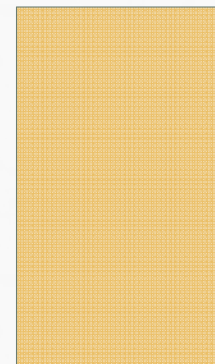
OVERVIEW OF THE FY 2017 IPPS FINAL RULE

SUMMARY OF CALCULATION ELEMENTS



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Rule to take effect October 1st

INDEX TO FFY 2017 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

SUMMARY OF CHANGES IN IPPS FINAL RULE FY 2017

- Will apply to approximately 3,330 acute care hospitals and 430 long-term care hospitals
- Market Basket update of 2.7%, but a 0.95% total impact
- Removal of -0.2% payment adjustment under 2 Midnight Policy; approx. 0.8% increase to make up for 0.2% payment reduction
- Reduction of 0.3% in DSH payments compared with FY 2016; reduction of approx. 1.4% for DSH and uncompensated care payments
- HRRP adding sixth condition: Coronary Artery Bypass Graft (CABG) Surgery
- 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
- Increases in VBP program coefficient reduction to 2%
- New Technology Add-On Payment (NTAP) Applications

FY 2017 IPPS FINAL RULE PAYMENT UPDATE: SUMMARY

Change in Medicare operating rates:	
Market Basket Update	2.7%
Less Multi-Factor Productivity	-0.3%
Less ACA Mandated Cuts	-0.75%
Less Documentation and Coding Recoupment (*ATRA*)	-1.5%
Plus Offset of Two-Midnight Rule	0.8%
TOTAL IMPACT	**0.95%**

Hospitals that report inpatient quality data and are meaningful users of EHRs will experience a 0.95% increase in payments in FY 2017 relative to FY 2016.

FY 2017 PAYMENT UPDATE: WITH AND WITHOUT **QUALITY REPORTING & MEANINGFUL USE**

FY 2017	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	-0.3	-0.3	-0.3	-0.3
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%	1.65	-0.375	0.975	-1.05

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.
- Permanent removal of -.02% payment adjustment under the Two Midnight Policy for FY 2017
- Increase of approx.. 0.8% in payments to make up for 0.2% reduction payment rates from FY 2014-2016

WAGE INDEX

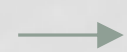
- FY 2016 uses same labor market areas to calculate wage indices with few exceptions
- Occupational mix- updated based on 2013 Medicare survey
  - Will be surveyed in 2016 for 2019 AWI
- National Average Hourly Wage (AHW) adjusted for occupational mix is $41.1615

RURAL WAGE INDEX ADJUSTMENTS

- Third year of transition policies for new OMB delineations of urban to rural.
  - Urban to rural delineation:
    - Keep former CBSA in which physically located in FY 2014 until 2017, IF not reclassified/redesignated (or closest labor market area if old area no longer exists)
    - Considered rural for all other policy purposes
- Outmigration-continue using data from ACS, 2008-2012 Microdata
- Frontier floor- applies 1.0 floor in MT, ND, NV, SD, WY
- Imputed floor- continues for 1 year the imputed rural floor for all-urban states (NK, DE) and alternative method for RI
- Urban to rural reclassification: “lock in” date of second Monday in June
  - Applications must be received 70 days in advance

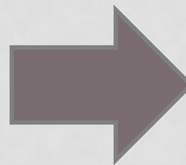
DSH PAYMENTS

FY 2016



Distributed in same way as current policy

Distributed based on 3 factors



2017 Final Value of factors for Uncompensated Care DSH Payments:

1. Total DSH payment pool in FY 2015
   - July 2016 estimate is $14.397 billion
   - 75% of $14.397 billion= **$10.797 billion**

2. Change in the percentage of uninsured
   - FY 2016 percent uninsured estimate= 10%
   - (1-percent change in uninsured)= available portion of **55.36% ($5.977 billion**)

3. Proportion of total uncompensated care each Medicare DSH hospital provides
   - Three-year rolling avg. to calculate uncompensated care (instead of one year)
   - $$\frac{\text{Hospital's Medicare SSI Days + Medicaid Days}}{\text{Total DSH Hospitals' Medicare SSI Days + Medicaid Days}}$$

