1. You will not hear any audio until the webinar begins.

2. To join the audio, select “call me” and enter your phone number or select “I will call in”. If you select “I will call in, follow the prompts and be sure to enter the access code and “Attendee ID”.

3. Submit typed questions through the Q&A panel. Send to All Panelists.

4. If you experience technical issues, type a message in the Chat Panel to AAMC Meetings.
Medicare Inpatient Prospective Payment System (IPPS) FY 2018
Final Rule

Mary Mullaney (mmullaney@aamc.org)

September 5, 2017
FY 2018 IPPS Final Rule

Published in Federal Register
August 14, 2017 (82 Fed Reg 37990)

Effective date October 1, 2017

AAMC OPPS Resources:
www.aamc.org/hospitalpaymentandquality
Webinar Agenda

- Payment Update
- Outlier Payments
- Documentation and Coding
- Disproportionate Share Hospital Payments
- EHR Incentive Program
- Hospital Quality Provisions
  - Readmission Reduction Program
  - VBP Program
  - HAC Program
  - Inpatient Quality Reporting
Payment Updates
FY 2018 Market Basket Update

Market Basket Projected Increase: +2.7%

Multifactor Productivity Adjustment: -0.6%

ACA Adjustment: -0.75%

Documentation and Coding: +0.4588%

Two-Midnight Rule: -0.6%

FY 2018 Payment Update: 1.2%

Overall Impact: All Hospital: 1.3%
Major Teaching Hospitals: 1.4%
Outlier Payments
FY 2018 Outlier Fixed Cost Threshold

FY 2018 fixed-loss threshold = $26,601

Qualifying for outlier payments

- Costs greater than sum of prospective payment rate for DRG
- Plus IME and DSH
- Plus new technology add-on payments
- Plus “outlier threshold” or “fixed cost amount”

Sum = outlier “fixed cost threshold”
Documentation and Coding
The American Taxpayer Relief Act of 2012 (ATRA) required $11B recoupment adjustment by FY2017 for documentation and coding.

FY2018 begins six-year process to restore payment adjustments from the $11 billion recoupment.

For FY2018, increase of 0.4588%, as required by the 21st Century Cures Act, to partially restore cuts made as a result of the documentation and coding changes from FYs 2010-2012.

For FY2019-FY2023, as required by MACRA, increase of 0.5% per year:
- Total Reduction = 3.9%
- Total Offset=2.9588%
Medicare DSH Payments
Medicare DSH Payments: Background

ACA Section 3133 modified methodology for computing Medicare DSH payment adjustment

Empirically Justified DSH Payment

The amount that will continue to be paid under the statutory formula for Medicare DSH payments

25%

Uncompensated Care Payment (UCP)

What otherwise would have been paid as Medicare DSH payments, reduced to reflect changes in the percentage of individuals under age 65 who are uninsured for FY 2014 – FY 2017 and the entire population beginning in FY 2018.

75%
DSH Uncompensated Care Payment (UCP)

Factor 1: $11.665 billion
- Equals 75 percent of the aggregate DSH payments that would have been made under the old statutory formula

Factor 2: 58.01%*
- Reduces the amount of Factor 1 by insured pre-ACA to uninsured post-ACA

Factor 3:
FY 2018 Final UCP Amount: $6.767 billion
- Amount to be distributed among all hospitals that receive Medicare DSH payments in FY2018

*CMS uses Office of the Actuary (OACT)’s National Health Expenditure Accounts (NHEA) to determine the rate of uninsured individuals. Previously, the law required use of CBO estimates.
Moving to Worksheet S-10

- Non-Medicare Uncompensated Care Costs (Line 30) = Charity Care Costs (Line 23) + Non-Medicare Bad Debt Costs (Line 29)

- Uncompensated care costs greater than 50% of total operating expenses considered aberrant
  - CMS will apply ratio of uncompensated care to total costs from 2015 to 2014 total costs for these hospitals

- Data accuracy / audit process

- Resubmission of FY 2014 and FY 2015 cost reports by 9/30/2017 allowed
  - FY 2014 data will not affect payments until FY 2019
EHR Incentive Programs
EHR Reporting in 2018

Modification of EHR reporting periods for 2018

- All participants (new and returning) attesting to CMS or to a state Medicaid agency to a minimum of any continuous 90-day period within CY 2018

21st Century Cures Act Exception

- Medicare Payment Adjustment for decertified EHR technology

<table>
<thead>
<tr>
<th>Entity</th>
<th>When entity qualifies for exception</th>
<th>Application Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible Provider</td>
<td>CY 2018 payment adjustment year</td>
<td>October 1, 2017*</td>
</tr>
<tr>
<td>Eligible hospital</td>
<td>Beginning with the FY 2019 payment adjustment year</td>
<td>July 1, 2018*</td>
</tr>
<tr>
<td>Critical Access Hospital</td>
<td>Beginning with the FY 2018 payment adjustment year</td>
<td>November 30, 2018*</td>
</tr>
</tbody>
</table>
Quality Programs
Hospital Readmissions Reduction Program
## SDS Payment Adjustment HRRP FY 2019

