximum payment for a case involving the Vistogard™ will remain at $37,500 for FY 2018.

CMS received nine applications for new technology add-on payments for FY 2018. Three applicants withdrew their applications prior to the issuance of this proposed rule. The 6 under consideration are:

- Bezlotoxumab (ZINPLAVA™)
- EDWARDS INTUITY Elite™ Valve System (INTUITY) and LivaNova Perceval Valve (Perceval)
- Ustekinumab (Stelara®)
- KTE-C19 (Axicabtagene Ciloleucel)
- VYXEOS™ (Cytarabine and Daunorubicin Liposome for Injection)
- GammaTile™

COMMENT

In the past, we have observed the length and discussion of new technologies. This year's material is more than 100 pages. It would help if the discussion on these items were placed in a separate appendix. One must assume that most readers are only interested in actions being taken by the agency and not all the ongoing discussions and rational positions between CMS and the manufacturers. Better yet, maybe put new technology in its own rulemaking system.

IV. OTHER DECISIONS AND PROPOSED CHANGES TO THE IPPS FOR OPERATING SYSTEM (PAGE 562)

Proposed Changes to MS-DRGs Subject to the Postacute Care Transfer and MS-DRGs Special Payment Policies (§ 412.4)

CMS says the statute directs the agency to identify MS-DRGs based on a high volume of discharges to postacute care facilities and a disproportionate use of postacute care services. CMS has identified three MS-DRGs that it is proposing to be included on the list of MS-DRGs subject to the special payment transfer policy.

CMS is proposing to delete MS-DRGs 984, 985, and 986 (Prostatic O.R. Procedure Unrelated to Principal Diagnosis with MCC, with CC and without CC/MCC, respectively) and reassign the procedure codes currently assigned to these three MS-DRGs to MS-DRGs 987, 988, and 989 (Non-Extensive O.R. Procedure Unrelated to Principal Diagnosis with MCC, with CC and without CC/MCC, respectively).

Proposed Rural Referral Centers: Proposed Annual Updates to Case-Mix Index and Discharge Criteria (§412.98) (Page 585)

A rural hospital with less than 275 beds may be classified as an RRC if—

- The hospital's case-mix index is at least equal to the lower of the median CMI for urban hospitals in its census region, excluding hospitals with approved teaching programs, or the median CMI for all urban hospitals nationally; and
- The hospital's number of discharges is at least 5,000 per year, or, if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located. (The number of discharges criterion for an osteopathic hospital is at least 3,000 discharges.)

In addition to meeting other criteria, if rural hospitals with fewer than 275 beds are to qualify for initial RRC status for cost reporting periods beginning on or

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after October 1, 2017, they must have a CMI value for FY 2016 that is at least—

- 1.6635; or
- The median CMI value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs as identified in § 413.75) calculated by CMS for the census region in which the hospital is located.

The CMI values by region are set forth in the following table:

Region		Case Mix Index Value
1	New England (CT, ME, MA, NH, RI, VT)	1.4186
2	Middle Atlantic (PA, NJ, NY)	1.5126
3	South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.5393
4	East North Central (IL, IN, MI, OH, WI)	1.5921
5	East South Central (AL, KY, MS, TN)	1.5179
6	West North Central (IA, KS, MN, MO, NE, ND, SD)	1.6346
7	West South Central (AR, LA, OK, TX)	1.6949
8	Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.7614
9	Pacific (AK, CA, HI, OR, WA)	1.6466

A hospital, if it is to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2017, must also have the number of discharges for its cost reporting period that began during FY 2017 a figure that is at least—

- 5,000 (3,000 for an osteopathic hospital); or
- The median number of discharges for urban hospitals in the census region in which the hospital is located.

All census proposed regional discharge numbers are greater than 5,000.

Proposed Payment Adjustment for Low-Volume Hospitals (§ 412.101) (Page 590)

Under section 1886(d)(12) of the Act, as amended, most recently by section 204 of MACRA, the temporary changes in the low-volume hospital payment policy originally provided by the ACA and extended through subsequent legislation are effective through FY 2017. Beginning with FY 2018, the preexisting low-volume hospital payment adjustment and qualifying criteria, as implemented in FY 2005 will resume.

Section 1886(d)(12)(C)(i) of the Act defines a low-volume hospital, for fiscal years other than FYs 2011 through 2017, as a subsection (d) hospital (as defined in paragraph (1)(B)) that the Secretary determines is located more than 25 road miles from another subsection (d) hospital and that has less than 800 discharges during the fiscal year. Section 1886(d)(12)(C)(ii) of the Act further stipulates that the term "discharge" means an inpatient acute care discharge of an individual, regardless of whether the individual is entitled to benefits under Medicare Part A.

For FY 2018, a hospital must make a written request for low-volume hospital status that is received by its MAC no later than September 1, 2017, in order for

continued

the 25-percent, low-volume, add-on payment adjustment to be applied to payments for its discharges beginning on or after October 1, 2017 (through September 30, 2018).

IME Adjustment Factor for FY 2018 (Page 603)

For discharges occurring during FY 2018, the formula multiplier is 1.35.

COMMENT

CMS says that there are 2,211 nonteaching hospitals in its analysis, 835 teaching hospitals with fewer than 100 residents, and 246 teaching hospitals with 100 or more residents.

Proposed Payment Adjustment for Medicare Disproportionate Share Hospitals for FY 2018 (§ 412.106) (Page 604)

Beginning with discharges in FY 2014, hospitals that qualify for Medicare DSH payments under section 1886(d)(5)(F) of the Act receive 25 percent of the amount they previously would have received under the statutory formula for Medicare DSH payments, updated, of course, based on current criteria.

