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Regulatory Advisor Volume Three

CMS Releases 2017 Proposed Rule for Inpatient Prospective Payment System (IPPS)

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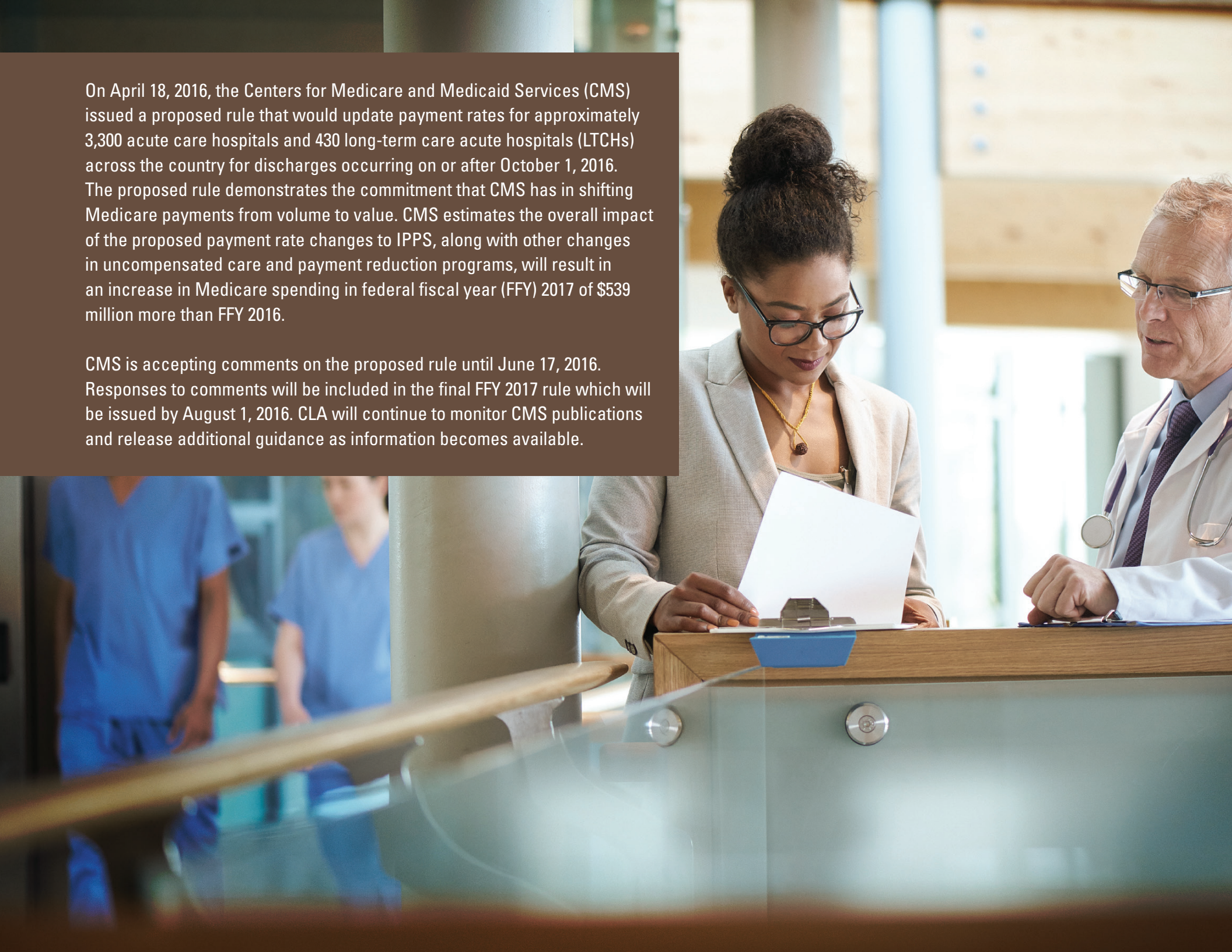
On April 18, 2016, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule that would update payment rates for approximately 3,300 acute care hospitals and 430 long-term care acute hospitals (LTCHs) across the country for discharges occurring on or after October 1, 2016. The proposed rule demonstrates the commitment that CMS has in shifting Medicare payments from volume to value. CMS estimates the overall impact of the proposed payment rate changes to IPPS, along with other changes in uncompensated care and payment reduction programs, will result in an increase in Medicare spending in federal fiscal year (FFY) 2017 of $539 million more than FFY 2016.

CMS is accepting comments on the proposed rule until June 17, 2016. Responses to comments will be included in the final FFY 2017 rule which will be issued by August 1, 2016. CLA will continue to monitor CMS publications and release additional guidance as information becomes available.



