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Medicare's Final FY 2017 IPPS Rule

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Comment

- Display versus Published Copies
- Display out several days/weeks sooner than published
  - Example FY 2017 IPPS Posted 8/2 Published 8/22
- Once display copy is superseded by published copy it is no longer available
- Bottom line – get the display copy

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FY 2017 IPPS

- Posted on 8/2/16
  - https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-18476.pdf
- Published in 8/22/16 *Federal Register*
  - Copy at:
- Tables for IPPS at:
  - http://www.cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html
- Tables for LTCH at:
  - http://www.cms.gov/Medicare/Medicare-Fee-for-Service-payment/LongTermCareHospitalPPS/index.html

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2017 IPPS Update Market Basket Increase

- MB is 2.7 percent –
- Offsets:
  - (0.3%) for productivity
  - (0.75%) for ACA mandate
  - (1.5%) for documentation & coding (per ATRA)
- Add back
  - 0.8% 2 midnight rule
- Net increase = 0.95 percent (with quality & EHR)
- Increase in total payments of $746 million

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Current FY 2016 IPPS Rates

- **Careful - CMS has corrected current FY 2016 rates twice since the August 2015 Final Rule**
  - **First on October 5th, 2015 retroactive to October 1 via Federal Register notice**
  - **Second in February 2016 retroactive to January 1, 2016 via Change Request instruction R3449 CP**
    - **Copy is at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2016-Transmittals-Items/R3449CP.html**

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Current FY 2016 IPPS Rates

Current FY 2016	Hospital Submitted Quality Data and is a Meaningful EHR User
Large Urban Areas	
Labor	$3,805.40
Non-Labor	$1,662.13
Total	**$5,467.53**
All Others	
Labor	$3,389.87
Non-Labor	$2,077.66
Total	**$5,467.53**

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Quality & EHR Reductions

- **FY 2017 regarding failures to report quality and be a meaningful EHR user**
  - **No Quality –**
    - **¼ of market basket**
  - **No EHR**
    - **¾ of market basket**
- **Note: the phase-in reduction to ¾ of market basket for failure to be EHR user is complete**
- **Failure to not report quality *and* be an EHR user is in effect a zero rate of increase w/o other adjustments**

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IPPS Update Labor Share

- No changes to labor share
  - "Large" Urban areas – those with wage index greater than 1.000 – at 69.6 percent
  - "Other" areas with wage index values equal to or less than 1.000 remain at 62.0 percent by law

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2017 IPPS Market Basket Increases

	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
Market Basket Rate-of-Increase	**2.7**	**2.7**	**2.7**	**2.7**
Adjustment for Failure to Submit Quality Data (1/4 of MB)	**0.0**	**0.00**	**-0.675**	**-0.675**
Adjustment for Failure to be a Meaningful EHR User (3/4 of MB)	**0.0**	**-2.025**	**0.0**	**-2.025**

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2017 IPPS Market Basket Increases

	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
Multi Factor Productivity (MFP) Adj	-0.3	-0.3	-0.3	-0.3
Statutory ACA Adjustment	-0.75	-0.75	-0.75	-0.75
Applicable Percentage Increase Applied to Standardized Amount	**1.65**	**-0.375**	**0.975**	**-1.05**

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FY 2016 IPPS Budget Neutrality

- **Budget neutrality adjustments for:**

1. Geographic reclassification
2. Rural community hospital demonstration program
3. Documentation & Coding
4. Outlier
5. Wage index changes
6. 2-Midnight Rule

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FY 2017 Rate Factors

	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 2016 Base Rate after removing: 1. FY 2016 Geographic Reclassification Budget Neutrality (**0.988169**) 2. FY 2015 Rural Community Hospital Demonstration Program Budget Neutrality (**0.999837**)	If Wage Index is Greater Than 1.0000: Labor (69.6%): $4,394.09 Non-labor (30.4%): $1,919.26 *(Combined labor and non-labor = **$6,313.35**)*	If Wage Index is Greater Than 1.0000: Labor (69.6%): $4,394.09 Non-labor (30.4%): $1,919.26 *(Combined labor and non-labor = **$6,313.35**)*	If Wage Index is Greater Than 1.0000: Labor (69.6%): $4,394.09 Non-labor (30.4%): $1,919.26 *(Combined labor and non-labor = **$6,313.35**)*	If Wage Index is Greater Than 1.0000: Labor (69.6%): $4,394.09 Non-labor (30.4%): $1,919.26 *(Combined labor and non-labor = **$6,313.35**)*

FY 2017 Rate Factors

	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
3. Cumulative Factor: FY 2008, FY 2009, FY 2012, FY 2013, FY 2014, and FY 2015 Documentation and Coding Adjustment and Documentation and Coding Recoupment Section 631 of the American Taxpayer Relief Act of 2012 (**0.9255**)	If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,914.28 Non-labor (38%): $2,399.07 *(Combined labor and non-labor = (**$6,313.35**)*	If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,914.28 Non-labor (38%): $2,399.07 *(Combined labor and non-labor = (**$6,313.35**)*	If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,914.28 Non-labor (38%): $2,399.07 *(Combined labor and non-labor = (**$6,313.35**)*	If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,914.28 Non-labor (38%): $2,399.07 *(Combined labor and non-labor = (**$6,313.35**)*

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FY 2017 Rate Factors

	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
4. FY 2016 Operating Outlier Offset (**0.948998**)				
5. FY 2016 Wage Index (**0.999998**)				
6. FY 2017 Proposed 2 Midnight (**0.998**)				
FY 2016 Current Rates	***$5,467.53***	***$5,467.53***	***$5,467.53***	***$5,467.53***

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FY 2017 IPPS Budget Neutrality

- **Budget neutrality adjustments for:**
  1. MS-DRG Recalibration
  2. Wage index changes
  3. Reclassification
  4. Outlier
  5. Documentation & Coding
  6. New Labor Market Delineation
  7. 2-Midnight Rule

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FY 2017 Rate Factors

	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 2017 MB Update Factor	**1.0165**	**0.99625**	**1.00975**	**0.9895**

FY 2017 Rate Factors

	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
1. FY 2017 MS-DRG **Recalibration** Budget Neutrality Factor	0.999079	0.999079	0.999079	0.999079
2. FY 2017 **Wage Index** Budget Neutrality Factor	1.000209	1.000209	1.000209	1.000209
3. FY 2017 **Reclassification** Budget Neutrality	0.988224	0.988224	0.988224	0.988224

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FY 2017 Rate Factors

	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
4. FY 2017 **Outlier**	0.948999	0.948999	0.948999	0.948999
5. FY 2017 **Documentation & Coding**	0.9118	0.9118	0.9118	0.9118
6. FY 2017 **New Labor Market** Budget Neutral	0.999994	0.999994	0.999994	0.999994
7.FY 2017 **2-Midnight Rule**	1.006	1.006	1.006	1.006

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FY 2017 Rate Factors

	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
Totals	**$5,516.63**	**$5,406.73**	**$5,479.99**	**$5,370.09**

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FY 2017 Rate Factors

	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
National Standardized Amount for FY 2016 if **Wage Index is Greater** Than 1.0000; Labor/Non-Labor Share Percentage (69.6/30.4)	**Labor: $3,839.57**	**Labor: $3,763.08**	**Labor: $3,814.07**	**Labor: $3,737.58**
	Non-labor: $1,677.06	**Non-labor: $1,643.65**	**Non-labor: $1,665.92**	**Non-labor: $1,632.51**

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FY 2017 Rate Factors

	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
National Standardized Amount for FY 2015 **if Wage Index is less Than or Equal to 1.0000;** Labor/Non-Labor Share Percentage (62/38)	**Labor: $3,420.31**	**Labor: $3,352.17**	**Labor: $3,397.59**	**Labor: $3,329.46**
	Non-labor: $2,096.32	**Non-labor: $2,054.56**	**Non-labor: $2,082.40**	**Non-labor: $2,040.63**

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IPPS Rate Quality/EHR Changes

- CMS says that 86 hospitals are estimated to not receive the full market basket rate-of-increase for FY 2017 because they failed the quality data submission process or did not choose to participate but are meaningful EHR users

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IPPS Rate Comparison (w/Quality & MU)

	FY 2016	**FY 2017**	Difference
➢			
▪	Large		
	$3,805.40	$3,839.57	
	1,662.13	1,677.06	
	$5,467.53	**$5,516.63**	**$49.10/ 0.90%**
▪	Other		
	$3,389.87	$3,420.31	
	2,077.66	2,096.32	
	$5,467.53	**$5,516.63**	**$49.10/ 0.90%**

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IPPS Offsets

- There are other offsets that impact further
  - Value-based purchasing
  - Readmissions
  - HAC
  - DSH

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Documentation & Coding

- ATRA mandates $11 billion reduction from 2014 – 2017
- Took $1 billion in 2014
- Took $2 billion in 2015
- Took $3 billion in 2016
- Still needs $5.08 billion more
- Taking 1.5 percent for FY 2017
- Next year, CMS has to start adding back the correction factors that has reduced payments by $11 billion

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Documentation & Coding

- **Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)**
  - **Limits CMS reinstatement of offsets**
  - **Offsets 3 years @ 0.8 = 2.4**
  - **FY 2017@ 1.5 = 1.5**
  - **Total = 3.9 percent to add-back**
- **MARCA = 0.5 percent from FY 2018 through 2023**
  - **Would total 3.0 percent**
  - **Shortfall is 0.9 percent**

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Capital

- **Rate will increase from $438.75 to $446.81**

	FY 2016	FY 2017	Change	Percent Change
Update Factor	1.0130	1.009	1.009	0.90
GAF/DRG Adjustment Factor	0.9976	0.9991	0.9993	-0.09
Outlier Adjustment Factor	0.9365	0.9386	0.9991	0.22
Permanent 2-midnight policy adjustment factor	NA	1.002	1.0022	0.20
One-time 2 midnight policy adjustment factor	NA	1.006	1.006	0.60
Capital Federal Rate	$438.75	**$446.81**	1.0184	1.84

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Excluded Hospitals

- Rate will increase 2.7 percent – full market basket
- Affects
  - Children's Hospital
  - 11 Cancer Hospitals
  - Hospitals outside 50 states & DC

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Outliers

- Outlier fixed-loss cost threshold for FY 2017 equal to the prospective payment rate for the DRG, plus any IME and DSH payments, and any add-on payments for new technology, plus **$23,570**
  - The current amount is $22,538
  - Estimates FY 2016 not reflected
    - How can the threshold be increased?

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Outliers

- CMS currently estimates that actual outlier payments for FY 2015 will be approximately 4.68 percent of actual total MS-DRG payments
- CMS continues to fail to recognize the amount it underestimates for outlier payments
  - ***No one seems to object" Why???***

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Wage Index

- No new/ additional changes to CBSAs
- Some FY 2015 Transitions would continue
  - Urban to Rural
    - Stay in urban for 3 years
    - Time to seek reclassification
    - Their wage index goes to rural
    - CMS says there are very few

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Wage Index

- No change to the statewide budget neutrality adjustment factor – federal versus state specific

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Wage Index – Rural Floor

FY 2017 IPPS Estimated Payments Due to Rural Floor and Imputed Floor with National Budget Neutrality				
State	Number of Hospitals	Number of Hospitals Receiving Rural Floor or Imputed Floor	Percent Change in Payments	Difference (in millions)
California	300	186	0.3	$139
Massachusetts	58	15	0.7	$24
Rhode Island	11	10	4.5	$17
Texas	320	3	-0.3	-$22
Pennsylvania	152	5	-0.3	-$17
New York	154	21	-0.2	-$15
Ohio	130	10	-0.3	-$11
North Carolina	84	1	-0.3	-$10
Missouri	74	2	-0.3	-$7

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More on Floors

- **Frontier Floor**
  - Montana, North Dakota, South Dakota, and Wyoming, covering 50 providers, will receive a frontier floor value of 1.0000
- **Imputed Floor**
  - Extended again till September 30, 2017
  - Benefits
    - 18/64 providers in New Jersey
    - 10/11 providers in Rhode Island
    - 2/6 providers in Delaware

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Occupational Mix

- Using FY 2013 survey
- FY 2017 occupational mix adjusted national average hourly wage is **$41.1615**

Occupational Mix Nursing Subcategory	Average Hourly Wage
National RN	**38.83416971**
National LPN and Surgical Technician	**22.73766832**
National Nurse Aide, Orderly, and Attendant	**15.95353295**
National Medical Assistant	**18.04809696**
National Nurse Category	**32.8589243**

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Reclassifications

- FY 2017 – 265 approved
- FY 2015 – 294 approved
- FY 2016 – 258 approved
- CMS says there are 817 hospitals reclassified for FY 2017

- Applications for FY 2018 to MGCRB due by September 1st

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Reclassifications

- **Geisinger ruling**
  - Effective for reclassification applications due to the MGCRB by September 1, 2016, for reclassification first effective for FY 2018, a hospital may apply for a reclassification under the MGCRB while still being redesignated from urban to rural under ¤ 412.103
  - Such hospitals are eligible to use distance and average hourly wage criteria designated for rural hospitals at ¤ 412.230(b)(1) and (d)(1)

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RRCs

- **FY 2017 – Case-Mix**
  - **National CMI 1.6111 for FY 2015 cost reporting periods or regional, if lower**

New England (CT, ME, MA, NH, RI, VT)	1.3633
Middle Atlantic (PA, NJ, NY)	1.4409
South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.5079
East North Central (IL, IN, MI, OH, WI)	1.5331
East South Central (AL, KY, MS, TN)	1.4472
West North Central (IA, KS, MN, MO, NE, ND, SD)	1.5946
West South Central (AR, LA, OK, TX)	1.64525
Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.6944
Pacific (AK, CA, HI, OR, WA)	1.6165

