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Medicare's FY 2018 Proposed IPPS Rules

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Comment

- **"GET" the Display vs *Federal Register* Published Version**
- **Display out several days/weeks sooner than published**
  - **Easier to read – double spaced, yes, it has many more pages [out 4/14]**
  - **Published copy is small print in column format -- much harder to read on line [out 4/28]**
- **Once display copy is superseded by published copy it is no longer available**
- **Bottom line – get the display copy**

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Comment

- **Another overly long rule – 1,832 pages:**
- **Again, repeating much history**
  - **CMS just takes previous rule and builds on top**
  - **Problem is CMS is always trying to defend itself against potential litigation**
  - **Finding proposals not always clear**

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Proposed FY 2018 IPPS Rule

- **Posted on 4/14/17**
- **Published in 4/28/17 *Federal Register***
- **Copy at: https://www.gpo.gov/fdsys/pkg/FR-2017-04-28/pdf/2017-07800.pdf**
- **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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Proposed 2018 Rates and Adjustments

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Proposed 2018 IPPS Update Market Basket Increase

- **MB is 2.9 percent –**
- **Offsets:**
  - **(-0.4%) for productivity**
  - **(-0.75%) for ACA mandate**
  - ***[CMS says increase = 1.75]***
  - **(+0.4588) for documentation and coding per 21st Century Cures Act and MACRA**

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Current FY 2017 IPPS Rates

- **Careful - CMS corrected FY 2017 rates since the August 22nd Final Rule**
  - **See October 5th, 2016 retroactive to October 1 via *Federal Register* notice**
    - **Copy is at: https://www.gpo.gov/fdsys/pkg/FR-2016-10-05/pdf/2016-24042.pdf**

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Quality & EHR Reductions

- **FY 2018 regarding failures to report quality and be a meaningful EHR user**
  - **No Quality –**
    - **¼ of market basket [0.25 x 2.9 = -0.725]**
  - **No EHR**
    - **¾ of market basket [0.75 x 2.9 = -2.175]**
- **Failure to not report quality or be an EHR user is in effect a zero rate of increase w/o other adjustments**

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Proposed FY 2018 IPPS Update Labor Share

- **CMS proposal to revise market basket computation**
- **Results in major change to large urban labor share**
  - **“Large” Urban areas – those with wage index greater than 1.000 – would be at 68.3 percent – down from 69.6**
  - **“Other” areas with wage index values equal to or less than 1.000 remain at 62.0 percent by law**
  - **Will impact all via budget neutrality**

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Proposed FY 2018 IPPS Rates

- **Following tables show how CMS arrives at proposed payment rates**

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Proposed 2018 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	**2.9**	**2.9**	**2.9**	**2.9**
Adjustment for Failure to Submit Quality Data (1/4 of MB)	**0.0**	**0.00**	**-0.725**	**-0.725**
Adjustment for Failure to be a Meaningful EHR User (3/4 of MB)	**0.0**	**-2.175**	**0.0**	**-2.175**

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Proposed 2018 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	-0.4	-0.4	-0.4	-0.4
Statutory ACA Adjustment	-0.75	-0.75	-0.75	-0.75
Applicable Percentage Increase Applied to Standardized Amount	**1.75**	**-0.425**	**1.025**	**-1.15**

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Current FY 2017 IPPS Rates

Current FY 2017 Raites	Hospital Submitted Quality Data and is a Meaningful EHR User
Large Urban Areas	
Labor	$3,839.23
Non-Labor	$1,676.91
Total	**$5,516.14**
All Others	
Labor	$3,420.01
Non-Labor	$2,096.13
Total	**$5,516.14**

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Proposed FY 2018 IPPS Rates

- **Divide current 2017 rates as follows:**
  - **$5,516.14 = current total labor/ non-labor**

1. **Geographic BN 0.988136 = $5,582.369**
2. **Outlier BN 0.948998 = $5,882.383**
3. **2 Midnight 1.006 = $5,847.299**
4. **Labor/wage BN 0.999997 = $5,847.32**

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Proposed FY 2018 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 2018 Base Rate after removing: 1. FY 2017 Geographic Reclassification Budget Neutrality **(0.988136)** 2. FY 2017 Operating Outlier Offset **(0.948998)** 3. FY 2017 2-Midnight Rule One-Time Prospective Increase **(1.006)** 4. FY 2017 Labor Market Delineation Wage Index Transition Budget Neutrality Factor **(0.999997)**	**If Wage Index is Greater Than 1.0000**: Labor (68.3%): $3,993.72 Nonlabor (31.7%): $1,853.60 *(Combined labor and nonlabor = $5,847.32)*	**If Wage Index is Greater Than 1.0000**: Labor (68.3%): $3,993.72 Nonlabor (31.7%): $1,853.60 *(Combined labor and nonlabor = $5,847.32)*	**If Wage Index is Greater Than 1.0000:** Labor (68.3%): $3,993.72 Nonlabor (31.7%): $1,853.60 *(Combined labor and nonlabor = $5,847.32)*	**If Wage Index is Greater Than 1.0000**: Labor (68.3%): $3,993.72 Nonlabor (31.7%): $1,853.60 *(Combined labor and nonlabor = $5,847.32)*