Proposed payment rate changes to IPPS

The rule proposes to increase payment rates for inpatient services by a net 0.85 percent increase in reimbursement. The increase is the net result after CMS applies the changes for market basket conditions and various provisions of the Affordable Care Act (ACA) and recoups estimated overpayments due to coding and documentation as outlined in the American Tax Relief Act of 2012 (ATRA):

- Hospital market basket increase 2.8%
- ACA mandated reduction to market basket increase -0.75%
- ACA mandated multi-factor productivity adjustment -0.50%
- ATRA documentation and coding recoupment -1.50%
- Removal of adjustment to offset estimated costs of two-midnight rule +0.80%

The published proposed standardized amount tables reflect a 1.55 percent net increase rather than the 0.85 percent increase in reimbursement as it is only comprised of the hospital market basket increase (2.8 percent) less the ACA mandated multi-factor productivity adjustment (0.50 percent) and ACA mandated reduction to market basket increase (0.75 percent). The table does not reflect the changes to documentation and coding or the two-midnight adjustments.

Hospitals that do not participate in the hospital inpatient quality reporting program (IQR) or submit required quality data will be subject to a one-fourth reduction (0.70 percent) to the market basket rate. Hospitals that are not an electronic health records (EHR) meaningful user will be subject to a three-fourths reduction (2.1 percent) to the market basket rate.

Table 1A. Proposed National Adjusted Operating Standardized Amounts; Labor/Nonlabor (69.6 Percent Labor Share/30.4 Percent Nonlabor Share If Wage Index Greater Than 1)

Hospital Submitted Quality Data and Is Meaningful EHR User (Update = 1.55 percent)		Hospital Submitted Quality Data Is NOT Meaningful EHR User (Update = -0.55 percent)		Hospital Did NOT Submit Quality Data and Is a Meaningful EHR User (Update = 0.85 percent)		Hospital Did NOT Submit Quality Data and Is NOT a Meaningful EHR User (Update = -1.25 percent)	
Labor-related	**Nonlabor-related**	**Labor-related**	**Nonlabor-related**	**Labor-related**	**Nonlabor-related**	**Labor-related**	**Nonlabor-related**
$3,836.20	$1,675.59	$3,756.87	$1,640.94	$3,809.76	$1,664.04	$3,730.43	$1,629.39

Table 1B. Proposed National Adjusted Operating Standardized Amounts, Labor/Nonlabor (62 Percent Labor Share/38 Percent Nonlabor Share If Wage Index Less Than or Equal to 1)

Hospital Submitted Quality Data and Is Meaningful EHR User (Update = 1.55 percent)		Hospital Submitted Quality Data Is NOT Meaningful EHR User (Update = -0.55 percent)		Hospital Did NOT Submit Quality Data and Is a Meaningful EHR User (Update = 0.85 percent)		Hospital Did NOT Submit Quality Data and Is NOT a Meaningful EHR User (Update = -1.25 percent)	
Labor-related	**Nonlabor-related**	**Labor-related**	**Nonlabor-related**	**Labor-related**	**Nonlabor-related**	**Labor-related**	**Nonlabor-related**
$3,417.31	$2,094.48	$3,346.64	$2,051.17	$3,393.76	$2,080.04	$3,323.09	$2,036.73

Table 1D. Proposed Capital Standard Federal Payment Rate

	Rate
National	$446.35

ACA adjustments

The ACA contains mandatory reductions to annual market basket increases and applies productivity factor adjustments to ensure health care providers are keeping pace with productivity changes in other industries. These provisions have been in effect since the inception of the ACA in March 2010. For FFY 2017, the scheduled reduction to the market basket increase is 0.75 percent.

The ACA mandated the use of the 10-year moving average of the "private non-farm business multifactor productivity" indicator to also reduce annual market basket increases. The FFY 2017 0.50 percent reduction is intended to encourage improvements in health care delivery efficiency by using this offset throughout all of annual payment updates.

ATRA adjustments

In FFY 2008, the transition from diagnosis related groups (DRG) to Medicare severity diagnosis related groups (MS-DRG) provided a better accounting of severity of illness and resource consumption for Medicare patients. As a result of the change to MS-DRGs, CMS estimated the impact of artificial documentation and coding overpayments to be $11 billion. For FFYs 2014, 2015, and 2016, CMS reduced the annual market basket by 0.8 percent to recoup the documentation and coding overpayments. FFY 2017 is the last year for recoupment. For FFY 2017, CMS is proposing a reduction of 1.50 percent

to the market basket rate as they estimate $5.08 billion of the original $11 billion must be recouped in this final year.