The remaining amount, equal to an estimate of 75 percent of what otherwise would have been paid as Medicare DSH payments, reduced to reflect changes in the percentage of individuals under age 65 who are uninsured, is available to make additional payments to each hospital that qualifies for Medicare DSH payments and that has uncompensated care. There are 3 factors in determining the amount of such payments.

Calculation of Factor 1 for FY 2018 (Page 616)

Factor 1 is the difference between CMS' estimates of: (1) the amount that would have been paid in Medicare DSH payments for the fiscal year, in the absence of the ACA payment provision; and (2) the amount of empirically justified Medicare DSH payments that are made for the fiscal year, which takes into account the requirement to pay 25 percent of what would have otherwise been paid under section 1886(d)(5)(F) of the Act. In other words, this factor represents CMS' estimate of 75 percent (100 percent minus 25 percent) of its estimate of Medicare DSH payments that would otherwise be made, in the absence of section 1886(r) of the Act, for the fiscal year.

The January 2017 Office of the Actuary estimate for Medicare DSH payments for FY 2018, without regard to the application of section 1886(r)(1) of the Act, is approximately $16.003 billion. This estimate excludes Maryland hospitals participating in the Maryland All-Payer Model and SCHs paid under their hospital-specific payment rate. Therefore, based on the January 2017 estimate, the estimate for empirically justified Medicare DSH payments for FY 2018, with the application of section 1886(r)(1) of the Act, is approximately $4.001 billion (or 25 percent of the total amount of estimated Medicare DSH payments for FY 2018).

Under § 412.106(g)(1)(i) of the regulations, Factor 1 is the difference between these two estimates of the Office of the Actuary. Therefore, in this proposed rule, CMS is proposing that Factor 1 for FY 2018 is $12,001,915,095.04, which is equal to 75 percent of the total amount of estimated Medicare DSH payments for FY 2018 ($16,002,553,460.05 minus $4,000,638,365.01).

[Factor 1 for FY 2017 is $10,797,476,782.62, which is equal to 75 percent of the total amount of estimated Medicare DSH payments for

continued

FY 2017 ($14,396,635,710.16 minus $3,599,158,927.54).]

Proposed Methodology for Calculation of Factor 2 for FY 2018 (Page 628)

The statute states that, for FY 2018 and subsequent fiscal years, the second factor is 1 minus the percent change in the percent of individuals who are uninsured, as determined by comparing the percent of individuals who were uninsured in 2013 (as estimated by the Secretary, based on data from the Census Bureau or other sources the Secretary determines appropriate, and certified by the Chief Actuary of CMS) and the percent of individuals who were uninsured in the most recent period for which data are available (as so estimated and certified), minus 0.2 percentage point for FYs 2018 and 2019. [The current formula is minus 0.1 percent.]

The calculation of the proposed Factor 2 for FY 2018 using a weighted average of OACT's projections for CY 2017 and CY 2018 is as follows:

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

1-|((0.0815-0.14)/0.14)| = 1- 0.4179 = 0.5821 (58.21 percent)

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

0.5801= Factor 2 [The 2017 factor 2= 0.5536]

The proposed FY 2018 uncompensated care amount is: $12,001,915,095.04 x 0.5801 = $6,962,310,946.63.

[The FY 2017 Final Uncompensated Care Amount is: $10,797,476,782.62 x 0.5536 = $5,977,483,146.86.]

Calculation of Proposed Factor 3 for FY 2018 (Page 637)

Factor 3 is equal to the percent, for each subsection (d) hospital, that represents the quotient of (1) the amount of uncompensated care for such hospital for a period selected by the Secretary (as estimated by the Secretary, based on appropriate data (including, in the case where the Secretary determines alternative data are available that are a better proxy for the costs of subsection (d) hospitals for treating the uninsured, the use of such alternative data)); and (2) the aggregate amount of uncompensated care for all subsection (d) hospitals that receive a payment under section 1886(r) of the Act for such period (as so estimated, based on such data).

Factor 3 is applied to the product of Factor 1 and Factor 2 to determine the amount of the uncompensated care payment that each eligible hospital will receive for FY 2018 and subsequent fiscal years; i.e., the pool amount of $6,962 billion.

COMMENT

CMS' proposed impact analysis found that, across all projected DSH eligible hospitals, FY 2018 DSH payments are estimated at approximately $10.930 billion, or an increase of approximately 14.4 percent from FY 2017 DSH payments (approximately $9.553 billion).

Proposed Time Period for Calculating Factor 3 for FY 2018, Including Methodology for Incorporating Worksheet S–10 Data (Page 649)

continued

For FY 2018, CMS is proposing to continue to use the methodology finalized in FY 2017 and to compute Factor 3 using an average of data from three cost reporting periods instead of one cost reporting period.

For FY 2018, in addition to the Worksheet S-10 data for FY 2014, CMS is proposing to use Medicaid days from FY 2012 and FY 2013 cost reports and FY 2014 and FY 2015 SSI ratios. CMS also is proposing to continue the policies that were finalized in the FY 2015 IPPS/LTCH PPS final rule to address several specific issues concerning the process and data to be employed in determining Factor 3 in the case of hospital mergers as well as the policies finalized in the FY 2017 IPPS/LTCH PPS final rule concerning multiple cost reports beginning in the same fiscal year.

