



FFY 2017 IPPS Proposed Rule CHA Member Forum

Tuesday, May 24th, 9:30 – 11:00 am PST

Dial-in: 1-888-317-6003

Passcode: 2104967

Adobe Room:

<http://connectpro16666225.adobeconnect.com/ffy17ipps/>



CALIFORNIA
HOSPITAL
ASSOCIATION



CHA Presenters



Anne O'Rourke
Senior Vice President,
Federal Relations



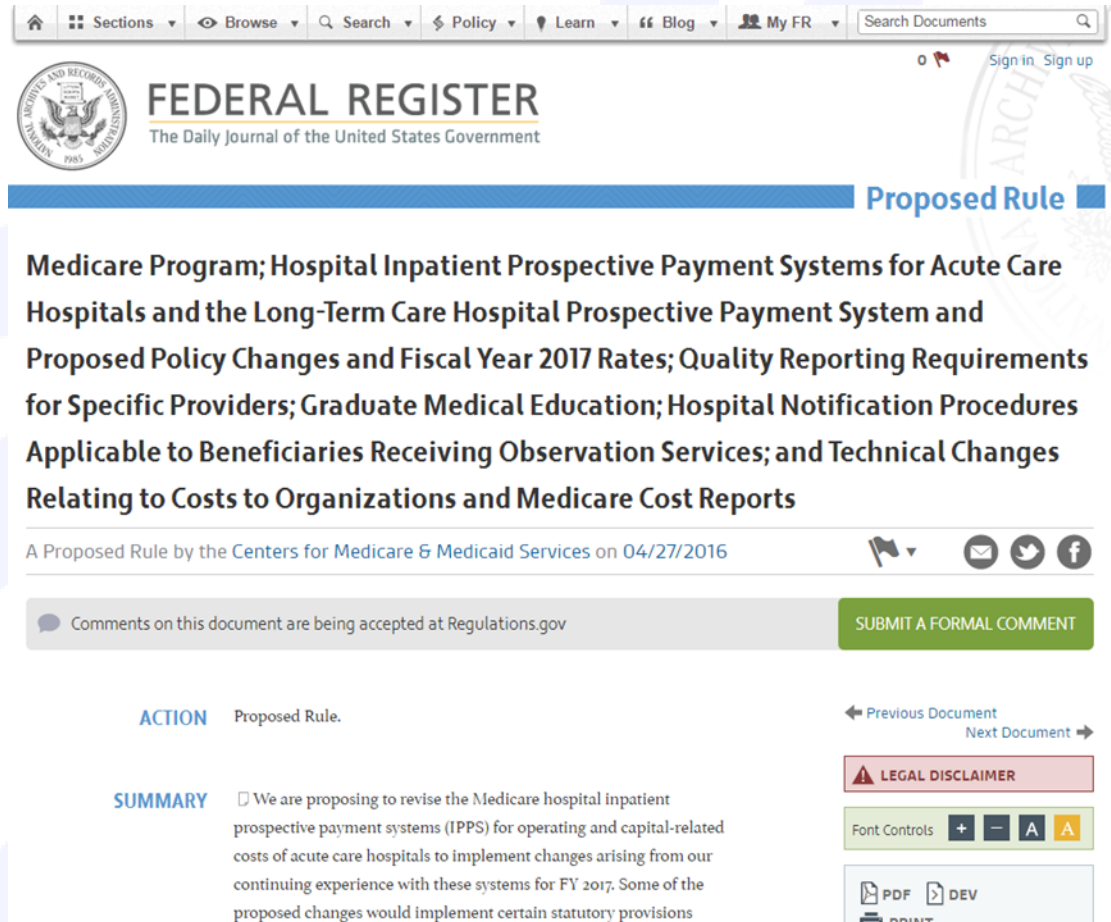
Alyssa Keefe
Vice President,
Federal Regulatory Affairs



Amber Ott
Vice President,
Finance

Agenda

- **HR 5273 Update**
- **IPPS Agenda**
- Rate updates
- DSH
- MOON
- IQR, VBP, HAC, HRRP
- DataSuite Report Overview