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FY 2018 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 2018 Base Rate after removing: 1. FY 2017 Geographic Reclassification Budget Neutrality **(0.988136)** 2. FY 2017 Operating Outlier Offset **(0.948998)** 3. FY 2017 2-Midnight Rule One-Time Prospective Increase **(1.006)** 4. FY 2017 Labor Market Delineation Wage Index Transition Budget Neutrality Factor **(0.999997)**	**If Wage Index is less Than or Equal to 1.0000:** Labor (62%): $3,625.34 Nonlabor (38%): $2,221.98 *(Combined labor and nonlabor = $5,847.32)*	**If Wage Index is less Than or Equal to 1.0000**: Labor (62%): $3,625.34 Nonlabor (38%): $2,221.98 *(Combined labor and nonlabor = $5,847.32)*	**If Wage Index is less Than or Equal to 1.0000:** Labor (62%): $3,625.34 Nonlabor (38%): $2,221.98 *(Combined labor and nonlabor = $5,847.32)*	**If Wage Index is less Than or Equal to 1.0000**: Labor (62%): $3,625.34 Nonlabor (38%): $2,221.98 *(Combined labor and nonlabor = $5,847.32)*

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Proposed FY 2018 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
Proposed FY 2018 Update Factor (refer table above)	1.01750	0.99575	1.01025	0.98950
Proposed FY 2018 MS-DRG Recalibration Budget Neutrality Factor	0.997573	0.997573	0.997573	0.997573
Proposed FY 2018 Wage Index Budget Neutrality Factor	1.000465	1.000465	1.000465	1.000465
Proposed FY 2018 Reclassification Budget Neutrality Factor	0.988522	0.988522	0.988522	0.988522
Proposed FY 2018 Operating Outlier Factor	0.948999	0.948999	0.948999	0.948999
Proposed Adjustment for FY 2018 Required under Section 414 of Pub. L. 114-10 (MACRA) and Section 15005 of Pub. L. 114-255	1.004588	1.004588	1.004588	1.004588

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Proposed FY 2018 Proposed 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
Proposed National Standardized Amount for FY 2018 **if Wage Index is Greater Than or Equal to 1.0000;** Labor/Non-Labor Share Percentage (68.3/31.7)	**Labor: $3,822.07**	**Labor: $3,740.37**	**Labor: $3,794.84**	**Labor: $3,713.14**
	Non-labor: $1,773.93	**Non-labor: $1,736.01**	**Non-labor: $1,761.29**	**Non-labor: $1,723.37**

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Proposed FY 2018 Proposed 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
Proposed National Standardized Amount for FY 2018 **if Wage Index is less Than or Equal to 1.0000;** Labor/Non-Labor Share Percentage (62/38)	**Labor: $3,469.52**	**Labor: $3,395.36**	**Labor: $3,444.80**	**Labor: $3,370.64**
	Non-labor: $2,126.48	**Non-labor: $2,081.02**	**Non-labor: $2,111.33**	**Non-labor: $2,065.87**

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IPPS Rate Comparison (w/Quality & MU)

➢ FY 2017	**Proposed FY 2018**	Difference
▪ Large		
$3,839.23	$3,822.07	
1,676.91	1,773.93	
$5,516.14	**$5,596.00**	**$79.86/ 1.45%**
▪ Other		
$3,420.01	$3,469.52	
2,096.13	2,126.48	
$5,516.14	**$5,596.00**	**$79.86/ 1.45%**

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IPPS Offsets

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

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Proposed FY 2018 IPPS Rate Changes

- CMS says 103 hospitals are estimated to not receive the full market basket rate-of-increase for FY 2018 because they are identified as **not** meaningful EHR users
- CMS says that 82 hospitals are estimated to not receive the full market basket rate-of-increase for FY 2018 because they **failed the quality** data submission
- CMS says 21 hospitals are estimated to not receive the full market basket rate-of-increase for FY 2018 because they are identified as **both** not meaningful EHR users and do not submit quality data

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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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Documentation & Coding

- 21st Century Cures Act limited FY 2018 add-back
- Reduced FY 2018 from 0.5 to 0.4588
- Revised shortfall would now be [0.9 + .0402 =] 0.9402

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Proposed FY 2018 Capital

- **Rate would increase from $446.79 to $451.37**
- **Comments**
  - **Why is there still a separate add-on?**
  - **Why does CMS spend time discussing exceptions that have long "died" off?**

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Proposed Excluded Hospitals

- **Rate will increase 2.9 percent – full market basket**
- **Affects**
  - **Children's Hospital**
  - **11 Cancer Hospitals**
  - **Hospitals outside 50 states & DC**