<table>
<thead>
<tr>
<th>Topics for Comment</th>
<th>Proposed Rule</th>
<th>Final Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identification of Dual Eligibles</td>
<td>Data from state Medicare Modernization Act (MMA) file of dual eligibility</td>
<td>Finalized</td>
</tr>
<tr>
<td>Proportion of Duals Inpatient Stays</td>
<td>Total # of dual eligible hospital stays / total # of FFS and MA enrollees</td>
<td>Finalized</td>
</tr>
<tr>
<td>Data Period</td>
<td>Three year measure performance period</td>
<td>Finalized</td>
</tr>
<tr>
<td>Assigning Hospitals to Peer Groups</td>
<td>Hospitals grouped into quintiles</td>
<td>Finalized</td>
</tr>
</tbody>
</table>
SDS Adjustment in the HRRP: Payment Adjustment Formula

CMS replaces current adjustment formula with median excess readmission reduction (ERR) ratio for the hospital’s peer group.

- *Compares every hospital’s ERR to a benchmark of 1.00*

Change will be made budget neutral to current formula
Value-Based Purchasing (VBP) Program
Hospital value-based purchasing (VBP)

• Removal of PSI 90 Measure for FY 2019
  • *Patient safety composite*

• Replace with new measure for FY 2023
  • *Patient safety and adverse events composite (PSI-90 composite)*

• **Added** – Pneumonia episode of care payment measure beginning FY 2022
Hospital Acquired Condition (HAC) Reduction Program
Accounting for Social Risk Factors: HAC

- Many program measures “never events”
- Should not be influenced by social risk factors
Inpatient Quality Reporting (IQR) Program
## HCAHPS Pain Management Questions

<table>
<thead>
<tr>
<th>Current “Pain Management”</th>
<th>Finalized “Communication about Pain”</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. During this hospital stay, did you need medicine for pain?</td>
<td>• HP1: “During this hospital stay, did you have any pain?”</td>
</tr>
<tr>
<td>1 □ Yes</td>
<td>□ Yes</td>
</tr>
<tr>
<td>2 □ No □ If No, Go to Question 15</td>
<td>□ No □ If No, Go to Question __</td>
</tr>
<tr>
<td>13. During this hospital stay, how often was your pain well controlled?</td>
<td>• “During this hospital stay, how often did hospital staff talk with you about how much pain you had?”</td>
</tr>
<tr>
<td>1 □ Never</td>
<td>□ Never</td>
</tr>
<tr>
<td>2 □ Sometimes</td>
<td>□ Sometimes</td>
</tr>
<tr>
<td>3 □ Usually</td>
<td>□ Usually</td>
</tr>
<tr>
<td>4 □ Always</td>
<td>□ Always</td>
</tr>
<tr>
<td>14. During this hospital stay, how often did the hospital staff do everything they could.</td>
<td>• “During this hospital stay, how often did hospital staff talk with you about how to treat your pain?</td>
</tr>
<tr>
<td>1 □ Never</td>
<td>□ Never</td>
</tr>
<tr>
<td>2 □ Sometimes</td>
<td>□ Sometimes</td>
</tr>
<tr>
<td>3 □ Usually</td>
<td>□ Usually</td>
</tr>
<tr>
<td>4 □ Always</td>
<td>□ Always</td>
</tr>
</tbody>
</table>
Refinements: Stroke Mortality

- 30 Day stroke mortality measure risk adjustment would incorporate NIH Stroke Scale
- The stroke scale is a 15 item neurologic exam evaluating stroke patient’s level of consciousness, language, neglect, etc.
- Implemented in IQR for FY 2023
- CMS would provide hospitals with confidential dry run reports on measure performance in 2021; public reporting in FY 2022
- Revised measure is not NQF endorsed
Voluntary Hybrid Hospital-Wide Readmissions Measure

- Voluntary Hospital Wide Readmissions (HWR) measure combines claims and EHR abstracted data (NQF# 2879)
- Participating hospitals report data on discharges for first two quarters of CY 2018
- Hospitals who report data will receive confidential feedback reports
- Data not publicly reported and does not impact payment determination
Questions?

Click the “Raise Hand” icon , to ask a question. Your name will be called and your phone line will be unmuted.

Click the hand again to put your hand down.

Submit typed questions through the Q&A panel.

Send to All Panelists.
AAMC Resources

Individual Institution Reports
• AAMC Hospital Medicare Inpatient Impact Report (mbaker@aamc.org)
• AAMC Hospital Compare Benchmark Report
• FY 2016 AAMC Report on Medicare Inpatient Quality Programs

General Resources
• AAMC IPPS & OPPS Regulatory Page - Contains previous IPPS webinars and comment letters (www.AAMC.org/hospitalpaymentandquality)
• AAMC Quality Spreadsheet (https://www.aamc.org/download/412838/data/aamcqualitymeasuresspreadsheet.xlsx)