The screenshot displays the Federal Register website interface. At the top, there is a navigation bar with links for Sections, Browse, Search, Policy, Learn, Blog, and My FR, along with a search box labeled 'Search Documents'. Below this is the Federal Register logo and the text 'FEDERAL REGISTER The Daily Journal of the United States Government'. A blue banner highlights the 'Proposed Rule' section. The main content area features the title 'Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2017 Rates; Quality Reporting Requirements for Specific Providers; Graduate Medical Education; Hospital Notification Procedures Applicable to Beneficiaries Receiving Observation Services; and Technical Changes Relating to Costs to Organizations and Medicare Cost Reports'. Below the title, it states 'A Proposed Rule by the Centers for Medicare & Medicaid Services on 04/27/2016'. There are social media icons for email, Twitter, and Facebook. A comment box indicates 'Comments on this document are being accepted at Regulations.gov' with a 'SUBMIT A FORMAL COMMENT' button. The 'ACTION' section shows 'Proposed Rule.' and the 'SUMMARY' section begins with 'We are proposing to revise the Medicare hospital inpatient prospective payment systems (IPPS) for operating and capital-related costs of acute care hospitals to implement changes arising from our continuing experience with these systems for FY 2017. Some of the proposed changes would implement certain statutory provisions'. On the right side, there are links for 'Previous Document' and 'Next Document', a 'LEGAL DISCLAIMER' box, 'Font Controls' with plus, minus, and text size buttons, and a 'PDF' download button with a 'PRINT' button below it.

HR 5273

- Introduced May 18
- Several provisions important to hospitals
 - HOPD
 - Readmissions and SES Adjustment

Visit CHA Federal Alerts for more info

<http://www.calhospital.org/calls-actionfederal>



May 19, 2016

CHA News

Daily briefing for California hospitals

TODAY'S TOP DEVELOPMENTS:

- **CHA Advocacy Alert: New Hospital Outpatient Department Legislation on Fast Track — Will it Help You?**
- Summary of Hospice Proposed Rule Available
- Membership Directory Released
- CHA Participates in ASHHRA Advocacy Day
- Medi-Cal DRG Provider Webinars Highlight Changes Effective July 1
- Upcoming CHA Education Events
- News Headlines - Top Stories From State & National Newspapers

CHA Advocacy Alert: New Hospital Outpatient Department Legislation on Fast Track — Will it Help You?

Alert

Action needed: CHA encourages hospital executives to review H.R. 5273, attached, to assess its potential impact on any new off-campus outpatient departments, and to share their findings with CHA.

Timing: Urgent — The bill could be voted on May 24.

On May 18, Reps. Pat Tiberi (R-OH) and Jim McDermott (D-WA), the chair and ranking member, respectively, of the House Ways and Means Health Subcommittee, introduced The Helping Hospitals Improve Patient Care Act of 2016, H.R. 5273. They plan to move the legislation quickly, perhaps as early next week. The bill would make adjustments to the hospital readmissions program and change the grandfathering provision of last year's Bipartisan Budget Act that changes the way new off-campus hospital facilities would be paid. The legislative language, a section-by-section summary and CHA's detailed summary of two key provisions are attached.

CHA is working to understand the impact the new dates and requirements outlined in H.R. 5273 would have on California hospitals with new off-campus facilities. Because the new requirements include documentation that only hospitals will have (attestation and building contracts), CHA needs to hear from hospitals about the bill's potential impact. Hospitals are asked to review the attached documents to determine if their hospital's new off-campus outpatient department would qualify and contact Anne O'Rourke in CHA's Washington, D.C.

**Current Law:
Section 603**

Off-campus HOPD Services
furnished or billing on or after
November 2, 2015



CY 2017
PFS/ASC/
CLFS Rates

HR 5273

Provider
Submits
Voluntary
Attestation

Off-campus HOPD Services
furnished or billing on or
after November 2, 2015



Voluntary Attestation
Received by CMS before
December 2, 2015

CY 2017
OPPS Payment
Rates

“Mid-Build Requirement”
Binding written agreement
executed for “actual
construction” of HOPD prior to
November 2, 2015

June 30, 2016
CMS receives voluntary
attestation and written
certification of
compliance with “mid-
build requirements”