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Proposed FY 2018 Outliers

- **Proposed outlier fixed-loss cost threshold** for FY 2018 equal to the prospective payment rate for the DRG, plus any IME and DSH payments, and any add-on payments for new technology, plus **$26,713**
  - The current amount is $23,573
  - Estimates FY 2016 were 5.37 percent

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Proposed FY 2018 Wage Index

- **No new/ additional changes to CBSAs**
  - There is a revised OMB Bulletin No 15-01
    - Makes some adjustments 3 areas
      - Petersburg, AK
      - La Salle Parish, LA
      - Shannon County, SD
  - CMS will eliminate use of SSA codes and only use Federal Information Processing Standard (FIPS) codes for determining CBSA definitions

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Proposed FY 2018 Wage Index

- Using info from MCR in FY 2014
- To use “other” wage related costs, costs ***MUST*** be reported on employees’ or contractors’ W-2 or 1099 forms
- No change to the statewide budget neutrality adjustment factor – federal versus state specific

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Proposed FY 2018 Wage Index – Rural Floor

Proposed FY 2018 IPPS Estimated Payments Due to Rural Floor with National Budget Neutrality				
State	Number of Hospitals	Proposed Number of Hospitals That Would Receive the Rural Floor	Proposed Percent Change in Payments due to Application of Rural Floor with Budget Neutrality	Proposed Difference (in $ millions)
California	299	177	1.3	$136.28
Massachusetts	57	36	1.3	$43.82
Arizona	57	44	0.9	$17.47
Texas	310	0	-0.3	-$21.42
Pennsylvania	150	3	-0.3	-$16.09
New Jersey	64	0	-0.4	-$16.05
Illinois	127	3	-0.3	-$15.87
Florida	171	17	-0.2	-$14.93
North Carolina	84	0	-0.3	-$9.60
Ohio	6	0	-0.3	-$11.62
Missouri	74	0	-0.2	-$3.89

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Proposed FY 2018 Floors

- **Frontier Floor**
  - Would benefit Montana, North Dakota, South Dakota, and Wyoming, covering 48 providers, would receive a frontier floor value of 1.0000
- **Imputed Floor**
  - Would not be extended
  - Benefited in FY 2017
    - 20 providers in New Jersey
    - 10 providers in Rhode Island
    - 0 providers in Delaware

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Proposed FY 2018 Occupational Mix

- Still using FY 2013 survey
- FY 2018 occupational mix adjusted national average hourly wage is **$41.9599** – current is $41.0651

Occupational Mix Nursing Subcategory	Average Hourly Wage
National RN	$38.84760578
National LPN and Surgical Technician	$22.72715122
National Nurse Aide, Orderly, and Attendant	$15.94890269
National Medical Assistant	$17.97139786
National Nurse Category	$32.84544016

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Proposed FY 2018 Occupational Mix

- FY 2019 requires new survey using 2016 data
- Hospitals are required to submit completed 2016 surveys to their MACs by July 3, 2017
- Forms at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files-Items/2016-Occupational-Mix-Survey-Hospital-Reporting-Form-CMS-10079-for-the-Wage-Index-Beginning-FY-2019.html

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FY 2018 Reclassifications

- FY 2018 – 375 approved
- FY 2017 – 274 approved
- FY 2016 – 257 approved
- CMS says there are 906 hospitals reclassified for FY 2018

- Applications for FY 2019 to MGCRB due by September 1st

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Proposed FY 2018 RRCs

- **FY 2018 – Case-Mix**
- **National CMI 1.6635 for FY 2016 cost reporting periods or regional, if lower**

New England (CT, ME, MA, NH, RI, VT)	1.4186
Middle Atlantic (PA, NJ, NY)	1.5126
South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.5393
East North Central (IL, IN, MI, OH, WI)	1.5921
East South Central (AL, KY, MS, TN)	1.5179
West North Central (IA, KS, MN, MO, NE, ND, SD)	1.6346
West South Central (AR, LA, OK, TX)	1.6949
Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.7614
Pacific (AK, CA, HI, OR, WA)	1.6466

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RRCs

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

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MDH/ SCH/ Low-Volume

- **MDH program terminates 9/30/2017 would move to IPPS Federal Rate**
- **SCH can qualify for volume decrease adjustment – must submit info to their MACs**
- CMS says there are:
  - 243 RRCs
  - 317SCHs
  - 129 both RRC and SCH
  - 96 MDHs will lose status

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Low-Volume Hospitals

- **Beginning with FY 2018, the preexisting low-volume hospital payment adjustment and qualifying criteria, as implemented in FY 2005 will resume**
  - Hospital must be 25 miles
  - Hospital must have 800 or fewer beds
  - Hospital must make a written request to its MAC no later than September 1, 2017

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Redesignations

- **“Lugar” Hospitals – by statute**
  - List available on the CMS Web site
  - Clarifying can “simultaneously an urban to rural classification” (can keep MGCRB and Lugar status)
- **Out-Migration Adjustment**
  - Can seek urban wage index
  - Now part of table 2

