OVERVIEW OF THE FY 2018 IPPS FINAL RULE

SUMMARY OF CALCULATION ELEMENTS

NEW HEALTH ANALYTICS

Published in the *Federal Register* August 14th
Rule to take effect October 1st

INDEX TO FFY 2018 CHANGES IN IPPS FACTORS

- Payment Updates
- Two Midnight Rule
- Wage Index
- DSH Payment Adjustment
- New Technology Add-On Payment (NTAP)
- Hospital Acquired Conditions
- Readmissions
- Value-Based Purchasing
- Quality Reporting Programs
- Expiration of the MDH program

SUMMARY OF CHANGES IN IPPS FINAL RULE FY 2017

- Will apply to approximately 3,330 acute care hospitals and 420 long-term care hospitals
- Market Basket update of 2.7%, but a 1.2088% total impact
- Removal of the temporary adjustment to IPPS rates under 2 Midnight Policy; 0.6% decrease to remove the temporary addition of 0.6% in FY 2017.
- Increase of 0.6% in DSH payments and uncompensated care payments combined compared with FY 2017; reduction of about 2.9% in the size of the total available DSH payments from FY 2017 to FY 2018, but payments made for uncompensated care increase by approx. 13% from FY 2017
- Removal of 15 measures for FY 2017 Reporting/FY 2019 Payment Determination and 13 measures removed for EHR Incentive Program; addition of four new measures for FY 2019 payment
- VBP program coefficient reduction remains 2%
- New Technology Add-On Payment (NTAP) Applications
- MDH Program expires effective 10/1/2017

FY 2018 IPPS FINAL RULE PAYMENT UPDATE: SUMMARY

Change in Medicare operating rates:	
Market Basket Update	2.7%
Less Multi-Factor Productivity	-0.6%
Less ACA Mandated Cuts	-0.75%
Less Documentation and Coding Recoupment (*ATRA*)	0.4588%
Plus Offset of Two-Midnight Rule	-0.6%
TOTAL IMPACT	**1.2088%**

Hospitals that report inpatient quality data and are meaningful users of EHRs will experience a 1.2088% increase in payments in FY 2018 relative to FY 2017.

FY 2018 PAYMENT UPDATE: WITH AND WITHOUT **QUALITY REPORTING & MEANINGFUL USE**

FY 2018	Submitted quality data & is meaningful EHR user	Submitted quality data but not a meaningful EHR user	Did not submit quality data but is a meaningful EHR user	Did not submit quality data and is not a meaningful EHR user
Adjustment for Failure to Submit Quality Data under Section 1886(b)(3)(B)(viii) of the Act	0.0	0.0	-0.675	-0.675
Adjustment for Failure to be a Meaningful EHR User under Section 1886(b)(3)(B)(xi) of the act	0.0	-2.025	0.0	-2.025
MFP Adjustment under Section 1886(b)(3)(B)(xi) of the Act	-0.6	-0.6	-0.6	-0.6
Statutory Adjustment under Section 1886(b)(3)(B)(xii) of the Act	-0.75	-0.75	-0.75	-0.75
Final applicable % increase applied to market basket rate of 2.7%	1.35	-0.675	0.675	-1.35

TWO MIDNIGHT POLICY

- Created in 2014: a patient that is expected to stay across two consecutive nights will be presumed appropriate for Part A payment
- FY 2017: permanent removal of -.02% payment adjustment under the Two Midnight Policy
  - Increase of approx. 0.6% in payments to make up for 0.2% reduction payment rates from FY 2014-2016
  - Temporary, 1-time prospective rate increase
- FY 2018: removal of the temporary, one-time 0.6% rate increase

WAGE INDEX

- FY 2018 uses the same labor market areas used in FY 2017 to calculate wage indices with few exceptions
  - Updated FIPS codes in 3 counties
- Occupational mix: updated based on 2013 Medicare survey
  - 2016 Medicare Wage Index Occupational Mix Survey will be used for 2019 AWI
- National Average Hourly Wage (AHW) adjusted for occupational mix is $42.0564

RURAL WAGE INDEX ADJUSTMENTS

- Rural floor – the wage index in an urban area cannot be less than the wage index in a rural area in that state
  - an estimated 366 hospitals will receive a wage index increase FY 2018 due to the application of the rural floor
- Removal of FY 2017 adjustment to offset the cost of the 3-year hold harmless transitional wage index provisions
- Outmigration – continue using data from American Community Survey (ACS), 2008-2012 Microdata
- Frontier floor – applies 1.0 wage index floor to 49 hospitals in MT, ND, NV, SD, WY
- Imputed floor – extended for another year (through 9/30/2018) imputed rural floor for all-urban states (NK [17 hospitals], DE [10 hospitals]) and alternative method for RI [6 hospitals]
- Urban to rural reclassification
  - Applications for FY 2019 must be received by 9/1/2017

DSH PAYMENTS

FY 2018

25%
Empirically Justified DSH Payments

→ Distributed in same way as current policy

75%
Uncompensated Care DSH Payments

→ Distributed based on 3 factors

2018 Final Value of factors for Uncompensated Care DSH Payments:

1. Total DSH payment pool in FY 2017
   - June 2017 estimate is $15.533 billion
   - 75% of $14.397 billion= **$11.665 billion**

2. Change in the percentage of uninsured
   - FY 2018 percent uninsured estimate= 8.15%
   - (1-percent change in uninsured)= available portion of **58.01%** (**$6.767 billion**)

3. Proportion of total uncompensated care each Medicare DSH hospital provides
   - Three-year rolling avg. to calculate uncompensated care (instead of one year)
   - $\frac{\text{Hospital's Medicare SSI Days + Medicaid Days}}{\text{Total DSH Hospitals' Medicare SSI Days + Medicaid Days}}$
     - Calculation indicated to be used for 2 years worth of data, and data from Worksheet S-10 to be used for the 3rd year
     - Average across 3 years

DSH PAYMENTS

- Only affects *operating* DSH, not *capital* DSH
- Adjusting for the factors on the previous slide, the uncompensated care pool for FY 2018 is $6.766 billion. This represents an $800 million increase from FY 2017.
- FY 2018 begins the 3 year transition period over to distributing the uncompensated care payments using Worksheet S-10 data.

DSH PAYMENTS

- For FY 2018 and beyond, CMS has finalized its proposed updates to the following elements of its payment methodology:
  - Using Worksheet S-10 data in addition to low-income insured days data
  - Formal definition of "uncompensated care"
    - Based on Line 30 of Worksheet S-10
    - Cost of charity care + cost of non-Medicare bad debt
    - Excludes cost of Medicaid shortfalls

NEW TECHNOLOGY ADD-ON PAYMENT (NTAP) APPLICATIONS

- Three criteria for evaluating eligibility for NTAP status

Newness	• Medical service or technology must be new
Cost	• Medical service or technology must be costly such that the DRG rate otherwise applicable to discharges involving the medical service or technology is determined to be inadequate
Substantial Clinical Improvement	• The service or technology must demonstrate a substantial clinical improvement over existing services or technologies. • Created new component within ICD-10 PCS codes, labeled Section "X" (analogous to outpatient C codes)

- If technology meets all three criteria, add-on payment eligibility can last 2-3 years
- Additional payments calculated to be 50% of estimated costs of new technology

NEW TECHNOLOGY ADD-ON PAYMENT (NTAP) APPLICATIONS

- 9 applications received; 3 considered for New Technology Add-On Payment
  - 3 withdrawn prior to release of the proposed rule
  - 2 withdrawn prior to release of the final rule
  - 1 lacked appropriate FDA approval

Product/Service	Status	Maximum Add-On
Bezlotoxlemab (ZINPLAVA™) – Merck & Co., Inc.	Approved	$1,900
EDWARDS INTUITY Elite™ Valve System (INTUITY) *and* LivaNova Perceval Valve (Perceval) – Edwards Lifesciences and LivaNova (respectively)	Approved	$6,110.23
Ustekinumab (Stelara®) – Janssen Biotech	Approved	$2,400

HOSPITAL-ACQUIRED CONDITION (HAC) REDUCTION PROGRAM

- One percentage point payment reduction to hospitals that rank in the lowest performing quartile HACs acquired during hospital stay

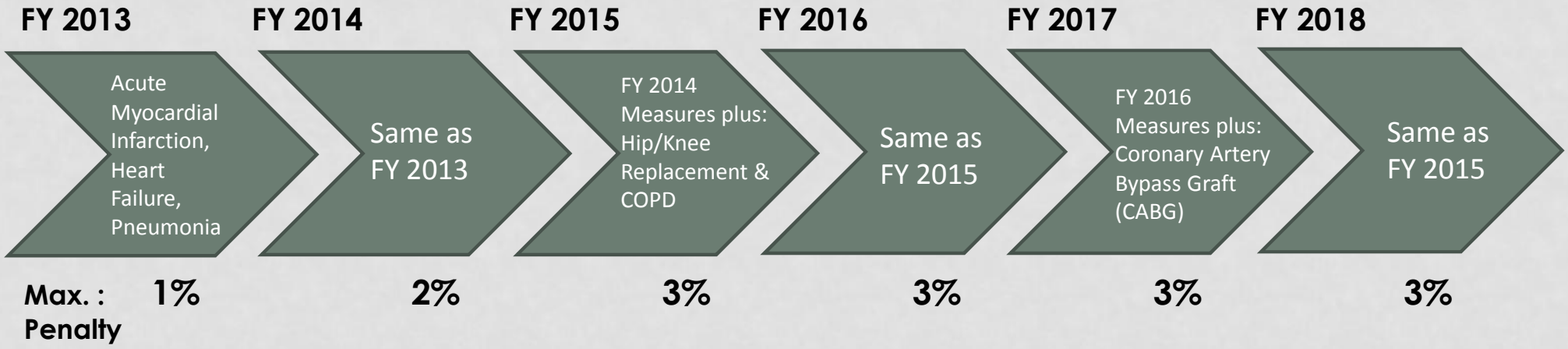
Total score derived from two domain scores:	
Domain 1: • Patient Safety Indicator (PSI) 90 measure – Patient Safety and Adverse Events Composite • 10 measures in composite score • Performance Period FY 2018: July 1, 2014 –Sept. 30, 2015 • Performance Period FY 2019: Oct. 1, 2015 – June 30, 2017 • Performance Period FY 2020: July 1, 2016 – June 20, 2018 • **15% weight for FY 2017**	**Domain 2:** • Consists of CAUTI, CDI, CLABSI, Colon and Abdominal Hysterectomy SSI, and MRSA Bacteremia • Performance Period FY 2018: Jan. 1, 2015 – Dec. 31, 2016 • Performance Period FY 2019: Jan. 1, 2016 – Dec. 31, 2017 • Performance Period FY 2020: Jan. 1, 2017 – December 31, 2018 • **85% weight for FY 2017**

HOSPITAL-ACQUIRED CONDITION (HAC) REDUCTION PROGRAM

- FY 2017 Finalized Changes/Clarifications
  - PSI-90 requires 12 months or more of data
  - Must submit CDC NHSN HAI data even when not required to do so for IQR
- FY-2018 to Adopt revised AHRQ PSI-90
  - Renamed to Patient Safety and Adverse Events Composite
  - Removed PSI 07
  - Added PSI 09, PSI 10, PSI 11
  - Re-defined PSI 12 and PSI 15
  - Weighting changed to account for harms associated with adverse events and number of adverse events
  - Uses a 15-month performance period (FY 2018 and FY 2019) to account for ICD-10 conversion (July 1, 2014 – September 30, 2015)
- FY 2018 Scoring
  - Replaced decile-based score with continuous scoring ("Winsorized Z-Score Method")
    - Relies on actual measure value rather than each measure being assigned a score from 1 to 10. "It ranks hospitals on a continuous spectrum from best performing to worse performing."
  - Improves accuracy reducing ties in Total HAC scores across hospitals, better representing performance

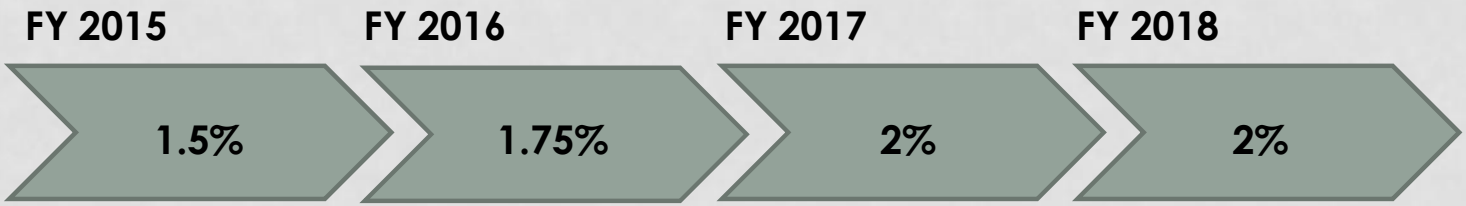
HOSPITAL READMISSIONS REDUCTION PROGRAM

- Began October 1, 2012 and adjusts payments based on each hospital's ratio of actual versus expected readmissions
  - FY 2018 applicable period: July 1, 2013 – June 30, 2016



VALUE-BASED PURCHASING PROGRAM (VBP)

- Budget-neutral policy ($1.9B redistributed) where bonuses are generated for hospitals when other hospitals fail to meet targets. Rewards for achievement or improvements
- Reduction coefficients:



VALUE BASED PURCHASING (VBP) PROGRAM

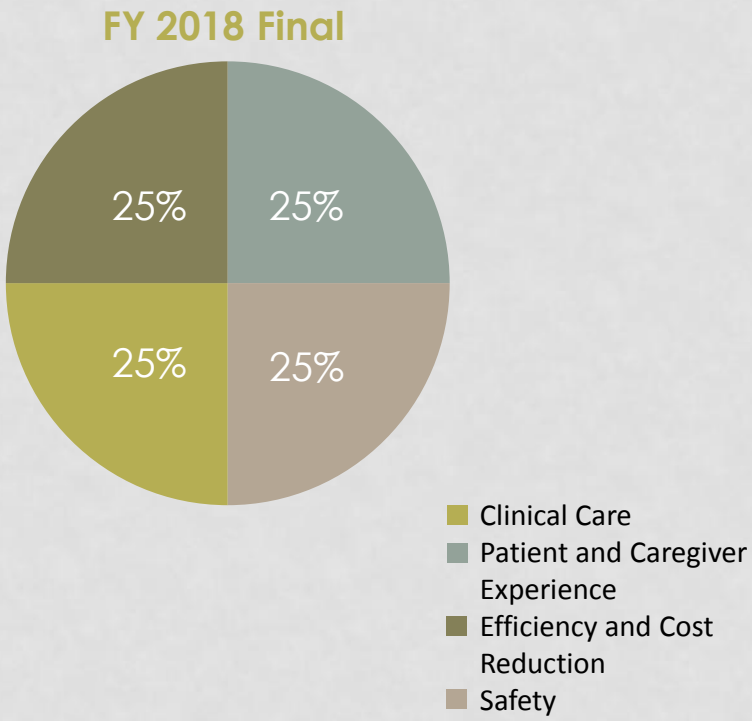
- Three new measures outlined
  - 2021 Program Year:
    - Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Acute Myocardial Infarction (AMI) (NQF #2431)
    - Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Heart Failure (HF) (NQF #2436)
  - 2022 Program Year:
    - Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery (#NQF 2558)

VALUE BASED PURCHASING (VBP) PROGRAM

- FY 2018 Final Rule includes adoptions of a modified 10 measure of the Patient Safety and Adverse Events Composite
  - Program begins in FY 2023
- FY 2022 Program Year:
  - Hospital-level, Risk Standardized Payment Associated with a 30-day Episode of Care for Pneumonia measure introduced
- Removal of the 8 indicator PSI 90 composite and revision of the efficiency and cost domain (FY 2021)
  - Goal: reflect the implementation of condition-specific payment measures

VALUE-BASED PURCHASING PROGRAM (VBP)
FY 2018

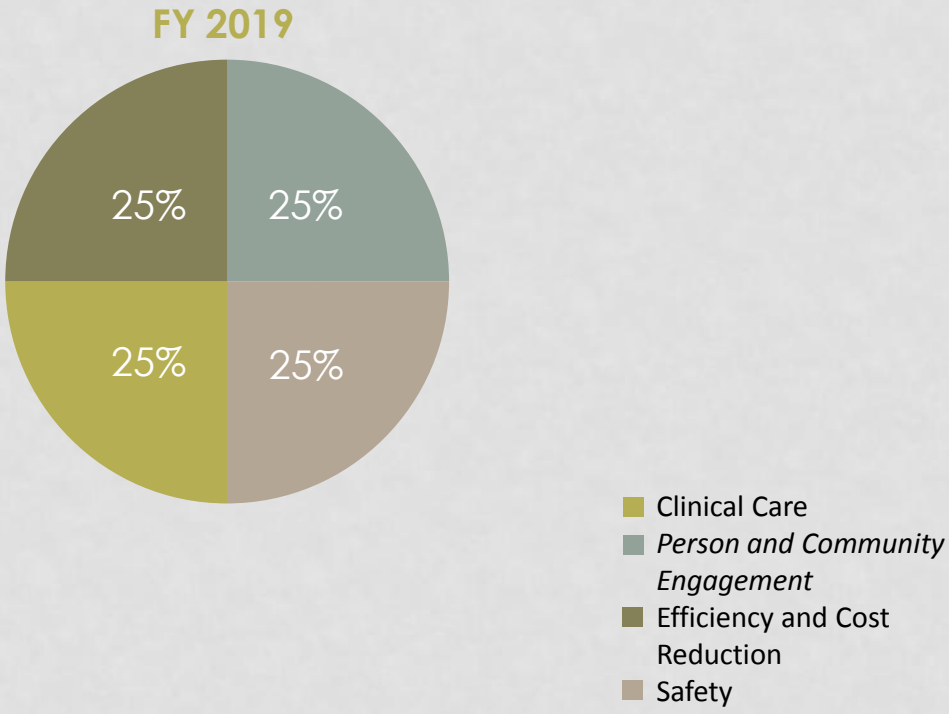
Measure ID	NQS-Based Domain
MORT-30-AMI	Clinical Care
MORT-30-HF	Clinical Care
MORT-30-PN	Clinical Care
HCAHPS CTM-3	Patient and Community Centered Experience of Care/ Care Coordination
CAUTI	Safety
CLABSI	Safety
MRSA	Safety
C. Diff	Safety
PSI-90	Safety
SSI	Safety
PC-01	Safety
MSPB-1	Efficiency and Cost Reduction



Source: Premier, Inc., Advisor Live, "IPPS FY 2017 Final Rule"

VALUE-BASED PURCHASING PROGRAM (VBP)
FY 2019

Measure ID	NQS-Based Domain
MORT-30-AMI	Clinical Care
MORT-30-HF	Clinical Care
MORT-30-PN	Clinical Care
THA/TKA	Clinical Care
HCAHPS	Patient and Community Engagement
CTM-3	
CAUTI	Safety
CLABSI	Safety
MRSA	Safety
C. Diff	Safety
PSI-90	~~Safety~~ Intend to propose modified PSI-90
SSI	Safety
PC-01	Safety
MSPB-1	Efficiency and Cost Reduction



Source: Premier, Inc., Advisor Live, "IPPS FY 2018 Final Rule"

INPATIENT VBP: OTHER FINAL

- FY 2019
  - Expand CAUTI and CLASBI measures to included non-ICU locations beginning with program year FY 2019
  - Domain name change to Person and Community Engagement
  - Immediate jeopardy citations
- FY 2021
  - Additional Efficiency and Cost Reduction Measures
    - Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Acute Myocardial Infarction (AMI) (NQF #2431)
    - Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Heart Failure (HF) (NQF #2436)
    - Use same scoring methodology as MSPB
  - Update to Pneumonia Mortality
- FY 2022
  - Add Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery (NQF #2558)

HOSPITAL INPATIENT QUALITY REPORTING (IQR) PROGRAM

For FY 2017 Reporting/FY 2019 Payment Determination:

- Removed the following measures from IQR program

Measure #	Measure Name
AMI-2	Aspirin Prescribed at Discharge for AMI (NQF #0142)
AMI-7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival
AMI-10	Statin Prescribed at Discharge
HTN	Healthy Term Newborn (NQF #0716)
PN-6	Initial Antibiotic Selection for Community-Acquired Pneumonia (CAP) in immunocompetent Patients (NQF #0147)
SCIP-Inf-1a	Prophylactic Antibiotic Received within 1 Hour Prior to Surgical Incision (NQF #0527)
SCIP-Inf-2a	Prophylactic Antibiotic Selection for Surgical Patients (NQF #0528)
SCIP-Inf-9	Urinary Catheter Removed on Postoperative Day 1 (POD1) or Postoperative Day 2 (POD2) with Day of Surgery Being Day Zero
STK-4	Thrombolytic Therapy (NQF #0437)

HOSPITAL INPATIENT QUALITY REPORTING (IQR) PROGRAM

For FY 2017 Reporting/FY 2019 Payment Determination con't:

- Removed the following measures from IQR program

Measure #	Measure Name
VTE-3	Venous Thromboembolism Patients with Anticoagulation Overlap Therapy (NQF #0373)
VTE-4	Venous Thromboembolism Patients Receiving Unfractionated Heparin (UFH) with Dosages/Platelet Count Monitoring by Protocol (or Nomogram)
VTE-5	Venous Thromboembolism Discharge Instructions
VTE-6	Incidence of Potentially Preventable VTE*
Structural Measures	Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care
Structural Measures	Participation in a Systematic Clinical Database Registry for General Surgery
STK-4	Thrombolytic Therapy (NQF #0437)
VTE-5	VTE Discharge Instructions

HOSPITAL INPATIENT QUALITY REPORTING (IQR) PROGRAM

- Refinement of two measures with FY 2018 payment determination:
  - Hospital-level, Risk-standardized Payment Associated with a 30-day Episode-of-Care for Pneumonia (NQF #2579)
  - Patient Safety and Adverse Events Composite (NQF #0531)

- New Efficiency Measures:
  - Aortic Aneurysm Procedure Clinical Episode-Based Payment Measure
  - Cholecystectomy and Common Duct Exploration Clinical Episode-Based Payment Measure
  - Spinal Fusion Clinical Episode-Based Payment Measure
  - Excess Days in Acute Care after Hospitalization for Pneumonia

- Starting with FY 2017 reporting period, hospitals required to submit a full calendar year of data on all eCQMs in Hospital IQR Program measure set on an annual basis

NEW HEALTH ANALYTICS

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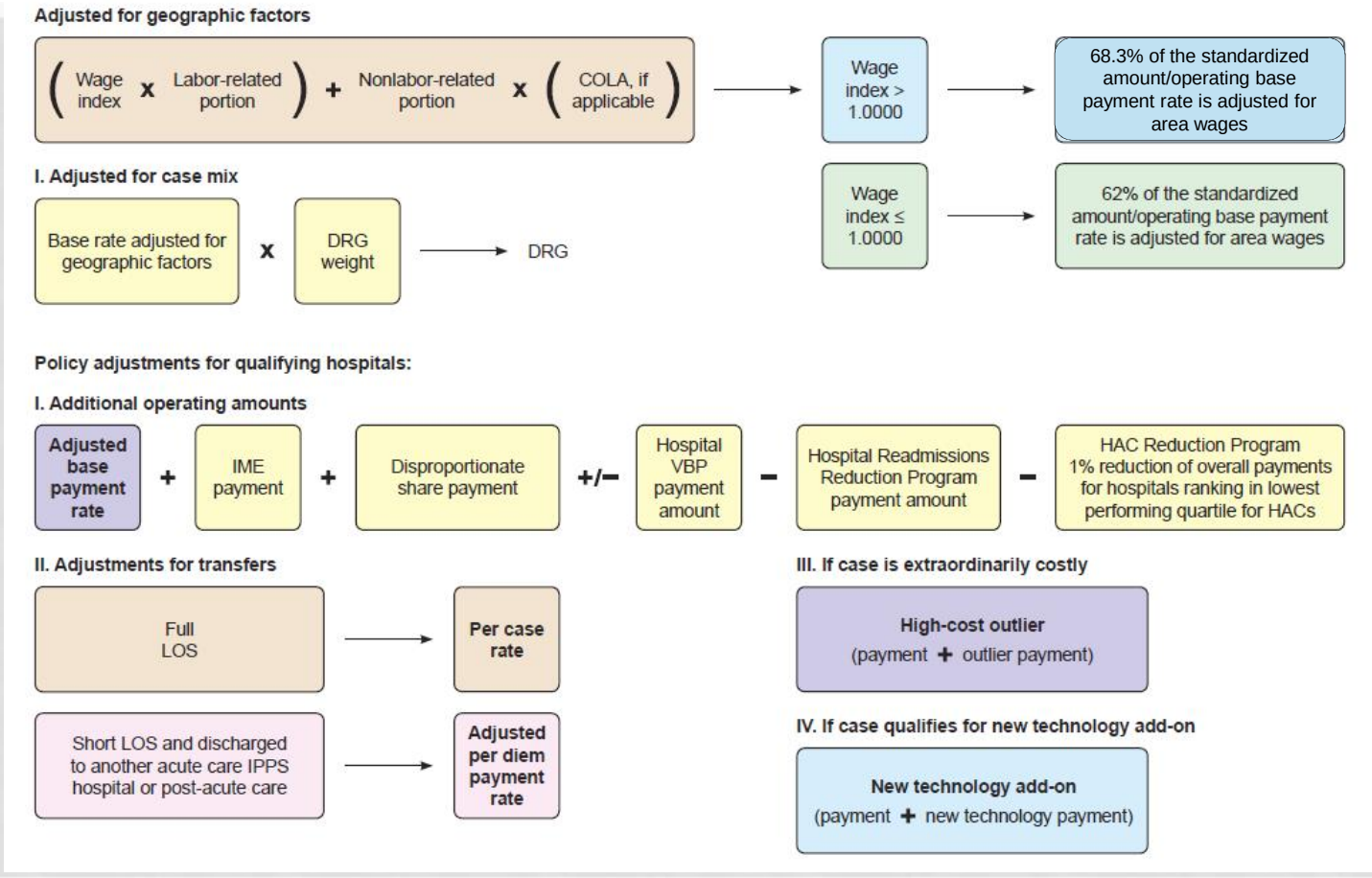
PERFORMANCE INSIGHT

APPENDIX

NW1

IPPS OPERATING BASE PAYMENT FORMULA



NW1 Labor share changed from 69.6% to 68.3%. I have to redo the image in order to make that change because this was saved as a picture and is not editable.
Nolyn Whitaker, 8/24/2017