Two-midnight adjustments

CMS adopted the two-midnight rule effective for admissions beginning on or after October 1, 2013. In general, the rule stated that inpatient admissions would be payable under the IPPS if the admitting provider documented that the patient would require a hospital stay which spanned two midnights. As a result, CMS expected that this policy would increase expenditures and made an adjustment to reduce the market basket by 0.2 percent for FFYs 2014, 2015, and 2016. In the FFY 2017 proposed rule, CMS is reversing their decision on this adjustment. They are proposing to increase the market basket by 0.8 percent in FFY 2017 rather than handle the change retrospectively.

Hospital inpatient quality reporting program

The IQR was originally mandated as part of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. It requires hospitals to report on IQR measures in order to receive the full annual update to the standardized amounts. As with most Medicare quality programs, payment determination is based on historical data. The measures in the IQR program are fairly fluid as certain "topped out" measures are removed when hospitals perform well and meaningful improvements can no longer be made.

FFY 2018 IQR changes for payment determination

CMS is proposing refinements to two claims-based measures effective with FFY 2018 payment determination. The first refinement relates to PN payment: Hospital-level, risk-standardized 30-day episode-of-care payment measure for pneumonia. The second refinement impacts PSI 90: Patient safety and adverse events composite.

The proposed refinement to PN payment would expand the hospitalizations included in this measure. The expanded cohort would now include patients with a principal discharge diagnosis of viral, bacterial, and aspirational pneumonia, as well as sepsis with a secondary diagnosis of viral, bacterial, and aspirational pneumonia present on admission. CMS believes that this would align this measure with others related to pneumonia (MORT-30-PN, READM-30-PN, and proposed PN excess days).

CMS is proposing a change to the performance period for the PSI 90 composite in FFY 2018 due to the change from ICD-9 to ICD-10. For the FFY 2018 period, CMS proposes using a reporting period from July 1, 2014, through September 30, 2015.

FFY 2019 IQR changes for payment determination

CMS is proposing to remove the following 15 measures for FFY 2019 payment determination:

- AMI-2: Aspirin prescribed at discharge for AMI
- AMI-7a: Fibrinolytic therapy received within 30 minutes of hospital arrival
- AMI-10: Statin prescribed at discharge
- HTN: Healthy term newborn
- PN-6: Initial antibiotic selection for community-acquired pneumonia in immunocompetent patients
- SCIP-Inf-1a: Prophylactic antibiotic received within one hour prior to surgical incision
- SCIP-Inf-2a: Prophylactic antibiotic selection for surgical patients
- SCIP-Inf-9: Urinary catheter removed on postoperative day one or postoperative day two with day of surgery being zero
- STK-4: Thrombolytic therapy
- VTE-3: Venous thromboembolism patients with anticoagulation overlap therapy
- VTE-4: Venous thromboembolism patients receiving unfractionated heparin with dosages/platelet count monitoring by protocol (or nomogram)
- VTE-5: Venous thromboembolism discharge instructions
- VTE-6: Incidence of potentially preventable venous thromboembolism (only removing this measure in electronic form)
- Participation in a systematic clinical database registry for nursing sensitive care
- Participation in a systematic clinical database registry for general surgery

The performance period will change for the PSI 90 composite in FFY 2019 due to the change from ICD-9 to ICD-10. For the FFY 2019 period, CMS proposes using a reporting period from October 1, 2015, through June 30, 2017.

For the FFY 2019 payment period, CMS has proposed adding three clinical episode-based payments and one outcome measure as follows:

- Aortic aneurysm procedure clinical episode-based payment (AA payment) measure
- Cholecystectomy and common duct exploration clinical episode-based payment (Chole and CDE payment) measure
- Spinal fusion clinical episode-based payment (SFusion payment) measure
- Excess days in acute care after hospitalization for pneumonia

Proposed changes to policies on reporting electronic clinical quality measures (eCQMs)

CMS is proposing two changes to policies on reporting eCQMs, which would increase reporting. CMS would require reporting of all eCQMs in the IQR measure set for a full calendar year (CY) of data for the CY 2017 reporting period, which would correlate to the FFY 2019 payment determination. The requirement to report four quarters of data would align with the Medicare and Medicaid EHR incentive programs.

Possible future quality measures

CMS is soliciting input on new quality measures currently under consideration:

- Refinement of stroke scale for the hospital 30-day mortality following acute ischemic stroke hospitalization measure
- New measure of National Healthcare Safety Network (NHSN) antimicrobial use measure
- New measure of behavioral health for the inpatient hospital setting

Hospital acquired conditions (HACs) reduction program

Section 3008 of the ACA requires CMS to make an adjustment to hospital payments effective October 1, 2014, for hospitals with HAC scores in the worst performing quartile relative to other hospitals in a fiscal year. Penalized hospitals will receive a per-discharge payment equal to 99 percent of the payment that would have otherwise applied after the hospital readmissions reduction program (HRRP) and value-based purchasing (VBP) program adjustments. This adjustment applies to total hospital payments, not just the base DRG payment amount.

FFY 2017 HAC proposed changes

In the FFY 2014 IPPS final rule, CMS finalized that hospitals in FFY 2017 would receive performance scores on two domains, each with multiple measures with a performance look-back period of two years. Patient safety indicators (PSI) is domain one with weighting of 15 percent and a performance measure period from July 1, 2013, through June 30, 2015. Hospital acquired infections (HAI) is domain two with weighting of 85 percent and performance measurement period from January 1, 2014, through December 31, 2015. CMS anticipates being able to provide hospitals with their hospital-specific reports used in the calculation of the FFY 2017 HAC score in late summer of 2016 via the QualityNet secure portal. Hospitals will have 30 days after the information is posted to review and submit corrections.

CMS issued a proposed clarification as to what constitutes complete data requirements for domain one. The complete data requirements are proposed to mean that a hospital has three or more eligible discharges for at least one component indicator and 12 months or more of data to receive a domain one score. This is a change to add the timeframe of 12 months or more of data to the definition for domain one. If a hospital does not have enough complete data to calculate a PSI 90 score in domain one, the entire HAC score will depend on its domain two score. Conversely, if a hospital has enough complete data to arrive at a domain one score but not a domain two score, the entire HAC score will depend on its domain one score.

Future HAC proposed changes

Beginning with FFY 2018 payment determination, proposed changes to the domain one PSI 90 measures are being considered. The name of the PSI 90 measures has changed to “patient safety and adverse events composite” and will be referred to as “modified PSI 90.” The modified PSI 90 measures add three indicators to the original eight indicators. It is based not only on the volume of each of the patient safety and adverse events, but also the harms associated with the events:

- PSI 3: Pressure ulcer rate
- PSI 6: Iatrogenic pneumothorax rate
- PSI 7: Central venous catheter-related blood stream infections rate (removed)
- PSI 8: Postoperative hip fracture rate
- PSI 12: Perioperative pulmonary embolism/deep vein thrombosis rate (respecified)

- PSI 13: Postoperative sepsis rate
- PSI 14: Postoperative wound dehiscence rate
- PSI 15: Accidental puncture and laceration rate (respecified)
- PSI 9: Perioperative hemorrhage or hematoma rate (new)
- PSI 10: Physiologic and metabolic derangement rate (new)
- PSI 11: Postoperative respiratory failure rate (new)

CMS generally uses 24 months of data in a performance period unless obtaining that data is not operationally feasible. A risk adjustment is necessary to adjust the transition of claims between ICD-9 and ICD-10 for domain one. As the risk adjustment data would not be available until a later date, CMS is proposing using the performance period for domain one for FFY 2018 of July 1, 2014 through September 30, 2015. For the FFY 2019 HAC reduction program, CMS proposes a domain one performance period of October 1, 2015, through September 30, 2017. The domain two performance periods would continue to be January 1, 2015, through December 31, 2016, for FFY 2018 and January 1, 2016, through December 31, 2017, for FFY 2019.

Another proposed change affects the HAC scoring methodology from a decile-based methodology to the Winsorized Z-score method. Z-scores represent a hospital's distance from the national mean for a measure in units of standard deviations. Under this methodology, a positive score would reflect a poorer performing hospital while a negative score would reflect a higher performing hospital. The Z-score for each measure is calculated as follows:

$$\text{Z-Score} = \frac{\text{(Hospital's Measure Performance - Mean Performance for All Hospitals)}}{\text{Standard Deviation for All Hospitals}}$$

CMS feels that the use of Z-scores is a better representation of hospital performance. Based upon FFY 2016 data, the Z-score approach would affect the penalty status of just over 200 hospitals.

Hospital value-based purchasing

As part of the ACA, value-based purchasing provided incentive payments to hospitals that meet or exceeded performance standards. Incentive payments are budget neutral in that they will be equal to the total amount of payment reductions for all participating for the fiscal year as estimated by CMS. For FFY 2017, 2 percent of base DRG payments or approximately $1.7 billion is available for value-based incentive payments.

CMS addressed hospital concerns as to the role that socio-demographic status plays in the care of patients and the impact it has on the VBP measures. Currently, a risk-adjustment is incorporated into the scoring of appropriate measures that accounts for age and comorbidities. CMS is concerned about holding hospitals to different standards based upon the socio-demographic status of their patient population. CMS monitors the impact of socio-demographic status on hospitals in their VBP measures. Currently, the National Quality Forum (NQF) is conducting a 2-year trial to determine whether new measures and measures undergoing maintenance review should be risk-adjusted for socio-demographic factors. Also, as part of the IMPACT Act, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) is conducting research to examine the impact of socio-demographic status on quality measures and resource use. The lack of adjustment for socio-demographic status continues to be a concern for many hospitals.