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Postcute Care Transfers

- **CMS has identified 3 MS-DRGs** to be included on the list of MS-DRGs subject to the special payment transfer policy
  - MS-DRGs 987, 988, and 989

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IME / GME

- **IME multiplier unchanged at 1.35 – by law**
- CMS says:
  - 2,211 non teaching hospitals
  - 835 teaching with fewer than 100 residents
  - 246 teaching with 100 or more residents

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MS-DRGs

MS-DRGs

- **Examples of changes:**
  - **Functional Quadriplegia --** reassign cases identified by diagnosis code R53.2 from MS-DRGs 052 and 053 to MS-DRGs 091, 092, and 093 for FY 2018
  - **Responsive Neurostimulator (RNS©) System_--** reassign all cases with a principal diagnosis of epilepsy and one of the following ICD-10-PCS code combinations capturing cases with the neurostimulator generators inserted into the skull (including cases involving the use of the RNS© neurostimulator), to MS-DRG 023, even if there is no MCC reported:
    - 0NH00NZ (Insertion of neurostimulator generator into skull, open approach), in combination with 00H00MZ (Insertion of neurostimulator lead into brain, open approach);
    - 0NH00NZ (Insertion of neurostimulator generator into skull, open approach), in combination with 00H03MZ (Insertion of neurostimulator lead into brain, percutaneous approach); and
    - 0NH00NZ (Insertion of neurostimulator generator into skull, open approach), in combination with 00H04MZ (Insertion of neurostimulator lead into brain, percutaneous endoscopic approach).

MS-DRGs

- **Examples of changes:**
  - **Responsive Neurostimulator (RNS©) System_–** would change title of MS-DRG 023 from “Craniotomy with Major Device Implant or Acute Complex Central Nervous System (CNS) Principal Diagnosis (PDX) with MCC or Chemo Implant” to “Craniotomy with Major Device Implant or Acute Complex Central Nervous System (CNS) Principal Diagnosis (PDX) with MCC or Chemotherapy Implant or Epilepsy with Neurostimulator” to reflect the proposed modifications to MS-DRG assignments
  - **Precerebral Occlusion or Transient Ischemic Attack with Thrombolytic –** would add ICD-10-CM diagnosis codes that are currently assigned to MS-DRGs 067 and 068 and the ICD-10-CM diagnosis codes to MS-DRG 069 to the GROUPER logic for MS-DRGs 061, 062, and 063 when those conditions are sequenced as the principal diagnosis and reported with an ICD-10-PCS procedure code describing use of a thrombolytic agent (for example, tPA). Would retitle MS-DRGs 061, 062, and 063 as “Ischemic Stroke, Precerebral Occlusion or Transient Ischemia with Thrombolytic Agent with MCC, with CC and without CC/MCC”, respectively, and to retitle MS-DRG 069 as “Transient Ischemia without Thrombolytic”.

MS-DRGs

- **Examples of changes:**
  - **Swallowing Eye Drops (Tetrahydrozoline)**
  - **Percutaneous Cardiovascular Procedures and Insertion of a Radioactive Element**
  - **Proposed Modification of the Titles for MS-DRG 246 (Percutaneous Cardiovascular Procedures with Drug-Eluting Stent with MCC or 4+ Vessels or Stents) and MS-DRG 248 (Percutaneous Cardiovascular Procedures with Non-Drug-Eluting Stent with MCC or 4+ Vessels or Stents)**
  - **Mitral Valve Replacement Procedures**
  - **Total Ankle Replacement (TAR) Procedures**
  - **Combined Anterior/Posterior Spinal Fusion**
  - **MS-DRG 782 (Other Antepartum Diagnoses without Medical Complications)**
  - **Shock During or Following Labor and Delivery**
  - **MDC 15 (Newborns and Other Neonates with Conditions Originating in Perinatal Period): Observation and Evaluation of Newborn**

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MS-DRGs

- **Proposed changes to the Medicare Code Editor (MCE)**
- **Proposed changes to Surgical Hierarchies**
- **Operating Room (OR) and non OR issues**
  - identified more than 800 code changes in 45 categories. Many are reflected in the rule's tables 6P4a through 6P4p. These tables are on the CMS web.

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MS-DRGs

- **Replaced Devices Offered without Cost or with a Credit**
  - **Proposing not to add any MS-DRGs to its policy without cost or with credit**

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

RELATIVE WEIGHTING FACTORS—FY 2018 Proposed Rule

MS-DRG	MS-DRG Title	Proposed FY 2018 Weights	Final FY 2017 Weights	Percentage Change
65	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC OR TPA IN 24 HRS	1.0330	1.0431	-0.97%
189	PULMONARY EDEMA & RESPIRATORY FAILURE	1.2265	1.2135	1.07%
190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	1.1573	1.1481	0.80%
193	SIMPLE PNEUMONIA & PLEURISY W MCC	1.3795	1.3860	-0.47%
194	SIMPLE PNEUMONIA & PLEURISY W CC	0.9344	0.9469	-1.32%
291	HEART FAILURE & SHOCK W MCC	1.4825	1.4796	0.20%
292	HEART FAILURE & SHOCK W CC	0.9610	0.9574	0.38%
378	G.I. HEMORRHAGE W CC	0.9744	0.9860	-1.18%

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

RELATIVE WEIGHTING FACTORS—FY 2018 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	0.7576	0.7402	2.35%
470	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	2.0473	2.0671	-0.96%
603	CELLULITIS W/O MCC	0.8559	0.8445	1.35%
682	RENAL FAILURE W MCC	1.4921	1.4989	-0.45%
683	RENAL FAILURE W CC	0.9297	0.9191	1.15%
690	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	0.7940	0.7777	2.10%
871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	1.8410	1.7660	4.25%
872	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W/O MCC	1.0591	1.0283	3.00%

MS-DRG Changes

- 16 above MS-DRGs account for 3.2 million discharges
- Total discharges = 9.5 million
- Result 16 = 33 percent
- This year (2017) had 2 more w/ 100,000 discharges
  - MS-DRG 191
  - MS-DRG 641

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New Technology Add-ons

- **For FY 2018 discontinuing :**
  - CardioMEMS™ HF (Heart Failure) Monitoring System
  - Lutonix® Drug Coated Balloon PTA Catheter and In.PACT™ Admiral™ Paclitaxel Coated Percutaneous Transluminal (PTA) Balloon Catheter
  - MAGEC® Spinal Bracing and Distraction System (MAGEC® Spine)
  - Blinatumomab (BLINCYTO®)

New Technology Add-ons

- **For FY 2018 continuing** :
  - Defitelio® (Defibrotide). The maximum payment will remain at $75,900.
  - GORE® EXCLUDER® Iliac Branch Endoprosthesis (IBE). The maximum payment will remain at $5,250.
  - Praxbind® Idarucizumab. The maximum payment for a case involving Idarucizumab will remain at $1,750
  - Vistogard™ (Uridine Triacetate). The maximum payment for a case involving the Vistogard™ will remain at $37,500 for FY 2018.

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New Technology Add-ons

- **For FY 2018 6 new applications received:**
  - Bezlotoxumab (ZINPLAVA™)
  - EDWARDS INTUITY Elite™ Valve System (INTUITY) and LivaNova Perceval Valve (Perceval)
  - Ustekinumab (Stelara®)
  - KTE-C19 (Axicabtagene Ciloleucel)
  - VYXEOS™ (Cytarabine and Daunorubicin Liposome for Injection)
  - GammaTile™

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New Technology Add-ons

- Comment
  - Extensive dialogue
  - More like a proposal than a rule

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IPPS DSH Formula

IPPS DSH Formula

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

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IPPS DSH Formula

- CMS is proposing to distribute roughly $7.0 billion in uncompensated care payments in FY 2018, *an increase of approximately $1.0 billion from the FY 2017* amount
- This change reflects CMS' proposal to incorporate data from its National Health Expenditure Accounts into the estimate of the percent change in the rate of uninsurance, which is used in calculating the total amount of uncompensated care payments available to be distributed

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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

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DSH Factor One

- The January 2017 ***Office of the Actuary*** estimate for Medicare DSH payments for FY 2018, without regard to the application of section 1886(r)(1) of the Act, is approximately **$16.003 billion**
- The estimate for empirically justified Medicare DSH payments for FY 2018, with the application of section 1886(r)(1) of the Act, is approximately **$4.001 billion** (or 25 percent of the total amount of estimated Medicare DSH payments for FY 2018)
- **Factor One is $12,001,915,095.04**

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DSH Factor One

- [Factor 1 for FY 2017 is **$10,797,476,782.62**, which is equal to 75 percent of the total amount of estimated Medicare DSH payments for FY 2017 ($14,396,635,710.16 minus $3,599,158,927.54)]

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DSH Factor Two

- Reduces Factor One amount by percentage reduction in **uninsured**
- The calculation of the proposed Factor 2 for FY 2018 using a weighted average of OACT's projections for CY 2017 and CY 2018 is as follows:

  - Percent of individuals without insurance for CY 2013: 14 percent.
  - Percent of individuals without insurance for CY 2017: 8.3 percent.
  - Percent of individuals without insurance for CY 2018: 8.1 percent.
  - Percent of individuals without insurance for FY 2018 (0.25 times 0.083) + (0.75 times 0.081): 8.15 percent

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DSH Factor Two

- Formula;
  - 1-|((0.0815-0.14)/0.14)| = 1- 0.4179 = 0.5821 (58.21 percent)
  - 0.5821 (58.21 percent) - .002 (***0.2 percentage points*** for FY 2018 under section 1886(r)(2)(B)(ii) of the Act) = 0.5801 or 58.01 percent
- **58.01 = FY 2018 Factor 2**
  - 0.6369 = was Factor 2 for FY 2016
  - 0.7619 = was Factor 2 for FY 2015
  - 0.5674 = is current FY 2017 Factor 2

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DSH Factor Two

- Formula;
  - By law, the current 0.1 percentage reduction increases to 0.2 for FY 2018

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DSH Factor Two

- The amount available for uncompensated care payments for FY 2018 will be **$6,962,310,946.63**
  - $12,001,915,095.04 x 0.5801 = **$6,962,310,946.63.**

  - The FY 2014 “pool” was $9.033 billion
  - The FY 2015 “pool” was $7.648 billion
  - The FY 2016 “pool” was $6.406 billion
  - The FY 2017 “pool” is $6.054 billion

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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 <u>all</u> PPS hospitals, but denominator is just DSH hospitals

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DSH Factor Three & S-10

- For FY 2018, CMS proposes to begin incorporating uncompensated care cost data from **Worksheet S-10** of the Medicare cost report in the methodology for distributing these funds
- Specifically, for FY 2018, CMS proposes to use Worksheet S-10 data from FY 2014 cost reports in combination with insured low income days data from the two preceding cost reporting periods to determine the distribution of uncompensated care payments

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DSH Factor Three & S-10

- **CMS is proposing to compute Factor 3 for each hospital by—**
  - Step 1: Calculating Factor 3 using the low-income insured days proxy based on FY 2012 cost report data and the FY 2014 SSI ratio;
  - Step 2: Calculating Factor 3 using the insured low-income days proxy based on FY 2013 cost report data and the FY 2015 SSI ratio;
  - Step 3: Calculating Factor 3 based on the FY 2014 Worksheet S–10 data, and
  - Step 4: Averaging the Factor 3 values from Steps 1, 2, and 3; that is, adding the Factor 3 values from FY 2012, FY 2013, and FY 2014 for each hospital, and dividing that amount by the number of cost reporting periods with data to compute an average Factor 3.

Readmissions, HVBP, HAC and Quality

Readmissions

- The Hospital Readmissions Reduction Program currently includes the following six applicable conditions:
  - acute myocardial infarction (AMI);
  - heart failure (HF);
  - pneumonia (PN);
  - total hip arthroplasty/total knee arthroplasty (THA/TKA);
  - chronic obstructive pulmonary disease (COPD); and
  - Coronary Artery Bypass Graft (CABG) Surgery

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Readmissions

- CMS is proposing to assess penalties based on a hospital's performance relative to other hospitals with a similar proportion of patients who are dually eligible for Medicare and full-benefit Medicaid. Specifically, CMS is proposing the following:
  - A methodology for calculating the proportion of dual-eligible patients;
  - A methodology for assigning hospitals to peer groups; and
  - A payment adjustment formula calculation methodology.

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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Readmissions

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

- **Readmissions Adjustment Factor for FY 2018 is the higher of the ratio or 0.9700**
- **CMS estimate that 2,591 hospitals will be impacted**
- **Impact expected to be $564 million a $27 million increase over FY 2017**

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Value Based Purchasing

- **Withhold amount would be 2.0 percent for all hospitals**
- Total amount available for performance-based incentive payments for FY 2016 will be approximately $1.9 billion
- Supposed to be budget neutral

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Strength In Numbers

Value Based Purchasing

- Would remove the current 8-indicator Patient Safety for Selected Indicators (PSI 90) measure from the Safety domain beginning with the FY 2019 program year;
- Would adopt the 10-indicator modified Patient Safety and Adverse Events Composite PSI 90 measure beginning in the FY 2023 program year;
- Would adopt the Hospital-Level, Risk-Standardized Payment Associated with a 30-day Episode of Care for Pneumonia measure for the Efficiency and Cost Reduction domain beginning with the FY 2022 program year; and
- Would revise the Efficiency and Cost Reduction domain weighting beginning with the FY 2021 program year to reflect the implementation of condition-specific payment measures in the Hospital VBP Program.

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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HAC Reduction

- **Lowest-performing quartile get 1.0 percent reduction**
- CMS is proposing to make five changes to existing HAC Reduction Program policies:
  - Specify the dates of the time period used to calculate hospital performance for the FY 2020 HAC Reduction Program;
  - Request comments on additional measures for potential future adoption;
  - Request comments on accounting for social risk factors;
  - Request comments on accounting for disability and medical complexity in the CDC NHSN measures in Domain 2; and
  - Update the Extraordinary Circumstance Exception policy.

Quality

- The section on Quality Reporting extends more than 440 pages

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Proposed Inpatient Quality Reporting

- **Proposing:**
  - To re-word the current pain management questions in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey to focus on the hospital's communications with patients about the patients' pain during the hospital stay beginning with surveys in January 2018; and
  - Changing the risk adjustment methodology used in the Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate following Acute Ischemic Stroke Hospitalization (Stroke 30-Day Mortality Rate) measure to include stroke severity codes (based on the NIH Stroke Scale), beginning with the FY 2023 payment determination.

Proposed Inpatient Quality Reporting

- **Proposing:**
  - Adding a voluntary reporting of one new measure, the Hybrid Hospital-Wide Readmission Measure with Claims and Electronic Health Record Data, for the CY 2018 reporting period

Proposed Inpatient Quality Reporting

Previously Adopted Hospital IQR Program Measures for the FY 2020 Payment Determination and Subsequent Years		
Short Name	Measure Name	NQF #
Healthcare-Associated Infection Measures		
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

Proposed Inpatient Quality Reporting

Previously Adopted Hospital IQR Program Measures for the FY 2020 Payment Determination and Subsequent Years		
Short Name	Measure Name	NQF #
Claims-based Patient Safety Measures		
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

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Proposed Inpatient Quality Reporting

Previously Adopted Hospital IQR Program Measures for the FY 2020 Payment Determination and Subsequent Years		
Short Name	Measure Name	NQF #
Claims-based Mortality Outcome Measures		
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

Proposed Inpatient Quality Reporting

Previously Adopted Hospital IQR Program Measures for the FY 2020 Payment Determination and Subsequent Years		
Short Name	Measure Name	NQF #
Claims-based Coordination of Care Measures		
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
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

Proposed Inpatient Quality Reporting

Previously Adopted Hospital IQR Program Measures for the FY 2020 Payment Determination and Subsequent Years		
Short Name	Measure Name	NQF #
Claims-based Coordination of Care Measures		
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	2881
HF Excess Days	Excess Days in Acute Care after Hospitalization for Heart Failure	2880
PN Excess Days**	Excess Days in Acute Care after Hospitalization for Pneumonia	2882

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Proposed Inpatient Quality Reporting

Previously Adopted Hospital IQR Program Measures for the FY 2020 Payment Determination and Subsequent Years		
Short Name	Measure Name	NQF #
Claims-based Payment Measures		
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
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

Proposed Inpatient Quality Reporting

Previously Adopted Hospital IQR Program Measures for the FY 2020 Payment Determination and Subsequent Years		
Short Name	Measure Name	NQF #
Claims-based Payment Measures		
Kidney/UTI Payment	Kidney/Urinary Tract Infection Clinical Episode- Based Payment Measure	N/A
AA Payment	Aortic Aneurysm Procedure Clinical Episode-Based Payment Measure	N/A
Chole and CDE Payment	Cholecystectomy and Common Duct Exploration Clinical Episode-Based Payment Measure	N/A
Sfusion Payment	Spinal Fusion Clinical Episode-Based Payment Measure	N/A

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Proposed Inpatient Quality Reporting

Previously Adopted Hospital IQR Program Measures for the FY 2020 Payment Determination and Subsequent Years		
Short Name	Measure Name	NQF #
Chart-abstracted Clinical Process of Care Measures		
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	+

Proposed Inpatient Quality Reporting

Previously Adopted Hospital IQR Program Measures for the FY 2020 Payment Determination and Subsequent Years		
Short Name	Measure Name	NQF #
EHR-based Clinical Process of Care Measures (that is, Electronic Clinical Quality Measure (eCQMs)		
AMI-8a	Primary PCI Received Within 90 Minutes of Hospital Arrival	+
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

Proposed Inpatient Quality Reporting

Previously Adopted Hospital IQR Program Measures for the FY 2020 Payment Determination and Subsequent Years		
Short Name	Measure Name	NQF #
EHR-based Clinical Process of Care Measures (that is, 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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Proposed Inpatient Quality Reporting

Previously Adopted Hospital IQR Program Measures for the FY 2020 Payment Determination and Subsequent Years		
Short Name	Measure Name	NQF #
Patient Experience of Care Survey Measures		
HCAHPS	HCAHPS + 3-Item Care Transition Measure (CTM-3)	0166 0228
Structural Patient Safety 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.
** Proposed measure refinement of the HCAHPS measure's Pain Management questions for the FY 2020 payment determination and for subsequent years, as described in section IX.A.6.a. of the preamble of this proposed rule.
*** Proposed measure refinement of the Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Ischemic Stroke, for the FY 2023 payment determination and for subsequent years, as described in section IX.A.6.b. of the preamble of this proposed rule.
+ NQF endorsement has been removed.