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RRCs

- **FY 2017 – Discharges – 5,000**
  - National or regional, if lower
  - None Lower

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Redesignations

- **"Lugar" Hospitals – by statute**
  - List available on the CMS Web site
- **Out-Migration Adjustment**
  - Now part of table 2

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MDH/ Low-Volume

- **MDH and Low-Volume Hospital programs extended till 9/30/2017**

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CAH Hospitals

- **Have 3 year transition if made urban under revised OMB delineations from 2015**

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IME / GME

- **IME multiplier unchanged at 1.35 – by law**

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MS-DRGs

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MS-DRGs

- **Comment**
  - **Huge amount of material presented**
  - **Not finance centered, but finance impacted**
  - **Need the medical records people**
  - **Cannot be ignored**

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MS-DRGs

- **Examples of changes being made:**
  - **Total Artificial Heart Replacement**
    - **Will assign codes 02RKOJZ and 02RLOJZ as code cluster to MS-DRGs 001 and 002**
  - **Mechanical Complication Codes**
    - **Will reassign T85.610A, T85.620A, T85.630A and T85.690A from MDC 21 MS-DRGs 919, 920, & 921 to MDC1 MS-DRGs 091, 092 and 093**

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MS-DRGs

- **Pacemaker Procedure codes**
  - **Involves MS-DRGs 242, 243, & 244**
  - **Involves MS-DRGs 258 & 259**
  - **Involves MS-DRGs 260, 261 & 263**
- **Transcatheter Mitral Valve Repair**
  - **Collapse MS-DRGs 228, 229 & 230 by deleting 230**
  - **Reassign other codes**
- **Combination Codes for Removal and Replacement of Knee Joints**
  - **Add 58 new code combinations**

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MS-DRGs

- Decompression Laminectomy
- Lordosis
- Pediatric Diagnosis Category
- Radical Prostatectomy

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MS-DRGs

- **Replaced Devices Offered without Cost or with a Credit**
  - **Not adding any MS-DRGs to its policy without cost or with credit**

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LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS-DRGS),

RELATIVE WEIGHTING FACTORS—FY 2017 Final Rule

MS-DRG	MS-DRG Title	Final FY 2017 Weights	Final FY 2016 Weights	Percentage Change
65	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC OR TPA IN 24 HRS	1.0431	1.0593	-1.53
189	PULMONARY EDEMA & RESPIRATORY FAILURE	1.2135	1.2265	-1.06
190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	1.1481	1.1578	-0.84
191	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC	0.9184	0.9321	-1.47
193	SIMPLE PNEUMONIA & PLEURISY W MCC	1.3860	1.4261	-2.81
194	SIMPLE PNEUMONIA & PLEURISY W CC	0.9469	0.9695	-2.33
291	HEART FAILURE & SHOCK W MCC	1.4796	1.4809	-0.09
292	HEART FAILURE & SHOCK W CC	0.9574	0.9707	-1.37
378	G.I. HEMORRHAGE W CC	0.9860	0.9949	-0.89

LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS-DRGS),

RELATIVE WEIGHTING FACTORS—FY 2017 Proposed Rule

MS-DRG	MS-DRG Title	Proposed FY 2017 Weights	Final FY 2016 Weights	Percentage Change
392	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	0.7402	0.7400	0.03
470	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	2.0671	2.0816	-0.70
603	CELLULITIS W/O MCC	0.8445	0.8429	0.19
641	MISC DISORDERS OF NUTRITION,METABOLISM,FLUIDS/ ELECTROLYTES W/O MCC	0.7181	0.7221	-0.55
682	RENAL FAILURE W MCC	1.4989	1.5085	-0.64
683	RENAL FAILURE W CC	0.9191	0.9406	-2.29
690	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	0.7777	0.7828	-0.65
871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	1.7660	1.7926	-1.48
872	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W/O MCC	1.0283	1.0427	-1.38

New Technology Add-ons

- For FY 2017 discontinuing 4 :

  - Kcentra™
  - Argus® II Retinal Prosthesis System
  - MitraClip® System
  - Responsive Neurostimulator (RNS®) System

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New Technology Add-ons

- Continuing 3:

  - CardioMEMS™ HF (Heart Failure) Monitoring System - 2017) - The maximum payment will remain at $8,875
    - Estimated costs = $11.3 million
  - Blinatumomab (BLINCYTO™Trade Brand) - The maximum payment will remain at $27,017.85
    - Estimated costs = $4.6 million
  - Lutonix® Drug Coated Balloon PTA Catheter and In.PACT™ Admiral™ Paclitaxel Coated Percutaneous Transluminal Angioplasty (PTA) Balloon Catheter - The maximum add-on payment will remain at $1,035.72
    - Estimated costs = $36.1 million

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New Technology Add-ons

- FY 2017 5 new:
  - MAGEC® Spinal Bracing and Distraction System (MAGEC® Spine). The maximum new technology add-on payment for a case involving the use of the MAGEC® Spinal Bracing Distraction system is $15,750 for FY 2017
    - Estimated costs = $267,750
  - Idarucizumab. The maximum new technology add-on payment for a case involving the use of Idarucizumab is $1,750 for FY 2017
    - Estimated costs = $14.67 million
  - Defitelio® (Defibrotide). The maximum new technology add-on payment amount for a case involving the use of Defitelio® is $75,900 for FY 2017
    - Estimated costs = $5.2 million

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New Technology Add-ons

- FY 2017 5 new:

  - GORE® EXCLUDER® Iliac Branch Endoprosthesis (IBE). The maximum new technology add-on payment for a case involving the use of the GORE IBE device is $5,250 for FY 2017
    - Estimated costs = $5.7 million
  - Vistogard™ (Uridine Triacetate). the maximum new technology add-on payment amount for a case involving the use of Vistogard™ is $37,500 for FY 2017
    - Estimated costs = $2.8 million

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New Technology Add-ons

- Comment
  - Extensive dialogue
  - More like a response to an RFP rather than a rule

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IPPS DSH Formula

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IPPS DSH Formula

- Mandated by Section 3133 of ACA
- Splits system
  - 25 percent remains as old formula
  - 75 percent of old being reduced
  - Uses 3 factors

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DSH Factor One

- Determines 75 percent of what would have been paid under the old methodology
- Excluded hospitals
  - MD waiver
  - SCHs paid on a hospital-specific basis
  - Hospitals in Rural Community Demo
- Using CMS actuary estimates – not hospital data

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Strength In Numbers

DSH Factor One

- The Office of the Actuary's estimates for FY 2017 begins with June 2016 baseline of **$14.397** billion for FY 2017
- 25% = **$3.599** billion
- 75% = $14.397-3.599 = **$10.797 billion**

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Strength In Numbers

DSH Factor Two

- Reduce Factor One amount by percentage reduction in **uninsured**
- Using CBO **"projections"**
  - CY 2016 rate of insurance coverage (March 2016 CBO estimate): 90 percent.
  - CY 2017 rate of insurance coverage (March 2016 CBO estimate): 90 percent.
  - FY 2016 rate of insurance coverage: (90 percent * .25) + (90 percent * .75) =90 percent.
  - Percent of individuals without insurance for 2013 (March 2010 CBO estimate):18 percent.
  - Percent of individuals without insurance for FY 2017 (weighted average): 10.0 percent.

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Strength In Numbers

DSH Factor Two

- Formula;
  - 1-|((0.10-0.18)/0.18)| = 1- 0.4444 = 0.5555 (55.55 percent)
  - 0.5555 (55.55 percent) less .002 (0.2 percentage points for FY 2017 under section 1886(r)(2)(B)(i) of the Act) = 0.5536 or 55.36 percent
- **0.5536 = FY 2017 Factor 2**
  - 0.6369 = was Factor 2 for FY 2016
  - 0.7619 = was Factor 2 for FY 2015

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Strength In Numbers

DSH Factor Two

- The amount available for uncompensated care payments for FY 2017 will be approximately **$5.977 billion**
  - **($10.797 X .5536 = $5.977 billion**
  - The FY 2014 “pool” was $9.033 billion
  - The FY 2015 “pool” was $7.648 billion
  - The FY 2016 “pool” was $6.406 billion

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Strength In Numbers

DSH Factor Three

- Factor 3 is “equal to the percent, for each subsection (d) hospital, that
- represents the quotient of (i) 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 is available which is a better proxy for the costs of subsection (d) hospitals for treating the uninsured, the use of such alternative data)); and (ii) the aggregate amount of uncompensated care for all subsection (d) hospitals that receive a payment under this subsection for such period (as so estimated, based on such data)”
- Based on each hospital’s share of total uncompensated care costs across all PPS hospitals that received DSH payments
  - So the numerator is all PPS hospitals, but denominator is just DSH hospitals