DSH PAYMENTS

- Only affects *operating* DSH, not *capital* DSH
- Adjusting for the factors on the previous slide, available pool money for FY 2016 is $9.598. DSH payments will be **cut by $134 million** in FY 2017 compared to the FY 2016 amount.
- CMS projects this impact to be a **downward payment of ≈1.4%** as compared to the Medicare DSH and uncompensated payments distributed in FY 2015

DSH PAYMENTS

CMS expects impact to vary among hospitals based on size and whether it is rural or urban

	Urban	**Rural**
Large	-1.3%	<-3.5%
Small	+0.9%	-6.3%
All Sizes	-1.2%	-4.3%

DSH PAYMENTS

- For FY 2018 and beyond, CMS has proposed the following updates to 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

Criterion	Description
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 las 2-3 years
- Additional payments calculated to be 50% of estimated costs of new technology

NEW TECHNOLOGY ADD-ON PAYMENT (NTAP) APPLICATIONS

Product/Service	Status	Maximum Add-On
MAGEC® Spinal Bracing and Distraction System (MAGEC® Spine) (Ellipse Technologies, Inc.)	Approved	$15,750
MIRODERM Biologic Wound Matrix (MICRODERM) (Miromatrix Medical, Inc.)	Not Approved	--
Idarucizumab (Boehringer Ingelheim Pharmaceuticals, Inc.)	Approved	$1,750
Titan Spine (Titan Spine Endoskeleton ® nanoLOCK™ Interbody Device) (Titan Spine)	Not Approved	--
Andexanet Alfa (Portola Pharmaceuticals, Inc.)	Not Approved	--
Defitelio® (Defibrotide) (Jazz Pharmaceuticals)	Approved	$75,900
EDWARDS INTUITY Elite™ Valve System (Edwards Lifesciences)	Not Approved	--
GORE ® EXCLUDER ® Iliac Branch Endoprosthesis (IBE) (W. L. Gore and Associates, Inc.)	Approved	$5,250
Vistogard™ (Uridine Triacetate) (BTG International Inc.)	Approved	$37,500

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

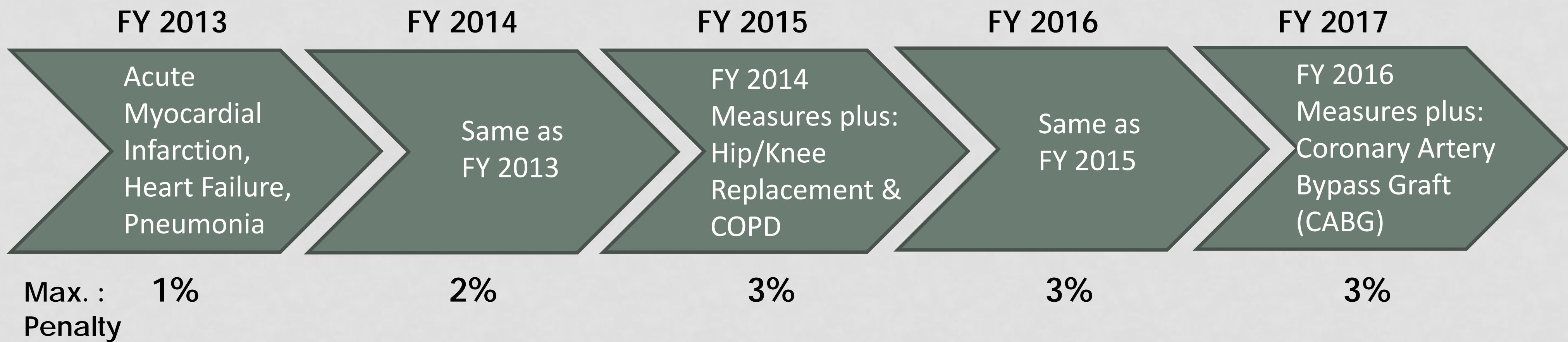
Total score derived from two domain scores:	
Domain 1: • Patient Safety Indicator (PSI) 90 measure, a composite of 8 measures • Performance Period FY 2018: July 1, 2014 –Sept. 30, 2015 • Performance Period FY 2019: Oct. 1, 2015 – June 30, 2017 • **15% weight for FY 2017**	**Domain 2:** • Includes CLABSI, CAUTI, SSI, MRSA Bacteremia, and CDI • Performance Period FY 2018: Jan. 1, 2015 – Dec. 31, 2016 • Performance Period FY 2019: Jan. 1, 2016 – Dec. 31, 2017 • **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
  - Renames to Patient Safety and Adverse Events Composite
  - Removes PSI 07
  - Adds PSI 09, PSI 10, PSI 11
  - Re-specifies 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 only) to account for ICD-10 conversion (July 1, 2014-September 30, 2015)
- FY 2018 Scoring
  - Replaces decile-based score with continuous scoring ("Winsorized Z-Score Method")
  - Helps Hospitals with only a PSI-90 score