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

- Step 1: Calculating Factor 3 using the low-income insured days proxy based on FY 2012 cost report data and the FY 2014 SSI ratio;
- Step 2: Calculating Factor 3 using the insured low-income days proxy based on FY 2013 cost report data and the FY 2015 SSI ratio;
- Step 3: Calculating Factor 3 based on the FY 2014 Worksheet S–10 data, and
- Step 4: Averaging the Factor 3 values from Steps 1, 2, and 3; that is, adding the Factor 3 values from FY 2012, FY 2013, and FY 2014 for each hospital, and dividing that amount by the number of cost reporting periods with data to compute an average Factor 3.

Hospital Readmissions Reduction Program: (Page 673)

CMS is proposing the following policy changes for the Hospital Readmissions Reduction Program: (1) the applicable time period for FY 2018; (2) the calculation of aggregate payments for excess readmissions for FY 2018; (3) changes to the payment adjustment factor in accordance with section 15002 of the Cures Act for FY 2019; and (4) updates to the Extraordinary Circumstance Exception policy beginning in FY 2018 as related to extraordinary circumstances that occur on or after October 1, 2017.

CMS is proposing that the "applicable period" for the Hospital Readmissions Reduction Program would be the 3-year period from July 1, 2013 through June 30, 2016.

The Hospital Readmissions Reduction Program currently includes the following six applicable conditions: acute myocardial infarction; heart failure; pneumonia; total hip arthroplasty/total knee arthroplasty; chronic obstructive pulmonary disease; and Coronary Artery Bypass Graft Surgery.

For FY 2018, CMS is proposing to calculate aggregate payments for excess readmissions, using MedPAR claims from July 1, 2013 through June 30, 2016, to identify applicable conditions based on the same ICD-9-CM codes or ICD-10-CM and ICD-10-PCS code sets, as applicable, used to identify the conditions for the readmissions measures, and to apply the proposed exclusions for the types of admissions. CMS says it is not proposing any changes to its existing methodology for calculating "aggregate payments for excess readmissions" for each hospital (the numerator of the ratio).

The Cures Act added Section 15002 of that law added subparagraphs (D) and (E) to section 1886(q)(3) of the Act, which directs the Secretary to assign hospitals to peer groups, develop a

continued

methodology that allows for separate comparisons for hospitals within these groups, and allows for changes in the risk adjustment methodology.

For discharges occurring after FY 2018, the Secretary may consider the removal as a readmission of an admission that is classified within one or more of the following: transplants; end-stage renal disease; burns, trauma; psychosis; or substance abuse.

For FY 2018, a hospital subject to the Hospital Readmissions Reduction Program will have an adjustment factor that is between 1.0 (no reduction) and 0.9700 (greatest possible reduction).

COMMENT

CMS estimates that 2,591 hospitals would have their base operating MS-DRG payments reduced by their proposed proxy FY 2018 hospital-specific readmissions adjustment. As a result, CMS estimates that the Hospital Readmissions Reduction Program would save approximately $564 million in FY 2018, an increase of $27 million over the estimated FY 2017 savings.

Hospital Value-Based Purchasing Program: Proposed Policy Changes (Page 717)

Section 1886(o) of the Act, as added by ACA section 3001(a)(1), requires the Secretary to establish a hospital value-based purchasing program (the Hospital VBP Program) under which value-based incentive payments are made in a fiscal year to hospitals that meet performance standards established for a performance period for such fiscal year. Both the performance standards and the performance period for a fiscal year are to be established by the Secretary.

Section 1886(o)(7)(B) of the Act instructs the Secretary to reduce the base operating DRG payment amount for a hospital for each discharge in a fiscal year by an applicable percent. The FY 2018 program year is 2.00 percent.

CMS estimates that the total amount available for value-based incentive payments for FY 2018 will be approximately $1.9 billion.
CMS is proposing to remove the current PSI 90 measure from the Hospital VBP Program beginning with the FY 2019 program year.

In summary, for the FY 2019 and FY 2020 program years, CMS has finalized the following measure set and is proposing to remove the current PSI 90 measure, as indicated: (page 727)

Previously Adopted Measures and Proposed Measure for Removal for the FY 2019 and FY 2020 Program Years		
Measure Short Name	**Domain/Measure Name**	**NQF #**
Person and Community Engagement Domain*		
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)** (including Care Transition Measure)	0166 (0228)
Clinical Care Domain		

continued

Previously Adopted Measures and Proposed Measure for Removal for the FY 2019 and FY 2020 Program Years		
Measure Short Name	**Domain/Measure Name**	**NQF #**
Person and Community Engagement Domain*		
MORT-30-AMI	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate(RSMR) Following Acute Myocardial Infarction (AMI) Hospitalization	0230
MORT-30-HF	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Heart Failure (HF) Hospitalization	0229
MORT-30-PN	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Pneumonia Hospitalization	0468
THA/ TKA	Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	1550
Safety Domain		
CAUTI	National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure	0138
CLABSI	National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure	0139
Colon and Abdominal Hysterectomy SSI	American College of Surgeons -- Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site (SSI) Infection Outcome Measure	0753
MRSA Bacteremia	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin - resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure	1716
CDI	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	1717
PSI 90***	Patient Safety for Selected Indicators (Composite Measure)	0531
PC-01	Elective Delivery	0469
Efficiency and Cost Reduction Domain		
MSPB	Payment-Standardized Medicare Spending Per Beneficiary (MSPB)	2158