FFY 2018 VBP proposed changes

CMS is proposing a change to the performance period for the PSI 90 composite in FFY 2018 due to the change from ICD-9 to ICD-10. The table below reflects the change to the shortened period.

Hospital VBP Program Domain	2018 Domain Weighting	2018 Baseline Period	2018 Performance Period
Patient and Caregiver Centered Experience of Care/Care Coordination	25%	1/1/14 to 12/31/14	1/1/16 to 12/31/16
Efficiency and Cost	25%	1/1/14 to 12/31/14	1/1/16 to 12/31/16
Clinical Care	25%	10/1/09 to 6/30/12	10/1/13 to 6/30/16
Safety	25%	See Below	See Below
- AHRQ PSI 90 Composite (Revised)		7/1/10 to 6/30/12	7/1/14 to 9/30/15
- PC-01		1/1/14 to 12/31/14	1/1/16 to 12/31/16
- HAI Measures		1/1/14 to 12/31/14	1/1/16 to 12/31/16

FFY 2019 VBP proposed changes

The first proposed change relates to a domain name change from "patient and caregiver centered experience of care/care coordination" to "person and community engagement." The second proposed change would include selected ward (non-ICU) locations in the catheter-associated urinary tract infection (CAUTI) and central line-associated bloodstream infection (CLABSI) outcome measures in the safety domain. The baseline and performance period for FFY 2019 would be as follows:

Hospital VBP Program Domain	2019 Domain Weighting	2019 Baseline Period	2019 Performance Period
Person and Community Engagement	25%	1/1/15 to 12/31/15	1/1/17 to 12/31/17
Efficiency and Cost	25%	1/1/15 to 12/31/15	1/1/17 to 12/31/17
Clinical Care	25%	See Below	See Below
- Mortality		7/1/09 to 6/30/12	7/1/14 to 6/30/17
- THA/TKA		7/1/10 to 6/30/13	1/1/15 to 6/30/17
Safety	25%	See Below	See Below
- AHRQ PSI 90 Composite (Revised)		7/1/11 to 6/30/13	7/1/15 to 6/30/17
- PC-01		1/1/15 to 12/31/15	1/1/17 to 12/31/17
- HAI Measures		1/1/15 to 12/31/15	1/1/17 to 12/31/17

CMS' previously adopted and newly proposed measure set for the FFY 2019 program year would be as follows:

Previously Adopted Measures and Newly Proposed Measure Refinements for FY 2019		
Domain	**Short Name**	**Domain/Measure Name**
Person and Community Engagement (Previously Patient and Caregiver Centered Experience of Care/Care Coordination	HCAHPS	HCAHPS + 3-Item Care Transition Measure
Clinical Care	Mort-30-AMI	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (AMI) Hospitalization
	Mort-30-HF	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Heart Failure (HF) Hospitalization
	Mort-30-PN	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Pneumonia Hospitalization
	THA/TKA	Hospital 30-Day, All-Cause, Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)
Safety	CAUTI	National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure
	CLABSI	National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure
	Colon and Abdominal Hysterectomy SSI MRSA Bacteremia	American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant Staphylococcus Aureus (MRSA) Bactermia Outcome Measure
	CDI	National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset Clostridium Difficile Infection (CDI) Outcome Measure
	PSI 90	Patient Safety for Selected Indicators (Composite Measure)
	PC-01	Elective Delivery
Efficiency and Cost Reduction	MSPB	Payment-Standardized Medicare Spending Per Beneficiary (MSBP)

FY 2021 VBP proposed changes

CMS is recommending changes to FFY 2021 existing measures along with adding new measures. CMS is proposing to change the existing measure for hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following pneumonia hospitalization for FFY 2021. Historically, only certain diagnoses were included in the set of hospitalizations included in the calculation. CMS would like to broaden the measure cohort to include the complete patient population receiving clinical management and treatment for pneumonia. The baseline period would run from July 1, 2012, through June 30, 2015, with a performance period of August 1, 2017, through June 30, 2019.

CMS would also like to add condition-specific or treatment-specific program measures for the FFY 2021 program year to facilitate a better understanding of service utilization and costs associated with conditions of treatment. The following additional measures are proposed due to the historical large variation in payment for high-volume conditions. The baseline period for FY 2021 for both measures would run from July 1, 2012, through June 30, 2015, with a performance period of July 1, 2017, through June 30, 2019.