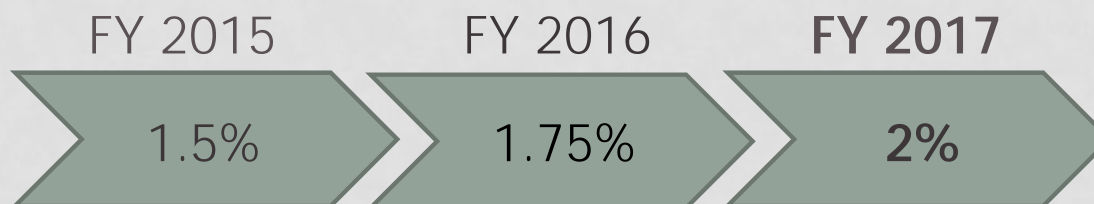
HOSPITAL READMISSIONS REDUCTION PROGRAM

- Began October 1, 2012 and adjusts payments based on each hospital's ratio of actual versus expected readmissions



VALUE-BASED PURCHASING PROGRAM (VBP)

- Budget-neutral policy ($1.8B 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

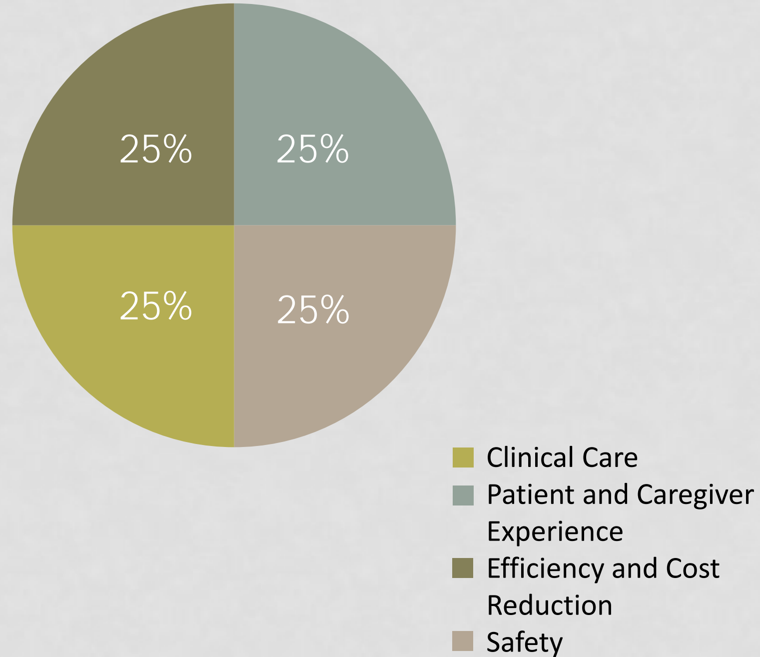
- Three new measures outlined
  - 2021 Program Year:
    - Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Acute Myocardial Infarction (AMI) (NQF #2431)
    - Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Heart Failure (HF) (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