** In section IV.H.3.b. of the preamble of the FY 2017 IPPS/LTCH PPS final rule (81 FR 56984), CMS renamed this domain from Patient- and Caregiver-Centered Experience of Care/Care Coordination domain to Person and Community Engagement domain beginning with the FY 2019 program year.*
*** In section XIX.B.3. of the preamble of the CY 2017 OPPS/ASC final rule with comment period (81 FR 79855 through 79862), CMS finalized the removal of the Pain Management dimension from the Hospital VBP Program beginning with the FY 2018 program year.*
**** Proposed for removal beginning with the FY 2019 program year as discussed in section V.J.3.b. of the preamble of this proposed rule.*

CMS is proposing a New Measure for the FY 2022 Program Year and Subsequent Years: Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Pneumonia (PN Payment). The proposed PN Payment measure

continued

is intended to be paired with the MORT-30-PN measure. The PN Payment measure would be added to the Efficiency and Cost Reduction domain. (Page 729)

The Patient Safety and Adverse Events (Composite) measure is a weighted average of the reliability-adjusted, indirectly standardized, observed-to-expected ratios for the following 10 individual PSI component indicators:

- PSI 03 Pressure Ulcer Rate;
- PSI 06 Iatrogenic Pneumothorax Rate;
- PSI 08 In-Hospital Fall with Hip Fracture Rate;
- PSI 09 Perioperative Hemorrhage or Hematoma Rate;
- PSI 10 Postoperative Acute Kidney Injury Requiring Dialysis Rate;
- PSI 11 Postoperative Respiratory Failure Rate;
- PSI 12 Perioperative Pulmonary Embolism or Deep Vein Thrombosi Rate;
- PSI 13 Postoperative Sepsis Rate;
- PSI 14 Postoperative Wound Dehiscence Rate; and
- PSI 15 Unrecognized Abdominopelvic Accidental Puncture/Laceration Rate.

CMS is proposing to adopt the Patient Safety and Adverse Events (Composite) measure for the Hospital VBP Program beginning with the FY 2023 program year. CMS is proposing that the measure would be added to the Safety domain, like the previously adopted PSI 90 measure. (Page 739)

Summary of Previously Adopted and Proposed Baseline and Performance Periods for the FY 2019 through FY 2023 Program Years (Page 755)

The tables that follow summarize the baseline and performance periods that CMS is proposing in this rule.

Previously Adopted Baseline and Performance Periods for the FY 2019 Program Year

Domain	Baseline Period	Performance Period
Person and Community Engagement HCAHPS Survey	January 1, 2015 – December 31, 2015	January 1, 2017 – December 31, 2017
Clinical Care Mortality (MORT-30-AMI, MORT-30-HF, MORT-30-PN)	July 1, 2009 – June 30, 2012	July 1, 2014 – June 30, 2017
THA/TKA	July 1, 2010 – June 30, 2013	January 1, 2015 – June 30, 2017
Safety PC-01 and NHSN measures (CAUTI, CLABSI, SSI, CDI,MRSA)	January 1, 2015 – December 31, 2015	January 1, 2017 – December 31, 2017
Efficiency and Cost Reduction MSPB	January 1, 2015 –December 31, 2015	January 1, 2017 – December 31, 2017

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Previously Adopted Baseline and Performance Periods for the FY 2020 Program Year		
Domain	**Baseline Period**	**Performance Period**
Person and Community Engagement HCAHPS Survey	January 1, 2016 – December 31, 2016	January 1, 2018 – December 31, 2018
Clinical Care Mortality (MORT-30-AMI, MORT-30-HF, MORT-30-PN) THA/TKA	July 1, 2010 – June 30, 2013 July 1, 2010 – June 30, 2013	July 1, 2015 – June 30, 2018 January 1, 2015 – June 30, 2018
Safety PC-01 and NHSN measures (CAUTI, CLABSI, SSI, CDI,MRSA)	January 1, 2016 – December 31, 2016	January 1, 2018 – December 31, 2018
Efficiency and Cost Reduction MSPB	January 1, 2016 –December 31, 2016	January 1, 2018 – December 31, 2018

Previously Adopted Baseline and Performance Periods for the FY 2021 Program Year		
Domain	**Baseline Period**	**Performance Period**
Person and Community Engagement HCAHPS Survey	January 1, 2017 – December 31, 2017	January 1, 2019 – December 31, 2019
Clinical Care Mortality (MORT-30-AMI, MORT-30-HF, MORT-30-PN) Mort -30 PN (updated cohort) THA/TKA	July 1, 2011 – June 30, 2014 July 1, 2012 – June 30, 2015 April 1, 2011, - March 31, 2014	July 1, 2016 – June 30, 2019 September 1, 2017 – June 30, 2019 April 1, 2016 – March 31, 2019
Safety PC-01 and NHSN measures (CAUTI, CLABSI, SSI, CDI,MRSA)	January 1, 2017 – December 31, 2017	January 1, 2019 – December 31, 2019
Efficiency and Cost Reduction MSPB Payment (AMI Payment and HF Payment	January 1, 2016 –December 31, 2017 July 1, 2012 – June 30, 2105	January 1, 2019 – December 31, 2019 July 1, 2017. – June 30, 2019

Previously Adopted Baseline and Performance Periods for the FY 2022 Program Year		
Domain	**Baseline Period**	**Performance Period**
Person and Community Engagement HCAHPS Survey	January 1, 2018 – December 31, 2018	January 1, 2020 – December 31, 2020
Clinical Care Mortality (MORT-30-AMI, MORT-30-HF, MORT-30-PN) Mort -30 PN (updated cohort) THA/TKA	July 1, 2011 – June 30, 2014 July 1, 2012 – June 30, 2015 April 1, 2012, - March 31, 2015	July 1, 2017 – June 30, 2020 September 1, 2017 – June 30, 2020 April 1, 2017 – March 31, 2020