Proposed Changes to Clinical Quality Measures (CQMs)

- **Proposing:**
  - For Calendar Year (CY) 2017;
    - For eligible hospitals and CAHs demonstrating meaningful use for the first time in 2017 or that have demonstrated meaningful use in any year prior to 2017, the reporting period would be two self-selected quarters of CQM data in CY 2017
    - If an eligible hospital or CAH is only participating in the EHR Incentive Program, or is participating in both the EHR Incentive Program and the Hospital IQR Program, the eligible hospital or CAH would report on at least six (self-selected) of the available CQMs
  - For CY 2018;
    - For eligible hospitals and CAHs reporting CQMs electronically that demonstrate meaningful use for the first time in 2018 or that have demonstrated meaningful use in any year prior to 2018, the reporting period would be the first 3 quarters of CY 2018. For the Medicare EHR Incentive Program only, the submission period for reporting CQMs electronically would be the 2 months following the close of the calendar year, ending February 28, 2019
    - CQMs: For eligible hospitals and CAHs participating only in the EHR Incentive Program, or is participating in both the EHR Incentive Program and the Hospital IQR Program, the eligible hospital or CAH would report on at least 6 (self-selected) of the available CQMs

Proposed Changes to Clinical Quality Measures (CQMs)

- **More:**
- Modifying the previously finalized eCQM reporting requirements for the CY 2017 reporting period/FY 2019 payment determination, such that hospitals would be required to select and submit six of the available eCQMs included in the Hospital IQR Program measure set and provide two, self-selected, calendar year quarters of data, in alignment with the electronic reporting requirements for CQMs in the Medicare EHR Incentive Program for hospitals;
- Modifying the previously finalized eCQM reporting requirements for the CY 2018 reporting period/FY 2020 payment determination, such that hospitals would be required to select and submit six of the available eCQMs, and provide data for the first three calendar quarters (Q1-Q3) of CY 2018, in alignment with the electronic reporting requirements for CQMs in the Medicare EHR Incentive Program for hospitals;
- Making changes to several related technical eCQM submission requirements beginning with the FY 2019 payment determination, including which Edition of certified EHR technology hospitals should use for eCQM reporting, in alignment with the Medicare EHR Incentive Program for hospitals;
- Modifying the previously finalized validation process for eCQM data to reduce the number of cases required to be submitted and to include additional exclusion criteria beginning with the FY 2020 payment determination and subsequent years; and
- Continuing the medical record submission requirements for validation of eCQM data that were finalized in the FY 2017 IPPS/LTCH PPS final rule for the FY 2021 payment determination and subsequent years.

PPS Exempt Cancer Hospital Quality Reporting

- **Adding 4 measures that assess end-of-life care:**
  - Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (NQF #0210);
  - Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life (NQF #0213);
  - Proportion of Patients Who Died from Cancer Not Admitted to Hospice (NQF #0215); and
  - Proportion of Patients Who Died from Cancer Admitted to Hospice for Less than Three Days (NQF #0216).

Long Term Care Hospital Quality Reporting Program (LTCH QRP)

- **Proposing to replace** the current pressure ulcer measure with an updated version of that measure, as well as adopt two new companion measures (one process and one outcome) related to ventilator weaning, beginning with the FY 2020 LTCH QRP. These proposed measures are:
  - Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury
  - Compliance with Spontaneous Breathing Trial (SBT) by Day 2 of the LTCH Stay
  - Ventilator Liberation Rate

Long Term Care Hospital Quality Reporting Program (LTCH QRP)

- **Proposing to remove:**
  - Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) and
  - All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from LTCHs

Inpatient Psychiatric Facility Quality Reporting Quality Reporting (IPFQR) Program

- **Proposing:**
  - One additional measure Medication Continuation following Inpatient Psychiatric Discharge, which is calculated from claims data.
  - Updating the IPFQR Program's extraordinary circumstances exception (ECE) policy to align with other programs' ECE provisions
  - Changing how the annual data submission period is specified in order to align the end of this period with the deadline for submitting a Notice of Participation (NOP) or withdrawing from the program.
  - Factors by which CMS would evaluate measures to be removed from or retained in the IPFQR Program.
-

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LTCHs

- Net Update of 1.00 percent
- Area wage factor of 1.000077
- Budget neutrality 0.9672
- Results in Federal rate of **$41,497.20**
  - Current is $42,476.41
  - (calculated as $42,476.41 (FY 2017 rate) X 1.01 x 1.000077 X 0.9672)
  - Labor share would be 66.3 percent
- HCO Threshold -- $30,081 standard; $26,713 site neutral

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LTCHs

- LTCHs failing to report quality – 2.0 percent less (0.99)
  - Update would be **$40,675,49** ($42,476.41 X 0.99 X 1.000077 X 0.9672)
- Tables 12A and 12B contain wage index values
- CMS projects decrease of $173 million
- Proposing moratorium on 25 percent policy threshold

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Notice Regarding Changes to Instructions for the Review of the Critical Access Hospital (CAH) 96-Hour Certification Requirement

- CMS is providing notice that it will direct Quality Improvement Organizations (QIOs), Medicare Administrative Contractors (MACs), the Supplemental Medical Review Contractor (SMRC), and Recovery Audit Contractors (RACs) to make the CAH 96-hour certification requirement a low priority for medical record reviews conducted on or after October 1, 2017
- This means that absent concerns of probable fraud, waste or abuse of the coverage requirement, these contractors will not conduct medical record reviews.

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Questions

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