- Change performance period for the PSI 90: Patient Safety for Selected Indicators measure for FY 2018 program year due to complexities of converting ICD-9 to ICD-10
  - Formerly July, 2014- June 30, 2016
  - Proposed to be July 1, 2014- September 30, 2015
- Change name of Patient-and Caregiver-Centered Experience of Care/Care Coordination to Person and Community Engagement beginning with FY 2019 program year
- Change from two to three surveys citing hospital for immediate jeopardy for hospital to be excluded from program

VALUE-BASED PURCHASING PROGRAM (VBP)
FY 2018

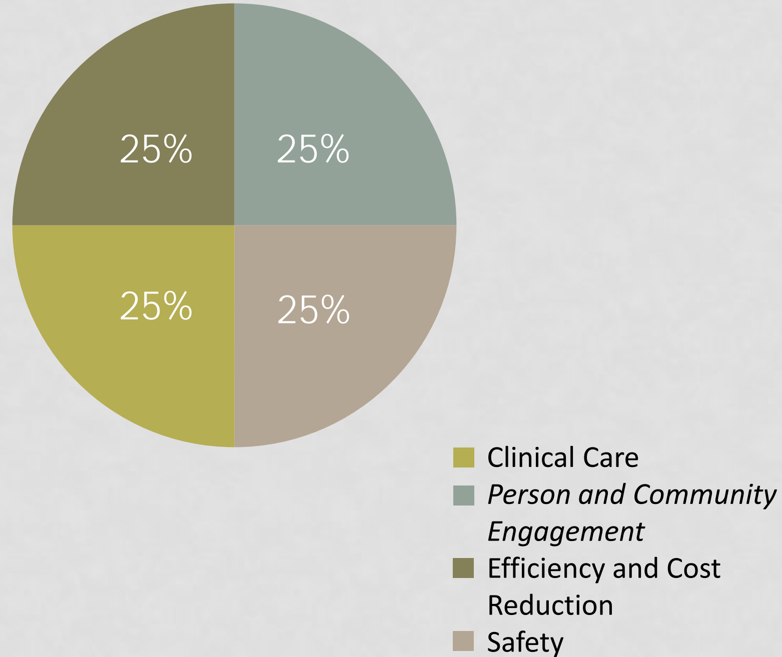
Measure ID	NQS-Based Domain
MORT-30-AMI	Clinical Care
MORT-30-HF	Clinical Care
MORT-30-PN	Clinical Care
HCAHPS CTM-3	Patient and Community Centered Experience of Care/ Care Coordination
CAUTI	Safety
CLABSI	Safety
MRSA	Safety
C. Diff	Safety
PSI-90	Safety
SSI	Safety
PC-01	Safety
MSPB-1	Efficiency and Cost 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
HCAHPS CTM-3	Patient and Community Engagement
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 2017 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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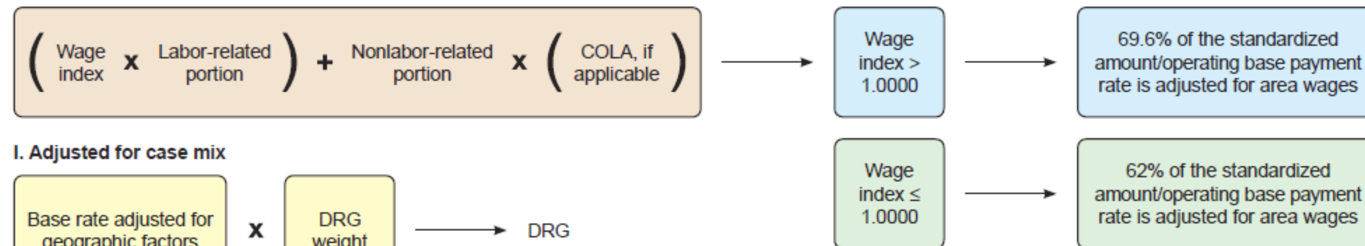
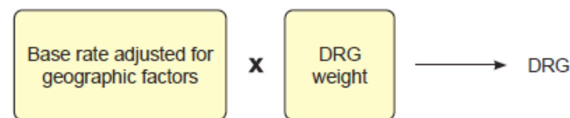
PERFORMANCE INSIGHT

APPENDIX

IPPS OPERATING BASE PAYMENT FORMULA





Policy adjustments for qualifying hospitals: