DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 412, 413, 414, 416, 486, 488, 489, and 495

[CMS–1677–P]

RIN 0938–AS98

Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices

AGENCY: Centers for Medicare and Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: We are proposing to revise the Medicare hospital inpatient prospective payment systems (IPPS) for operating and capital-related costs of acute care hospitals to implement changes arising from our continuing experience with these systems for FY 2018. Some of these proposed changes would implement certain statutory provisions contained in the Pathway for Sustainable Growth Rate (SGR) Reform Act of 2013, the Improving Medicare Post-Acute Care Transformation Act of 2014, the Medicare Access and CHIP Reauthorization Act of 2015, the 21st Century Cures Act, and other legislation. We also are making proposals relating to the provider-based status of Indian Health Service (IHS) and Tribal facilities and organizations and to the low-volume hospital payment adjustment for hospitals operated by the IHS or a Tribe. In addition, we are providing the proposed estimated market basket update that would apply to the rate-of-increase limits for certain hospitals excluded from the IPPS that are paid on a reasonable cost basis subject to these limits for FY 2018. We are proposing to update the payment policies and the annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs) for FY 2018.

In addition, we are proposing to establish new requirements or revise existing requirements for quality reporting by specific Medicare providers (acute care hospitals, PPS-exempt cancer hospitals, LTCHs, and inpatient psychiatric facilities). We also are proposing to establish new requirements or revise existing requirements for eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) participating in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. We are proposing to update policies relating to the Hospital Value-Based Purchasing (VBP) Program, the Hospital Readmissions Reduction Program, and the Hospital-Acquired Condition (HAC) Reduction Program.

We also are proposing changes relating to transparency of accrediting organization survey reports and plans of correction of providers and suppliers; electronic signature and electronic submission of the Certification and Settlement Summary page of the Medicare cost reports; and clarification of provider disposal of assets.

DATES: *Comment Period:* To be assured consideration, comments must be received at one of the addresses provided in the **ADDRESSES** section, no later than 5 p.m. EDT on June 13, 2017.

ADDRESSES: In commenting, please refer to file code CMS–1677–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (no duplicates, please):

1. *Electronically.* You may (and we encourage you to) submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the instructions under the ''submit a comment'' tab.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1677–P, P.O. Box 8011, Baltimore, MD 21244–1850.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments via express or overnight mail to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1677–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:

a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, please call the telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, we refer readers to the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT:

Donald Thompson, (410) 786–4487, and Michele Hudson, (410) 786–4487, Operating Prospective Payment, MS–DRGs, Wage Index, New Medical Service and Technology Add-On Payments, Hospital Geographic Reclassifications, Graduate Medical Education, Capital Prospective Payment, Excluded Hospitals, Sole Community Hospitals, Medicare Disproportionate Share Hospital (DSH) Payment Adjustment, Medicare-Dependent Small Rural Hospital (MDH) Program, and Low-Volume Hospital Payment Adjustment Issues.

Michele Hudson, (410) 786–4487, Mark Luxton, (410) 786–4530, and Emily Lipkin, (410) 786–3633, Long-Term Care Hospital Prospective Payment System and MS–LTC–DRG Relative Weights Issues.

Mollie Knight, (410) 786–7948, and Bridget Dickensheets, (410) 786–8670, Rebasing and Revising the Hospital Market Basket Issues.

Siddhartha Mazumdar, (410) 786–6673, Rural Community Hospital Demonstration Program Issues.

its Web site within 90 days after such information is made available to those facilities for the most recent 3 years. This provision would include all triennial, full, follow-up, focused, and complaint surveys, whether they are performed onsite or offsite.

In addition, pursuant to section 1834(e) of the Act, State Survey Agencies do not evaluate suppliers of the technical component of advanced diagnostic imaging services. CMS-approved advanced diagnostic imaging AOs are the only source of compliance data for suppliers of the technical component of advanced diagnostic imaging services. Therefore, we believe it is critical that these AOs also be required to post survey reports and acceptable PoCs on their Web sites. Otherwise, it will not be possible to provide health care consumers with compliance information about Medicare-participating suppliers of advanced diagnostic imaging services. We are proposing to amend our regulations at 42 CFR 414.68 governing imaging accreditation under Medicare by redesignating paragraphs (c)(7) through (c)(14) as paragraphs (c)(8) through (c)(15), respectively, and adding a new paragraph (c)(7) to require that each national advanced diagnostic imaging AO that applies or reapplies for CMS approval of its Medicare advanced diagnostic imaging accreditation program must provide a statement acknowledging that it agrees to make all Medicare advanced diagnostic imaging final accreditation survey reports as well as acceptable PoCs publicly available on its Web site within 90 days after such information is made available to the supplier of advanced diagnostic imaging services for the most recent 3 years. This provision would apply to all full, follow-up, focused, and complaint surveys, regardless of whether they are performed onsite or offsite.

We are inviting public comments on these proposals.

B. Proposed Changes to Termination Public Notice Requirements for Certain Providers and Suppliers

1. Background

Under the provisions of sections 1866(b)(2) of the Act and implementing regulations at 42 CFR 489.53, the Secretary may terminate an agreement with a provider of services if it is determined that the provider is not in substantial compliance with applicable requirements governing provider agreements. For instance, CMS must determine that the provider:

- Is not complying substantially with the terms of the agreement, the provisions of title XVIII, or regulations promulgated thereunder;
- Has failed to supply information necessary to determine whether payments are or were due and the amounts of such payments;
- Refuses to permit examination of fiscal and other records (including medical records) necessary for the verification of information furnished as a basis for claiming payment under the Medicare program; or
- Refuses to permit photocopying of any records or other information necessary to determine or verify compliance with participation requirements.

Sections 1866(b)(1) and (2) of the Act require reasonable public notice, as prescribed in regulations, of both voluntary and involuntary terminations of Medicare and Medicaid participating providers and suppliers. Various existing regulations specify the requirements of public notice for voluntary and involuntary terminations prior to termination of a provider or supplier agreement. Specifically, for voluntary terminations, providers at 42 CFR 489.52(c)(2), RHCs at 42 CFR 405.2404(d), FQHCs at 42 CFR 405.2442, ASCs at 42 CFR 416.35(d), and OPOs at 42 CFR 486.312(e) are required to publish termination notices in the local public newspaper.

2. Basis for Proposed Changes

The existing regulations requiring termination notices to be published in local newspapers have become outdated over time as the public and beneficiaries increasingly turn to the Internet and other electronic forums for information. Currently, rural health centers (RHCs), Federally qualified health centers (FQHCs), ambulatory surgical centers (ASCs), and organ procurement organizations (OPOs) are required to publish public notices of voluntary and involuntary termination of participation in the Medicare and Medicaid programs in one or more local newspapers. Providers and suppliers that voluntarily terminate their participation agreement must give notice to the public at least 15 days before the effective date of termination and the notice must be published in one or more local newspapers. The use of hard copy local newspaper through time has become less effective, as a large majority of the public uses alternate sources such as Web sites or other online news and resources.

According to national studies, approximately 23 percent of the general public continues to read print newspapers.[507] Many individuals have turned to digital platforms to read news rather than print news, which continues to decline on an annual basis, therefore, limiting the effectiveness of publishing termination notices in local newspapers. In light of the public's increased access to the Internet and other electronic forums for information and the decline of print newspaper readership, in this proposed rule, we are proposing changes in the existing regulations noted earlier regarding newspaper publication of termination notices to allow CMS Regional Offices and providers and suppliers more media platforms in which to publish termination notices, both voluntary and involuntary, with the intent of making these notices more visible and effective.

3. Proposed Changes to Regulations

In this proposed rule, we are proposing to remove the regulatory language specifying public notice of terminations for FQHCs, RHCs, ASCs, and OPOs to be exclusively in newspapers to allow for more flexibility for both the CMS Regional Offices and providers and suppliers. Specifically, we are proposing changes to the regulations for RHCs at 42 CFR 405.2404(d), for FQHCs at 42 CFR 405.2442(a) and (b), for ASCs at 42 CFR 416.35(d), and for OPOs at 42 CFR 486.312(e) to remove the reference to publication in newspapers as the means for notifying the community of involuntary and voluntary terminations from participation in Medicare and Medicaid programs. This proposal for termination notices to the public for RHCs, FHQCs, ASCs, and OPOs would align with the termination notices CMS currently has set forth for all other providers and suppliers. For example, under 42 CFR 488.456(c) (enforcement procedures for long-term care facilities), CMS must notify the public of a termination of a nursing home's provider agreement, but the regulation does not specify through which public forum this notice is to be given. Similarly, 42 CFR 489.53(d)(5) also does not specify the method of public notification required for terminations. Through this proposed change, RHCs, FQHCs, ASCs, and OPOs would have the same requirement for the notice to the public as under 42 CFR 489.53(d)(5), where there is a termination by CMS in which public notice is required but the method for these providers or suppliers

[507] PewResearchCenter (2012) *Number of Americans Who Read Print Newspapers Continues Decline.* Available at: *http://www.pewresearch.org/daily-number/number-of-americans-who-read-print-newspapers-continues-decline/.*

for providing public notice is not specified, to allow for flexibility.

In addition, we are proposing to revise 42 CFR 489.52(c)(2) to remove the requirement to publish notice in one or more local newspapers in circumstances of the termination of a provider agreement by a provider and instead to allow providers to inform the community via public notice, without specifying the method used for public notice. We believe that these proposed changes will ensure that the community continues to be aware of terminations of Medicare and Medicaid participating providers and suppliers.