1. Hospital-level, risk-standardized payment associated with 30-day episode-of-care for acute myocardial infarction (AMI) to be added to the efficiency and cost reduction domain
2. Hospital-level, risk-standardized payment associated with 30-day episode-of-care for heart failure (HF) to be added to the efficiency and cost reduction domain

FY 2022 VBP proposed changes

One new measure for FFY 2022 is for a hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following coronary artery bypass graft (CABG) surgery. CABG will be added because of the large volume and concerns over high morbidity, mortality, and health care spending. This measure would be added to the clinical care domain.

Proposed immediate jeopardy policy changes

The hospital VBP program applies to subsection (d) hospitals, but excludes hospitals with "cited deficiencies that pose immediate jeopardy to the health or safety of patients." Historically, CMS excluded hospitals with at least two Form CMS-2567 Statement of Deficiencies and Plan of Correction surveys. CMS is proposing to change the number of survey citations to at least three effective October 1, 2016.

Hospital readmissions reduction program

As part of Section 3025 of the ACA, hospitals with excess readmissions will receive a payment reduction effective for discharges on or after October 1, 2012. The maximum reduction for FFY 2017 is 3 percent of the base MS-DRG and is based upon hospital-specific retrospective data compared to the national average. Public reporting of excess readmissions ratios will be posted on Hospital Compare annually. As with the VBP program, hospitals have concerns about the socio-demographic impact on the HRRP measures. CMS will consider the evaluations and recommendations by the NQF and ASPE when available.

The HRRP for FFY 2017 includes tracking 30-day readmissions for the following measures over the three-year measurement period of July 1, 2012, through June 30, 2015:

- Heart failure (HF)
- Pneumonia (PN)
- Acute myocardial infarction (AMI)
- Chronic obstructive pulmonary disease (COPD)
- Total hip and total knee arthroplasties (THA/TKA)
- Coronary artery bypass grafts (CABG)

Wage index

The proposed FFY 2017 wage index values are derived from cost reporting periods beginning in FY 2013 adjusted by an occupational mix factor based upon the 2013 occupational mix survey. The proposed FFY 2017 national average hourly wage (unadjusted for occupational mix) is $41.1026. The proposed FFY 2017 national average hourly wage (adjusted for occupational mix) is $41.0651.

The wage index is determined based upon the core-based statistical area (CBSA) in which the hospital is located or reclassified. Generally, CBSAs are revised every 10 years based upon census results. Changes may be made outside of that timeframe. The following proposed changes will impact the IPPS wage index in FFY 2017:

- New CBSA 21420 (Enid, OK): added Garfield County, OK to new CBSA 21420
- Revised CBSA 31420 (Macon-Bibb, GA): renamed CBSA from Macon, GA to Macon-Bibb, GA

CMS collected calendar year 2013 data to compute the occupational mix adjustment. The 2013 survey is used to adjust the occupational mix for FFYs 2016, 2017, and 2018. CMS is required to collect similar data every three years. A new survey will be required to set the occupational mix for FFY 2019. The FFY 2019 occupational mix adjustment will be based on a new calendar year 2016 survey. The new survey forms are awaiting approval by OMB but can be viewed at http://www.reginfo.gov/public/do/PRAViewICR?ref_nbr=201512-0938-011.

Hospital redesignation and reclassification

Hospitals may request a geographic reclassification from the Medicare Geographic Classification Review Board (MGCRB) no later than 13 months prior to the start of the fiscal year for which reclassification is sought. In general, hospitals must be in proximate location and possess similar characteristics to the labor market and hospitals in the area in which it wishes to reclassify.

CMS is proposing to revise the regulations to make it easier to submit a MGCRB application. The proposal specifies that an MGCRB application for FFY 2018 and forward must be submitted to the MGCRB according to the method prescribed by the MGCRB, with an electronic copy of the application sent to CMS. (The current method prescribed by the MGCRB is by mail or delivery). CMS copies should be sent via email to wageindex@cms.hhs.gov.

CMS also made regulatory changes in order to implement the decisions in the Geisinger Community Medical Center v. Secretary, United States Department of Health and Human Services and Lawrence + Memorial Hospital v. Burwell court cases in a nationally consistent manner. The change removes the regulatory provision to allow hospitals nationwide to reclassify based on their acquired rural status, effective with reclassifications beginning with FFY 2018. This ruling also gives hospitals with an existing MGCRB reclassification the opportunity to seek rural reclassification for IPPS payment and other purposes and keep their existing MGCRB reclassification. CMS is proposing that this date for ''locking in'' hospitals with rural status achieved under § 412.103 would be the second Monday in June of each year, which requires that the hospital must file its application with CMS regional office no later than 70 days prior to the second Monday in June.

Stakeholder input on overhead and home office costs in the wage index calculation

CMS is soliciting comments to better understand hospitals' reporting of overhead and home office costs in the wage index calculation. Specifically, CMS is concerned about the inconsistent reporting of wage-related costs and home office salaries and wage-related costs.

Hospital wage-related costs are reported on Worksheet S–3, Part IV, and CMS wants to ensure that they are properly handling those costs associated with overhead areas. Currently, CMS estimates and removes overhead wage-related costs associated with excluded areas from the wage index calculation. They want input as to statistical allocation methods used to allocate wage-related costs and suggestions for possible modifications for more consistent and appropriate determination of overhead excluded wage-related costs.

CMS would also like stakeholder input on home office salaries and wage-related costs. CMS believes there is inconsistent and improper reporting of home office salaries and wage-related costs on Worksheet S-3, Part II, line 14, especially as it relates to overhead and excluded areas. CMS is considering ending the reporting on line 14 and may require reporting home office costs as part of overhead lines.

Medicare disproportionate share (DSH)

Section 3133 of the ACA outlines a methodology for calculating Medicare DSH payments that are intended to reflect the change in the percentage of individuals under age 65 who are uninsured as a result of coverage expansion beginning January 1, 2014.

Beginning with discharges on October 1, 2013, eligible hospitals will have their DSH payments reduced to 25 percent of the payment they would have normally received under current formulas. CMS refers to this payment as the "empirically justified payment." The remaining 75 percent will be reduced to reflect the change in the percentage of individuals who are uninsured and under age 65, then redistributed to hospitals in the form of an additional DSH payment. This payment will be based on each hospital's amount of uncompensated care for a specific period relative to the total uncompensated care by all hospitals during that period. The annual determined pool of payments is estimated to decrease by $400 million from the FFYE 2016 pool.

Formula guiding additional DSH payments

Each hospital's additional DSH payment will be the product of three factors, which are outlined below.

- **Factor one:** CMS Office of the Actuary estimated total DSH payments for all hospitals, minus the 25 percent that will be distributed as "empirically justified" payments. According to CMS, the total estimated DSH payments for 2017 equate to approximately $14.2 billion. Factor one would be determined as follows:

Factor One: Pool for Additional DSH Payments	
Variable Description	**DSH Pool**
CMS Office of Actuary Estimated 2015 DSH Payments	14,227,372,794
Less: 75 percent reduction (DSH pool withheld to be used as factor one)	(10,670,529,596)
Empirically justified DSH payments FFY 2017 for all hospitals	3,556,843,199
Remaining DSH amount for factor one	10,670,529,596

- **Factor two:** This factor will identify the change in uninsured from a baseline time period to 2017, which will represent the most recently available estimate prior to coverage expansion. The data will be calculated using the Congressional Budget Office (CBO) estimate of uninsured population from 2013 as 18 percent as the baseline, compared to their most recent estimate from 2016 of 10.25 percent.

Factor Two: Estimated Change in Uninsured Population	
Variable Description	**Percent**
CY 2016 Rate of Insurance Coverage	89.00%
CY 2017 Rate of Insurance Coverage	90.00%
FY 2016 Rate of Insurance Coverage	89.75%
Percent of Individuals Without Insurance 2017	10.25%
Percent of Individuals Without Insurance 2013	18.00%
CBO Estimated Percent Change in Uninsured	56.94%
Additional Reduction Per ACA	-.20%
Factor two	56.74%

Uncompensated Care Pool	
Variable Description	**DSH Pool**
Remaining DSH amount for factor one	10,670,529,296
Factor two	56.74%
FY 2017 Uncompensated Care Amount	6,054,458,492.68

- **Factor three:** The final factor used in the calculation will reflect a hospital's specific portion of uncompensated care as a percent of uncompensated care provided by all hospitals. CMS is proposing new policies in relation to the factor three calculation in FFY 2017. Historically, CMS has used one year of data to determine factor three. For FFY 2017, the factor three calculation will use three years of Medicaid days from cost reports in FFYs 2011, 2012, and 2013, along with three years of supplemental security income (SSI) published days from FFYs 2012, 2013, and 2014.

Effective with FFY 2018, CMS is also proposing to determine factor three by using cost report Worksheet S-10 uncompensated care data rather than the historic use of Medicaid and SSI days. For example, for FFY 2018, CMS would use days for two of the three periods, and uncompensated care data for the third period. The FFY 2019 factor three would use days for one of the three periods, and uncompensated care data for two periods. The FFY 2020 factor three would represent the use of only three periods of uncompensated care data.

In addition, the uncompensated care definition would only include bad debts and charity care. CMS has proposed a revision to the cost report instructions for Worksheet S-10 that require charity care to be reported in the year of the write-off rather than the current cost reporting period.

CMS would allow hospitals to work with Medicare administrative contractors (MACs) to correct any inaccurate data on Worksheet S-10. CMS has indicated that they will publish FFY 2013 Worksheet S-10 data in a public use file (PUF) similar to wage index. There are a several unanswered questions about this process such as, whether the MAC will audit this data, provide a review process, or offer better guidance as to what should be reported as charity care and bad debts.

Graduate medical education (GME) and indirect medical education (IME) costs

Hospitals which begin training residents in new programs for the first time on or after October 1, 2012, are given a five-year window to establish and grow the new programs. Effective with the beginning of the cost reporting period that coincides with or follows the sixth program year of the first new program, a cap will be established for both GME and IME in order to control medical education spending.

To encourage training of residents in rural areas, CMS allows for an addition to the cap for urban hospitals which establishes a medical residency training program in a rural area. When making the regulatory changes, CMS changed the GME growth period from three to five years but inadvertently missed the change in the IME growth period. The FFY 2017 proposes to adjust the IME growth period to five years.

Proposed payment adjustment for low-volume hospitals

The ACA and ATRA adjusted the criteria for qualification to receive additional payments from Medicare for those hospitals considered to have low-volume. The original ACA adjustment criteria expired on September 30, 2012, but was extended by the ATRA and additional Congressional action.

To qualify for low-volume adjustment in FFY 2017, hospitals have to meet the following criteria:

1. Be a subsection (d) hospital
2. Be more than 15 road miles from another subsection (d) hospital
3. Have less than 1,600 discharges of individuals entitled to, or enrolled for, benefits under Medicare Part A during the fiscal year

The low-volume payment adjustment has been extended through September 30, 2017. If a hospital qualifies or continues to qualify for the low-volume adjustment, the MAC must be notified in writing by September 1, 2016.

Medicare dependent hospitals (MDH)

Section 205 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) extended the MDH program through FFY 2017. To qualify as a MDH hospital, the following criteria must be met:

1. Be a subsection (d) hospital located in a rural area;
2. Is not classified as a sole community hospital (SCH)
3. During the cost reporting period beginning in FY 1987, or two of the three most recently audited cost reports, not less than 60 percent of its inpatient days or discharges must be Medicare (which includes Medicare Part C days and discharges)

In the proposed rule, CMS is clarifying that in order to comply with the 60 percent Medicare threshold, hospitals may use logs to substantiate the Medicare Part C days and discharges if they do not have IME, GME, or DSH. Per the proposed rule, there is no requirement for hospitals to shadow bill Medicare Part C claims with the absence of these additional payments.

Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act)

On August 6, 2015, the NOTICE Act began requiring hospitals and critical access hospitals (CAHs) to provide written notification and an oral explanation to individuals receiving observation services as outpatients for more than 24 hours. The effective date for the notification requirement is August 6, 2016.

CMS is proposing the use of a standardized notice referred to as Medicare outpatient observation notice (MOON), which explains the implications of receiving outpatient observation care. Notification must be provided to all individuals entitled to benefits under Title XVIII of the Social Security Act. Notification should be no later than 36 hours after observation services are initiated or sooner if the individual is transferred, discharged, or admitted as an inpatient. CMS expects hospitals and CAHs to employ normal practices, similar to the provision of advance beneficiary notice of non-coverage (ABN), to ensure patient comprehension of the MOON. The MOON must be signed by the individual receiving observation services or by somebody acting on the individual's behalf along with the staff member who presents the MOON to the individual.

Conclusion

The health care industry is in the midst of tremendous change. Access to accurate information is the first step in positioning your organization for future success. The CLA Regulatory Advisor keeps you informed as new legislation is enacted.

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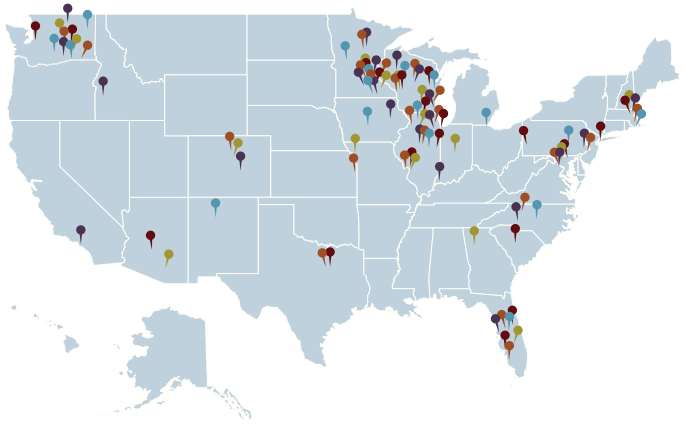

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