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Strength In Numbers

DSH Factor Three

- CMS is using the utilization of insured low-income patients defined as inpatient days of Medicaid patients plus inpatient days of Medicare SSI patients as defined in 42 CFR 412.106(b)(4) and 412.106(b)(2)(i), respectively to determine Factor 3

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Strength In Numbers

DSH Factor Three

- **No S-10 Data as proposed**
- **CMS postponing**
- **Says industry said to wait**
  - **S-10 not yet ready – has inconsistent data**
  - **Still requires definitions**

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Strength In Numbers

Notice of Observation Treatment and Implication for Care Eligibility Act

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Strength In Numbers

Notice Act

- **Requires hospitals & CAHS to provide notification to individuals receiving observation status**
- **Within 24 hours but later than 36 hours or discharge, whichever is sooner**
- **Use MOON [**Medicare Outpatient Observation Notice]
- MOON to explain why in observation status and implications such as cost sharing and post-hospitalization services (SNF)

REIMBURSEMENT ALLIANCE GROUP, LLC
Strength In Numbers

Notice Act

- Requires both oral and written signature
- If patient refuses to sign, hospital staff member must sign
- MOON currently being approved
  - Will have 30 day comment period

REIMBURSEMENT ALLIANCE GROUP, LLC
Strength In Numbers

Readmissions, HVBP, HAC and Quality

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Strength In Numbers

Readmissions

- Adds CABG to Heart attack, heart failure; pneumonia; chronic obstructive pulmonary disease, and hip/knee arthroplasty
- Will revise pneumonia cohort for FY 2017 and future
- **Is not budget neutral**

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Strength In Numbers

Readmissions

- **Aggregate payments for excess readmissions** = [sum of base operating DRG payments for **AMI** x (Excess Readmissions Ratio for AMI-1)] + [sum of base operating DRG payments for **HF** x (Excess Readmissions Ratio for HF-1)] + [sum of base operating DRG payments for **PN** x (Excess Readmissions Ratio for **PN-1)]** + [sum of base operating DRG payments for **COPD**) x (Excess Readmissions Ratio for COPD-1)] + [sum of base operating DRG payments for **THA/TKA** x (Excess Readmissions Ratio for THA/TKA-1)] + [sum of base operating DRG payments for **CABG** x (Excess Readmissions Ratio for CABG-1)]
- **Aggregate payments for all discharges** = sum of base operating DRG payments for all discharges.

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Strength In Numbers

Readmissions

- Ratio = 1-(Aggregate payments for excess readmissions/ Aggregate payments for all discharges)

- **Readmissions Adjustment Factor for FY 2017 is the higher of the ratio or 0.9700**
- **CMS estimates 2,588 hospitals will be impacted**
- **Impact expected to be $528 million a $108 million increase over FY 2016**

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Strength In Numbers

Value Based Purchasing

- **Withhold amount increases to 2.0 percent for all hospitals**
- Total amount available for performance-based incentive payments for FY 2017 will be approximately $1.8 billion
- Supposed to be budget neutral

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Strength In Numbers

Value Based Purchasing

- Changing Domain name from Patient- and Caregiver-Centered Experience of Care/Care Coordination to, Person and Community Engagement beginning with the FY 2019 program year
- Will include (non-ICU) ward locations in the CAUTI and CLABSI measures for FY 2019

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Strength In Numbers

Value Based Purchasing

- Measures for FY 2019

  - HCAHPS
  - MORT-30 AMI; MORT-30-HF; MORT-30 PN
  - THA/TKA
  - CAUTI
  - CLABSI
  - Colon & Abdominal Hysterectomy SSI
  - MRSA bacteremia
  - CDI
  - PSI-90
  - PC-01
  - MSPB-1

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Value Based Purchasing

- Contains proposed changes to the FY 2021 program year
- Benchmarks, Thresholds & Performance
  - Refer rule (page 685 of display copy)

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Strength In Numbers

Value Based Purchasing

- Scoring
  - Items for FY 2021 Program Year and Beyond
    - Will add 2 condition-specific 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)
  - Will use same method as MSPB for AMI & HF
- Summary of Changes begins on page 1000

Value Based Purchasing
FY 2019 Performance Standards

Previously Adopted and Newly Finalized Performance Standards for the FY 2019 Program Year: Safety, Clinical Care, and Efficiency and Cost Reduction Measures			
Measure ID	**Description**	**Achievement Threshold**	**Benchmark**
Safety Measures			
CAUTI*	National Healthcare Safety Network (NHSN) Catheter- associated Urinary Tract Infection (CAUTI) Outcome Measure	0.464	0.000
CLABSI*	National Healthcare Safety Network (NHSN)Central line- associated Bloodstream Infection (CLABSI) Outcome Measure	0.427	0.000
CDI*	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium Difficile Infection (CDI) Outcome Measure	0.816	0.012
MRSA Bacteremia*	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure	0.823	0.000
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	• 0.832 • 0.698	• 0.000 • 0.000

Value Based Purchasing
FY 2019 Performance Standards

Measure ID	Description	Achievement Threshold	Benchmark
Safety Measures			
PSI 90*±	Patient Safety for Selected Indicators (Composite)	0.840335	0.589462
PC-01*	Elective Delivery	0.010038	0.000000
PSI 90*±	Patient Safety for Selected Indicators (Composite)	0.840335	0.589462
Clinical Care Measures			
MORT-30- AMI±	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (AMI) Hospitalization	0.850671	0.873263
MORT-30- HF±	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Heart Failure (HF) Hospitalization	0.883472	0.908094
MORT-30- PN±	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Pneumonia Hospitalization	0.882334	0.907906
THA/TKA*±	Hospital-Level Risk-Standardized Complication Rate (RSMR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	0.032229	0.023178

Value Based Purchasing
FY 2019 Performance Standards

Performance Standards for the FY 2019 Program Year Person and Community Engagement Domain*			
HCAHPS Survey Dimension	**Floor (Percent)**	**Achievement Threshold (Percent)**	**Benchmark (Percent)**
Communication with Nurses	28.10	78.69	86.97
Communication with Doctors	33.46	80.32	88.62
Responsiveness of Hospital Staff	32.72	65.16	80.15
Pain Management	22.31	70.01	78.53
Communication about Medicines	11.38	63.26	73.53
Hospital Cleanliness & Quietness	22.85	65.58	79.06
Discharge Information	61.96	87.05	91.87
3-Item Care Transition	11.30	51.42	62.77
Overall Rating of Hospital	28.39	70.85	84.63

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Strength In Numbers

HAC Reduction

- **Affects payment in FY 2017**
- **Lowest-performing quartile get 1.0 percent reduction**
  - CMS is adopting the following policies:
    - (1) clarification data requirements for the term “complete data” for the PSI 90 measure within Domain 1 to require that hospitals have three or more eligible discharges for at least one component indicator and 12 months or more of data to receive a Domain 1 score; and
    - (2) for NHSN CDC HAI data submission requirements for newly opened hospitals.

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Strength In Numbers

HAC Reduction

- **For 2018**
  - (1) adoption of the modified version of the NQF-endorsed PSI 90: Patient Safety and Adverse Events Composite;
  - (2) defining the applicable time periods for the FY 2018 HAC Reduction Program and the FY 2019 HAC Reduction Program;
  - (3) changes to the scoring methodology

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Strength In Numbers

Quality Reporting

- Quality covers more than 200 pages
- The Hospital IQR Program had previously finalized 65 measures for FY 2018
- Removing 15 measures as proposed: 2 measures listed twice
  - STK-4: Thromolytic Therapy (NQF # 0437)
  - VTE-5: VTE discharge instructions
    - once as an eCQM and again as a chart-abstracted measure

REIMBURSEMENT ALLIANCE GROUP, LLC
Strength In Numbers

Quality Reporting

- CMS is adopting 2 proposed refinement claims-based measures for FY 2018
  - (1) PN Payment: Hospital-Level, Risk-Standardized 30-Day Episode-of-Care Payment Measure for Pneumonia; and
  - (2) PSI 90: Patient Safety and Adverse Events Composite (previously known as the Patient Safety for Selected Indicators Composite Measure)

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Strength In Numbers

Quality Reporting

- CMS is adopting 3 proposed clinical episode-based payment measures for FY 2019
  - Aortic Aneurysm Procedure Clinical Episode-Based Payment (AA Payment) Measure;
  - Cholecystectomy and Common Duct Exploration Clinical Episode-Based Payment (Chole and CDE Payment) Measure; and
  - Spinal Fusion Clinical Episode-Based Payment (SFusion Payment) Measure

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Strength In Numbers

Quality Reporting

- CMS is adopting 1 proposed outcome measure:
  - Excess Days in Acute Care after Hospitalization for Pneumonia.

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Strength In Numbers

Quality Reporting

- Will remove following measures for FY 2019
  - ***Clinical Measures***
  - 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 One 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);

Quality Reporting

- Removing following measures for FY 2019 (continued)

  - 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 Venous Thromboembolism;
  - ***Structural Measures***
  - Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care;
  - Participation in a Systematic Clinical Database Registry for General Surgery;
  - ***Chart Abstracted Measures***
  - STK-4: Thromolytic Therapy (NQF # 0437)
  - VTE-5: VTE discharge instructions

REIMBURSEMENT ALLIANCE GROUP, LLC
Strength In Numbers

Quality Reporting

Hospital IQR Program Measure Set for the FY 2019 Payment Determination and Subsequent Years		
Short Name	Measure Name	NQF #
NHSN		
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
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

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Strength In Numbers

Quality Reporting

Hospital IQR Program Measure Set for the FY 2019 Payment Determination and Subsequent Years		
Short Name	Measure Name	NQF #
Chart-abstracted		
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 (Collected in aggregate, submitted via Web-based tool or electronic clinical quality measure)	0469
Sepsis	Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)	0500
VTE-6	Incidence of Potentially Preventable Venous Thromboembolism	+

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Strength In Numbers

Quality Reporting

Hospital IQR Program Measure Set for the FY 2019 Payment Determination and Subsequent Years		
Short Name	Measure Name	NQF #
Claims-based Outcomes		
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
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

Quality Reporting

Hospital IQR Program Measure Set for the FY 2019 Payment Determination and Subsequent Years		
Short Name	Measure Name	NQF #
Claims-based Outcomes		
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	N/A
HF Excess Days	Excess Days in Acute Care after Hospitalization for Heart Failure	N/A

Quality Reporting

Hospital IQR Program Measure Set for the FY 2019 Payment Determination and Subsequent Years		
Short Name	Measure Name	NQF #
Claims-based Outcomes		
PN Excess Days**	Excess Days in Acute Care after Hospitalization for Pneumonia	N/A
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 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 Payment		
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

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Quality Reporting

Hospital IQR Program Measure Set for the FY 2019 Payment Determination and Subsequent Years		
Short Name	Measure Name	NQF #
Claims-based Outcomes		
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
Chole and CDE Payment**	Cholecystectomy and Common Duct Exploration Clinical Episode-Based Payment Measure	N/A
AA Payment**	Aortic Aneurysm Procedure Clinical Episode-Based Payment Measure	N/A
Sfusion Payment**	Spinal Fusion Clinical Episode-Based Payment Measure	N/A

Quality Reporting

Hospital IQR Program Measure Set for the FY 2019 Payment Determination and Subsequent Years		
Short Name	Measure Name	NQF #
Electronic Clinical Quality Measure (eCQMs)		
AMI-8a	Primary PCI Received Within 90 Minutes of Hospital Arrival	0163
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 (Collected in aggregate, submitted via Web-based tool or electronic clinical quality measure)	0469
PC-05	Exclusive Breast Milk Feeding***	0480
STK-02	Discharged on Antithrombotic Therapy	0435

Quality Reporting

Hospital IQR Program Measure Set for the FY 2019 Payment Determination and Subsequent Years		
Short Name	Measure Name	NQF #
Electronic Clinical Quality Measure (eCQMs)		
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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Quality Reporting

Hospital IQR Program Measure Set for the FY 2019 Payment Determination and Subsequent Years		
Short Name	Measure Name	NQF #
Patient Survey		
HCAHPS	HCAHPS + 3-Item Care Transition Measure (CTM-3)	0166 0228
Structural Measures		
Patient Safety Culture**	Hospital Survey on Patient Safety Culture	NA
Safe Surgery Checklist	Safe Surgery Checklist Use	NA

* Measure listed twice, as both chart-abstracted and electronic clinical quality measure
**Newly finalized measures for the FY 2019 payment determination and for subsequent years
***Measure name has been shortened. Please refer to annually updated electronically clinical quality measure specifications on the CMS eCQI Resource Center Page for further information: https://www.healthit.gov/newsroom/ecqi-resource-center.
+ NQF endorsement has been removed

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Strength In Numbers

PPS Exempt Cancer Hospital Quality Reporting

- Updating specifications of the Oncology: Radiation Dose Limits to Normal Tissues (NQF #0382) measure for FY 2019
- Adopting the Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy measure as proposed

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Strength In Numbers

LTCHs

- **Net Update of 1.75 percent**
  - MB of 2.8 percent
  - MFP of -0.3
  - ACA of -0.75
- Area wage factor of 0.999593
- Results in Federal rate of **$42,476.41**
  - (calculated as $41,762.85 (FY 2016 rate) X 1.0175 X 0.999593)
  - **Labor share = 66.5 percent** from 62.0

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Strength In Numbers

LTCHs

- Payment reduced 2 percent for no quality
- 2 HCO Thresholds
  - $21,943 standard
  - $23,500 site neutral
- Comment
  - CMS estimates 45 percent of LTCH cases could be classified as site neutral
  - CMS estimates LTCH payments to decrease $388 million (23 percent)

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Questions

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