The method for delivering the required public notice is no longer being specified by removing the word ''newspaper'' from the regulations for RHCs, FQHCs, ASCs, and OPOs. Instead, we are proposing to allow for flexibility for the CMS Regional Offices and the providers or suppliers to post public notices through a manner in which the maximum number of community individuals and beneficiaries would be informed. This may include, but is not limited to State Web site postings, facility Web sites, or local news and social media channels. It also would not preclude publication in local newspapers. Through this proposed rule, we will continue to fulfill the regulatory requirement to publically post involuntary termination notices. We are also operationally considering allowing voluntarily terminating providers and suppliers the same public notice platform used for involuntary notices in order to meet their regulatory public notice requirements. This could include media venues such as Web site postings and press releases through the use of CMS Regional press officers.

We are inviting public comments on our proposals. In addition, we are seeking suggestions from the public on sufficient mechanisms to provide public information, other than local newspapers, for posting Medicare and Medicaid participating provider and supplier termination notices.

XII. MedPAC Recommendations

Under section 1886(e)(4)(B) of the Act, the Secretary must consider MedPAC's recommendations regarding hospital inpatient payments. Under section 1886(e)(5) of the Act, the Secretary must publish in the annual proposed and final IPPS rules the Secretary's recommendations regarding MedPAC's recommendations. We have reviewed MedPAC's March 2017 ''Report to the Congress: Medicare Payment Policy'' and have given the recommendations in the report consideration in conjunction with the proposed policies set forth in this proposed rule. MedPAC recommendations for the IPPS for FY 2018 are addressed in Appendix B to this proposed rule.

For further information relating specifically to the MedPAC reports or to obtain a copy of the reports, contact MedPAC at (202) 653–7226, or visit MedPAC's Web site at: *http://www.medpac.gov*.

XIII. Other Required Information

A. Publicly Available Data

IPPS-related data are available on the Internet for public use. The data can be found on the CMS Web site at: *http://www.cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html*. Following is a listing of the IPPS-related files that are available.

1. CMS Wage Data Public Use File

This file contains the hospital hours and salaries from Worksheet S–3, Parts II and III from FY 2014 Medicare cost reports used to create the proposed FY 2018 IPPS wage index. Multiple versions of this file are created each year. For a complete schedule on the release of different versions of this file, we refer readers to the wage index schedule in section III.M. of the preamble of this proposed rule.

Processing year	Wage data year	PPS fiscal year
2017	2014	2018
2016	2013	2017
2015	2012	2016
2014	2011	2015
2013	2010	2014
2012	2009	2013
2011	2008	2012
2010	2007	2011
2009	2006	2010
2008	2005	2009
2007	2004	2008

Media: Internet at: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files.html*.

Periods Available: FY 2007 through FY 2018 IPPS Update.

2. CMS Occupational Mix Data Public Use File

This file contains the CY 2013 occupational mix survey data to be used to compute the occupational mix adjustment wage indexes. Multiple versions of this file are created each year. For a complete schedule on the release of different versions of this file, we refer readers to the wage index schedule in section III.M. of the preamble of this proposed rule.

Media: Internet at: *https://www.cms.gov/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files.html*.

Period Available: FY 2018 IPPS Update.

3. Provider Occupational Mix Adjustment Factors for Each Occupational Category Public Use File

This file contains each hospital's occupational mix adjustment factors by occupational category. Two versions of these files are created each year to support the rulemaking.

Media: Internet at: *https://www.cms.gov/Medicare/Medicare-Fee-for-AService-Payment/AcuteInpatientPPS/Wage-Index-Files.html*.

Period Available: FY 2018 IPPS Update.

4. Other Wage Index Files

CMS releases other wage index analysis files after each proposed and final rule.

Media: Internet at: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files.html*.

Periods Available: FY 2005 through FY 2018 IPPS Update.

5. FY 2018 IPPS SSA/FIPS CBSA State and County Crosswalk

This file contains a crosswalk of State and county codes used by the Social Security Administration (SSA) and the Federal Information Processing Standards (FIPS), county name, and a list of Core-Based Statistical Areas (CBSAs).

Media: Internet at: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Acute-Inpatient-Files-for-Download.html*.

Period Available: FY 2018 IPPS Update.

6. HCRIS Cost Report Data

The data included in this file contain cost reports with fiscal years ending on or after September 30, 1996. These data files contain the highest level of cost report status.

Media: Internet at: *https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports/Cost-Reports-by-Fiscal-Year.html*.

(We note that data are no longer offered on a CD. All of the data collected are now available free for download from the cited Web site.)