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Previously Adopted Baseline and Performance Periods for the FY 2022 Program Year		
Domain	**Baseline Period**	**Performance Period**
Safety PC-01 and NHSN measures (CAUTI, CLABSI, SSI, CDI,MRSA)	January 1, 2018 – December 31, 2018	January 1, 2020 – December 31, 2020
Efficiency and Cost Reduction MSPB	January 1, 2018 –December 31, 2018	January 1, 2020 – December 31, 2020
Payment (AMI Payment and HF Payment	July 1, 2012 – June 30, 2015	July 1, 2017. – June 30, 2020
PN Payment	July 1, 2013 – June 30, 2016	August 1, 2018 – June 30, 2020

Previously Adopted Baseline and Performance Periods for the FY 2023 Program Year		
Domain	**Baseline Period**	**Performance Period**
Person and Community Engagement HCAHPS Survey	January 1, 2019 – December 31, 2019	January 1, 2021 – December 31, 2021
Clinical Care Mortality (MORT-30-AMI, MORT-30-HF, MORT-30-PN) Mort-COPD, Mort 30 CABG, Mort 30 PN (updated cohort)	July 1, 2013 – June 30, 2016	July 1, 2018 – June 30, 2021
THA/TKA	April 1, 2013, - March 31, 2016	April 1, 2018 – March 31, 2021
Safety PC-01 and NHSN measures (CAUTI, CLABSI, SSI, CDI, MRSA)	January 1, 2019 – December 31, 2019	January 1, 2020 – December 31, 2020
Patient Safety and Adverse Events (Composite)	October 1, 2015-June 30, 2017	July 1, 2019 – June 30, 2021
Efficiency and Cost Reduction MSPB	January 1, 2019 –December 31, 2019	January 1, 2021 – December 31, 2021
Payment (AMI Payment and HF Payment	July 1, 2013 – June 30, 2016	July 1, 2018. – June 30, 2021
PN Payment	July 1, 2013 – June 30, 2016	August 1, 2018 – June 30, 2021

COMMENT

This is another section with extensive and complex material. The document contains additional tables regarding standards beyond FY 2019 as well as much scoring information.

Proposed Changes to the Hospital-Acquired Condition Reduction Program (Page 780)

For the FY 2020 program, CMS is proposing to return to a two-year time period for the calculation of HAC Reduction Program measure results.

CMS is proposing to modify the Extraordinary Circumstances Exception policy for the HAC Reduction Program by:

continued

- (1) allowing the facility to submit a form signed by the facility's CEO or designated personnel;
- (2) specifying that CMS will strive to provide a formal response notifying the facility of its decision within 90 days of receipt of the facility's request; and
- (3) specifying that CMS may grant ECEs due to CMS data system issues which affect data submission.

V. PROPOSED CHANGES TO THE LONG-TERM CARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM FOR FY 2017 (PAGE 872)

Proposed Updates to the Payment Rates for the LTCH PPS for FY 2018 (Page 1,610)

CMS is establishing an annual update to the LTCH PPS standard Federal payment rate of 1.0 percent.
MARCA requires that the annual update for FY 2018, after applications of the reductions for the MFP adjustment and the "other adjustment" (under section 1886(m)(3)(A)) is 1.0 percent.

For LTCHs that fail to submit required quality reporting data for FY 2018, the proposed update is reduced further by 2.0 percentage points, or an (negative) update factor of -1.0 percent.

CMS is proposing to apply an area wage level budget neutrality factor to the proposed FY 2018 LTCH PPS standard Federal payment rate of 1.000077. Further, CMS is proposing a budget neutrality factor of 0.9672. Therefore, CMS is proposing a LTCH PPS standard Federal payment rate $41,497.20 (calculated as $42,476.41 x 1.01 x 1.000077 x 0.9672).

For LTCHs that fail to submit quality reporting data for FY 2017 in accordance with the requirements of the LTCHQRP under section 1886(m)(5) of the Act, CMS is establishing a LTCH PPS standard Federal payment rate of $40,675.49 (calculated as $42,476.41 x 0.99 X 1.000077 x 0.9672) for FY 2018.

CMS is proposing that the labor-related share under the LTCH PPS for FY 2018 is 66.3 percent.

The proposed FY 2018 LTCH PPS standard Federal payment rate wage index values are presented in Table 12A (for urban areas) and Table 12B (for rural areas), available on the CMS Web site.

Adjustment for LTCH PPS High-Cost Outlier Cases

Section 1886(m)(7)(A) of the Act makes CMS' existing regulatory budget neutrality requirement at § 412.523(d)(1) for the 8.0 percent HCO target for standard Federal payment rate cases a statutory requirement beginning in FY 2018.

In addition, section 1886(m)(7)(B) of the Act requires, beginning in FY 2018, that the fixed-loss amount for HCO payments be determined so that the estimated aggregate amount of HCO payments for such cases in a given year are equal to 99.6875 percent of the 8 percent estimated aggregate payments for standard Federal payment rate cases (that is, 7.975 percent). In other words, sections 1886(m)(7)(A) and (7)(B) requires that CMS adjust the standard Federal payment rate each year to ensure budget neutrality for HCO payments as if estimated aggregate HCO payments made for standard Federal payment rate discharges remain at 8.0 percent, while the fixed-loss amount for the HCO payments is set each year so that the estimated aggregate HCO payments for standard Federal payment rate cases are 7.975 percent of estimated aggregate payments for standard Federal payment rate cases.

continued

CMS is proposing to determine a fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2018 of $30,081.

CMS is proposing a fixed-loss amount for site neutral payment rate cases of $26,713.

CMS says that approximately 58 percent of LTCH cases are expected to meet the patient-level criteria for exclusion from the site neutral payment rate in FY 2018, and would be paid based on the proposed LTCH PPS standard Federal payment rate for the full year.

VI. QUALITY DATA REPORTING REQUIREMENTS FOR SPECIFIC PROVIDERS AND SUPPLIERS (PAGE 969)

Hospital IQR (Page 973)

CMS is proposing refinements to two measures. First, CMS is proposing refinements to the Hospital Consumer Assessment of Healthcare Providers and Systems Survey (NQF #0166) measure for FY 2020 and subsequent years by refining the current Pain Management questions (HCAHPS Q12, Q13, and Q14) to focus on the hospital's communications with patients about the patients' pain during the hospital stay. In accord with this new focus, CMS is proposing to update the name of the composite measure from "Pain Management" to "Communication About Pain." CMS would begin to use the new Pain Management items on the HCAHPS Survey in January of 2018

Second, CMS is proposing refinements to the Stroke 30-Day Mortality Rate (MORT-30-STK) measure for the FY 2023 payment determination and subsequent years by changing the measure's risk adjustment to include stroke severity (Stroke 30-Day Mortality Rate with the refined risk adjustment) obtained from International Classification of Disease, Tenth Edition Clinical Modifier (ICD-10-CM) codes in the administrative claims. CMS is proposing this measure to inform hospitals that they should begin to include the NIH stroke severity scale codes in the claims they submit for patients with a discharge diagnosis of ischemic stroke. CMS is proposing that the first measurement period would include discharges between July 1, 2018 and June 30, 2021 for public reporting in FY 2022 and for the FY 2023 payment determination.

The table below outlines the Hospital IQR Program measure set (including previously adopted measures and proposed refinements from this proposed rule) for the FY 2020 payment determination and subsequent years. The proposed, refined measures, as discussed above, are denoted with a superscript as defined in the legend below the table.

Previously Adopted Hospital IQR Program Measures for the FY 2020 Payment Determination and Subsequent Years		
Short Name	**Measure Name**	**NQF #**
Health Care-Associated Infection Measures		
CAUTI	National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure	0138
CDI	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	1717
CLABSI	National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure	0139

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Previously Adopted Hospital IQR Program Measures for the FY 2020 Payment Determination and Subsequent Years		
Short Name	**Measure Name**	**NQF #**
Colon and Abdominal Hysterectomy SSI	American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	0753
HCP	Influenza Vaccination Coverage Among Healthcare Personnel	0431
MRSA Bacteremia	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin -resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure	1716
Claims-based Patient Safety Measures		
Hip/knee complications	Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	1550
PSI 04	Death Rate among Surgical Inpatients with Serious Treatable Complications	0351
PSI 90	Patient Safety for Selected Indicators Composite Measure, Modified PSI 90 (Updated Title: Patient Safety and Adverse Events Composite)	0531
	Claims-based Mortality Outcome Measures	
MORT-30-AMI	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (AMI) Hospitalization	0230
MORT-30-CABG	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery	2558
MORT-30-COPD	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	1893
MORT-30-HF	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Heart Failure (HF) Hospitalization	0229
MORT-30-PN	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization	0468
MORT-30-STK	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Ischemic Stroke***	N/A
Claims-based Coordination of Care Measures		
READM-30-AMI	Hospital 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) Following Acute Myocardial Infarction (AMI) Hospitalization	0505
READM-30-CABG	Hospital 30-Day, All-Cause, Unplanned, Risk- Standardized Readmission Rate (RSRR) Following Coronary Artery Bypass Graft (CABG) Surgery	2515
READM-30-COPD	Hospital 30-Day, All-Cause, Unplanned, Risk- Standardized Readmission Rate (RSRR) Following Coronary Artery Bypass Graft (CABG) Surgery	1891
READM-30-HF	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Heart Failure (HF) Hospitalization	0330
READ-30-HWR	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	1789
READM-30-PN	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Pneumonia Hospitalization	0506
READM-30-STK	30-Day Risk Standardized Readmission Rate Following Stroke Hospitalization	N/A
READM-30-THA/TKA	Hospital-Level 30-Day, All-Cause Risk-Standardized Readmission Rate (RSRR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	1551
AMI Excess Days	Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction	2881
HF Excess Days	Excess Days in Acute Care after Hospitalization for Heart Failure	2880
PN Excess Days**	Excess Days in Acute Care after Hospitalization for Pneumonia	2882

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Previously Adopted Hospital IQR Program Measures for the FY 2020 Payment Determination and Subsequent Years		
Short Name	**Measure Name**	**NQF #**
Claims-based Payment Measures		
AMI Payment	Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Acute Myocardial Infarction (AMI)	2431
HF Payment	Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care For Heart Failure (HF)	2436
PN Payment	Hospital-Level, Risk-Standardized Payment Associated with a 30-day Episode-of-Care For Pneumonia	2579
THA/TKA Payment	Hospital-Level, Risk-Standardized Payment Associated with an Episode-of-Care for Primary Elective Total Hip Arthroplasty and/or Total Knee Arthroplasty	N/A
MSPB	Payment-Standardized Medicare Spending Per Beneficiary (MSPB)	2158
Cellulitis Payment	Cellulitis Clinical Episode-Based Payment Measure	N/A
GI Payment	Gastrointestinal Hemorrhage Clinical Episode-Based Payment Measure	N/A
Kidney/UTI Payment	Kidney/Urinary Tract Infection Clinical Episode- Based Payment Measure	N/A
AA Payment	Aortic Aneurysm Procedure Clinical Episode-Based Payment Measure	N/A
Chole and CDE Payment	Cholecystectomy and Common Duct Exploration Clinical Episode-Based Payment Measure	N/A
Sfusion Payment	Spinal Fusion Clinical Episode-Based Payment Measure	N/A
Chart-abstracted Clinical Process of Care Measures		
ED-1*	Median Time from ED Arrival to ED Departure for Admitted ED Patients	0495
ED-2*	Admit Decision Time to ED Departure Time for Admitted Patients	0497
Imm-2	Influenza Immunization	1659
PC-01*	Elective Delivery	0469
Sepsis	Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)	0500
VTE-6	Incidence of Potentially Preventable Venous Thromboembolism	+
EHR-based Clinical Process of Care Measures (that is, Electronic Clinical Quality Measures)		
AMI-8a	Primary PCI Received Within 90 Minutes of Hospital Arrival	+
CAC-3	Home Management Plan of Care Document Given to Patient/ Caregiver	+
ED-1*	Median Time from ED Arrival to ED Departure for Admitted ED Patients	0495
ED-2*	Admit Decision Time to ED Departure Time for Admitted Patients	0497
EHDI-1a	Hearing Screening Prior to Hospital Discharge	1354
PC-01*	Elective Delivery	0469
PC-05	Exclusive Breast Milk Feeding	0480
STK-02	Discharged on Antithrombotic Therapy	0435
STK-03	Anticoagulation Therapy for Atrial Fibrillation/Flutter	0436
STK-05	Antithrombotic Therapy by the End of Hospital Day Two	0438
STK-06	Discharged on Statin Medication	0439
STK-08	Stroke Education	+
STK-10	Assessed for Rehabilitation	0441
VTE-1	Venous Thromboembolism Prophylaxis	0371
VTE-2	Intensive Care Unit Venous Thromboembolism Prophylaxis	0372

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Previously Adopted Hospital IQR Program Measures for the FY 2020 Payment Determination and Subsequent Years		
Short Name	**Measure Name**	**NQF #**
	Patient Experience of Care Survey Measures	
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems** (including Care Transition Measure (CTM-3) and Communication About Pain composite measure)	0166 (0228)
Structural Patient Safety Measures		
Patient Safety Culture	Hospital Survey on Patient Safety Culture	N/A
Safe Surgery Checklist	Safe Surgery Checklist Use	N/A

** Measure listed twice, as both chart-abstracted and electronic clinical quality measure.*
*** Proposed measure refinement of the HCAHPS measure's Pain Management questions for the FY 2020 payment determination and for subsequent years, as described in section IX.A.6.a. of the preamble of this proposed rule.*
**** Proposed measure refinement of the Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Ischemic Stroke, for the FY 2023 payment determination and for subsequent years, as described in section IX.A.6.b. of the preamble of this proposed rule.*
+ NQF endorsement has been removed.

Proposal for Voluntary Reporting of Electronic Health Record Data for the Hybrid HWR Measure (NQF #2879)

CMS is proposing the Hybrid HWR measure as a voluntary measure for the reporting of data on discharges over a 6-month period in the first two quarters of CY 2018 (January 1, 2018 through June 30, 2018). A hospital's annual payment determination would not be affected by this voluntary measure.

Proposed Changes to Policies on Reporting of eCQMs

Refer the material at the start of this analysis for information.

COMMENT

The section on Quality Reporting extends more than 440 pages. It's just long, too long to summarize. This analysis has not discussed issues relating to eCQMs, timing and reporting, and validations, etc., PPS Cancer Hospitals, LTCH hospitals, Psychiatric Hospitals, and other related items. Refer to the material at the start of this analysis for very brief content.

Those individuals responsible for quality reporting need to pay careful attention to the numerous changes presented. Failure to do so could result in reduced payments for not providing required quality measures.

FINAL COMMENTS AND REGULATORY ANALYSIS

CMS provides an extensive regulatory analysis section identifying and quantifying many of the changes being proposed. CMS says that "the applicable percentage increase to the IPPS rates required by the statute, in conjunction with other proposed payment changes in this proposed rule, would result in an estimated $3.1 billion increase in FY 2018 proposed payments, including a $3.8 billion increase in FY 2018 proposed operating payments (or 1.7 percent change), an estimated $212 million increase in FY 2018 proposed capital payments (or 2.4 percent change), and an estimated $1.0 billion increase in proposed uncompensated care payments (or a 1.2 percent change)."

Somehow the math seems funny. The increases shown are greater than the estimated total increase. What are and where are the reductions?

Over the past few years, there has been both consternation and dismay by many states over an ACA amendment that reversed a CMS rule that would have set area wage index budget neutrality on a statewide basis when urban areas in a state have a lower wage index value than the statewide rural amount. The ACA requirement imposes such budget neutrality on a national basis. The reversal has to-date been extremely beneficial in New England and California.

CMS estimates that 392 hospitals would receive the proposed rural floor in FY 2018. All IPPS hospitals in CMS' model would have their wage index reduced by the rural floor budget neutrality adjustment of 0.993672. CMS projects that, in aggregate, rural hospitals would experience a 0.63 percent decrease in payments as a result of the application of the proposed rural floor budget neutrality because the rural hospitals do not benefit from the rural floor, but have their wage indexes downwardly adjusted to ensure that the application of the rural floor is budget neutral overall.

The following is CMS' FY 2018 estimate of the national budget neutrality statewide calculations.

Proposed FY 2018 IPPS Estimated Payments Due to Rural Floor with National Budget Neutrality				
State	Number of Hospitals (1)	Proposed Number of Hospitals That Will Receive the Rural Floor or Imputed Floor (2)	Proposed Percent Change in Payments due to Application of Rural Floor and Imputed Floor with Budget Neutrality (3)	Proposed Difference (in millions) (4)
Alabama	84	3	-0.2	3.05
Alaska	6	4	1.4	2.62
Arizona	57	44	0.9	17.47
Arkansas	44	1	-0.3	-3.39
California	299	177	1.3	136.28
Colorado	47	4	0.4	4.97
Connecticut	30	10	0.4	6.31
Delaware	6	0	-0.3	-1.61
Washington, D.C.	7	0	-0.3	-1.67
Florida	171	17	-0.2	-14.93
Georgia	103	0	-0.3	-8.07
Hawaii	12	0	-0.3	-0.83
Idaho	14	0	-0.2	-0.77
Illinois	127	3	-0.3	-15.97
Indiana	85	7	-0.2	-5.92
Iowa	34	0	-0.3	-2.94
Kansas	53	0	-0.3	-2.62
Kentucky	66	0	-0.3	-4.87
Louisiana	94	3	-0.3	-4.21
Maine	17	0	-0.3	-1.59
Massachusetts	57	36	1.3	43.82
Michigan	94	0	-0.3	-13.74
Minnesota	49	0	-0.3	-5.66
Mississippi	60	0	-0.3	-3.40
Missouri	74	0	-0.2	-3.89
Montana	12	4	0.0	0.08
Nebraska	24	0	-0.3	-1.88

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Proposed FY 2018 IPPS Estimated Payments Due to Rural Floor with National Budget Neutrality				
State	Number of Hospitals (1)	Proposed Number of Hospitals That Will Receive the Rural Floor or Imputed Floor (2)	Proposed Percent Change in Payments due to Application of Rural Floor and Imputed Floor with Budget Neutrality (3)	Proposed Difference (in millions) (4)
Nevada	23	0	-0.4	-3.04
New Hampshire	13	9	2.5	14.09
New Jersey	64	0	-0.4	-16.05
New Mexico	25	0	-0.2	-1.01
New York	154	21	-0.1	-11.13
North Carolina	84	0	-0.3	-9.60
North Dakota	6	0	-0.2	-0.62
Ohio	128	6	-0.3	-11.62
Oklahoma	84	4	-0.2	-2.81
Oregon	34	5	-0.3	-2.64
Pennsylvania	150	3	-0.3	-16.09
Puerto Rico	51	10	0.2	0.38
Rhode Island	11	0	-0.4	-1.56
South Carolina	56	0	-0.3	-4.66
South Dakota	17	0	-0.2	-0.72
Tennessee	91	6	-0.3	-7.25
Texas	310	0	-0.3	-21.42
Utah	33	1	-0.3	-1.49
Vermont	6	0	-0.2	-0.44
Virginia	73	1	-0.2	-6.70
Washington	48	3	-0.2	-4.36
West Virginia	29	3	-0.1	-0.46
Wisconsin	66	7	-0.2	-3.57
Wyoming	10	0	-0.1	-0.18

The following table identifies those MS-DRGs with 100,000 or more discharges (from tables 5 and 7B).

LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS-DRGS), RELATIVE WEIGHTING FACTORS—FY 2018 Proposed Rule				
MS-DRG	MS-DRG Title	Proposed FY 2018 Weights	Final FY 2017 Weights	Percentage Change
65	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC OR TPA IN 24 HRS	1.0330	1.0431	-0.97%
189	PULMONARY EDEMA & RESPIRATORY FAILURE	1.2265	1.2135	1.07%
190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	1.1573	1.1481	0.80%
193	SIMPLE PNEUMONIA & PLEURISY W MCC	1.3795	1.3860	-0.47%
194	SIMPLE PNEUMONIA & PLEURISY W CC	0.9344	0.9469	-1.32%
291	HEART FAILURE & SHOCK W MCC	1.4825	1.4796	0.20%

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LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS-DRGS), RELATIVE WEIGHTING FACTORS—FY 2018 Proposed Rule				
MS-DRG	MS-DRG Title	Proposed FY 2018 Weights	Final FY 2017 Weights	Percentage Change
292	HEART FAILURE & SHOCK W CC	0.9610	0.9574	0.38%
378	G.I. HEMORRHAGE W CC	0.9744	0.9860	-1.18%
392	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	0.7576	0.7402	2.35%
470	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	2.0473	2.0671	-0.96%
603	CELLULITIS W/O MCC	0.8559	0.8445	1.35%
682	RENAL FAILURE W MCC	1.4921	1.4989	-0.45%
683	RENAL FAILURE W CC	0.9297	0.9191	1.15%
690	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	0.7940	0.7777	2.10%
871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	1.8410	1.7660	4.25%
872	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W/O MCC	1.0591	1.0283	3.00%

These 16 MS-DRGs contain 3.2 million discharges or approximately 33.0 percent of the 9.5 million MS-DRG discharges.

Two MS-DRGs that had more than 100,000 dropped below the 100,000 mark this year – MS-DRG 191 Chronic Obstructive Pulmonary Disease w MCC, and MS-DRG 641 – Misc Disorders of Nutrition, Metabolism, Fluids, Electrolytes w/o MCC.

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

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