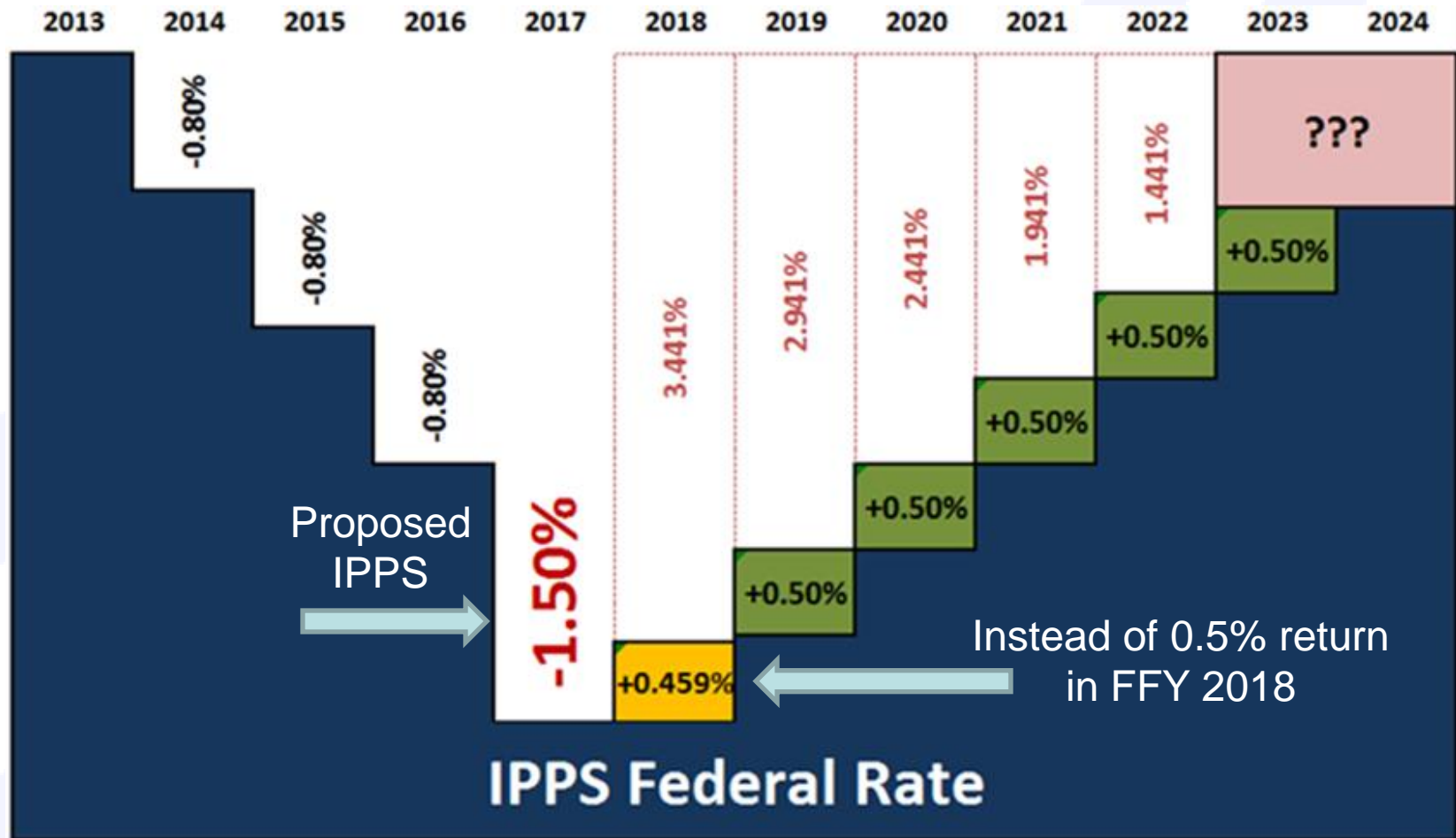


Nov. 2,
2015

Submission of
CMS
Enrollment
(Form 855)

CY 2018
OPPS Payment
Rates

HR 5273 – 0.041 offset





Next Steps: HR 5273

- CHA is gathering information
- Please contact us if this helps your organization
 - Aorourke@calhospital.org or akeefe@calhospital.org
- Hearing and Mark-up in Committee
- Fast Track



Questions?





IPPS Overview

- Proposed rule issued on April 27
- CHA summary available at www.calhospital.org/regulatory-tracker
- Comments due June 17
- Comments can be submitted online at www.regulations.gov
- Comments are encouraged!
- CHA draft comments will be available via CHA News and posted to website approximately one week prior to deadline



Proposed FFY 2017 Rate Update





Operating and Capitol Rates

	Final FFY 2016	Proposed FFY 2017	Percent Change
Federal Operating Rate	\$5,467.53	\$5,511.79	+0.81%
Federal Capital Rate	\$438.75	\$446.35	+1.73%

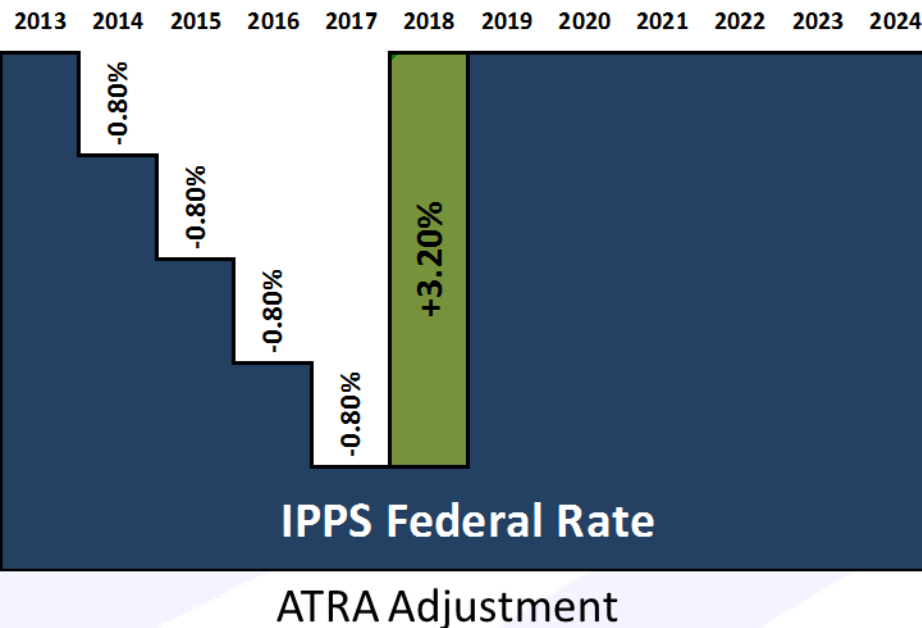


Proposed Rate Update Operating Market basket

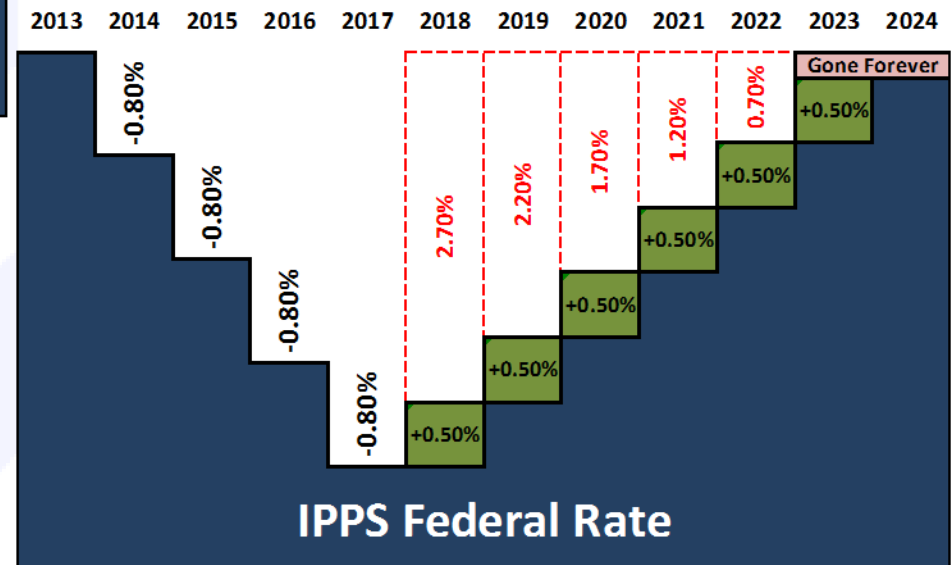
- Base Market basket: **2.8%** (+\$2.7 billion)
 - Reduced by:
 - ACA Multifactor Productivity Adjustment of **0.5** percentage points (**-\$486 million**)
 - Predetermined ACA offset for FFY 2017 of **0.75** percentage points (**-\$730 million**)
 - Proposed FFY 2017 Market basket Update: **1.55%**



ATRA IPPS 3.2% Retrospective Coding Adjustment

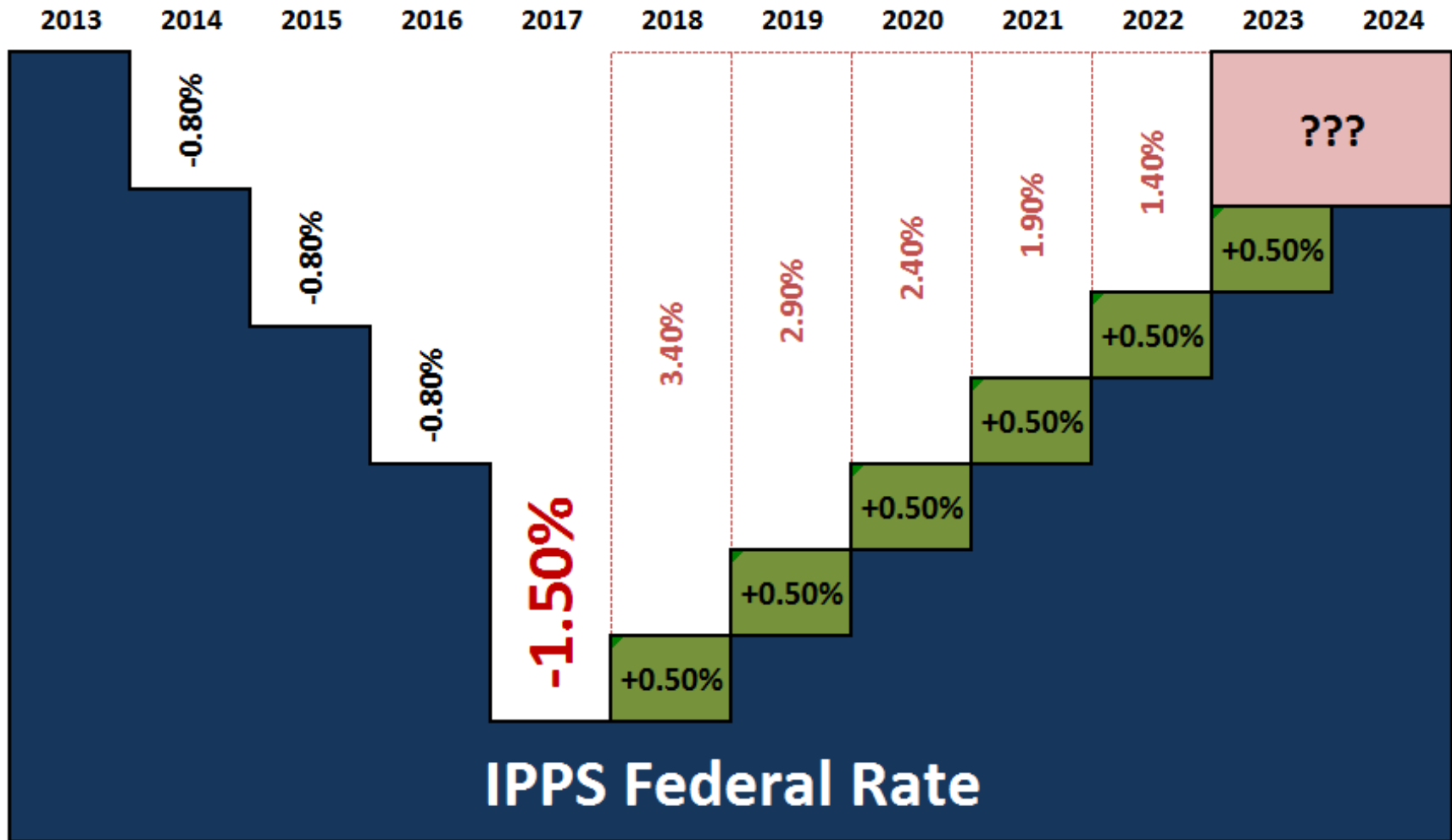


What had been predicted...





ATRA IPPS 3.9% Retrospective Coding Adjustment







2-Midnight Policy Adjustment

- Shands Jacksonville Medical Center, Inc. v. Burwell
- CMS responded with two proposed adjustments:
 - Permanent +0.2% to eliminate the reduction going forward (+210.4 million, including Capital)
 - Temporary +0.6% to account for reduction to FFYs 2014, 2015 and 2016 rates (+632.4 million, including Capital)

Proposed Rate Update

	Passes Both Meaningful Use and IQR	Fails Meaningful Use	Fails IQR	Fails Both Meaningful Use and IQR
Proposed Baseline Market Basket Rate-of-Increase	2.8%			
Proposed Penalty for Failure to Submit IQR Quality Data	0.0	0.0	-0.7 PPT	-0.7 PPT
Proposed Penalty for Failure to be a Meaningful EHR User	0.0	-2.1 PPT	0.0	-2.1 PPT
Proposed Market Basket Update With ACA Reductions	1.55%			
Proposed Market Basket Update, less EHR/IQR	1.55%	-0.55%	0.85%	-1.25%
ATRA Reduction	 -1.5%			
2-Midnight Prospective Adjustment	+0.02%			
2-Midnight Temporary Retrospective Adjustment	 +0.06%			
Calculated Update Factor (Excluding Budget Neutrality)	0.83%	-1.26%	0.15%	-1.95%



California Impact FY 2016-2017

Inpatient Prospective Payment System (IPPS) Federal Fiscal Year (FFY) 2017 Proposed Rule Analysis

Estimated Change in Medicare Payments

FFY 2016 Final Rule Compared to FFY 2017 Proposed Rule

California

	Operating		Capital		Total	
	Dollar Impact	% Change	Dollar Impact	% Change	Dollar Impact	% Change
Estimated FFY 2016 IPPS Payments	\$10,100,691,100		\$746,715,500		\$10,847,406,300	
Marketbasket Update (Includes Budget Neutrality)	\$260,060,600	2.6%	\$9,157,100	1.2%	\$269,217,900	2.5%
ACA-Mandated Marketbasket Reductions	(\$116,870,900)	-1.2%	Not Applicable		(\$116,870,900)	-1.1%
Forecast Error Adjustment	Not Applicable		(\$2,245,700)	-0.3%	(\$2,245,700)	0.0%
ATRA-Mandated Coding Adjustment	(\$139,566,200)	-1.4%	Not Applicable		(\$139,566,200)	-1.3%
2-Midnight Rule Adjustment	\$74,952,500	0.7%	\$6,050,700	0.8%	\$81,003,600	0.7%
Wage Index/GAF	(\$16,352,400)	-0.2%	(\$1,379,600)	-0.2%	(\$17,732,500)	-0.2%
DSH: Traditional DSH Payment Changes	\$0	0.0%	\$0	0.0%	\$0	0.0%
(1) DSH: UCC Payment Changes	(\$39,168,200)	-0.4%	Not Applicable		(\$39,168,200)	-0.4%
Change in Hospital Specific Rate	\$0	0.0%			\$0	0.0%
MS-DRG Updates	\$12,535,900	0.1%	\$1,030,000	0.1%	\$13,565,600	0.1%
(2) Quality Based Payment Adjustments	(\$19,002,000)	-0.2%	(\$762,000)	-0.1%	(\$19,763,500)	-0.2%
Net Change due to Low Volume Adjustment	\$917,300	0.0%	\$66,800	0.0%	\$984,400	0.0%
Estimated FFY 2017 IPPS Payments	\$10,118,197,900		\$758,634,500		\$10,876,832,300	
Total Estimated Change FFY 2016 to FFY 2017 *	\$17,506,800	0.2%	\$11,919,000	1.6%	\$29,425,400	0.3%

* The bottom line impacts shown in the table above do not include the impact of the 2.0% sequestration reduction to all lines of Medicare payment authorized by Congress in the FFY 2016 Final Rule.



FFY 2017 Medicare DSH

DSH Payment Projections
Under Traditional Formula
(\$14.227 B)

25%
Paid Under Traditional Method
\$3.556B

75% [FACTOR 1]
Dedicated to New Pool
\$10.6 B

Step 1: Reduce Pool
[FACTOR 2: relative to national rates of insurance]

Step 2: Distribute Pool
[FACTOR 3: based on hospitals' "uncompensated care"]
\$6.054 B



Medicare DSH – UC Pool

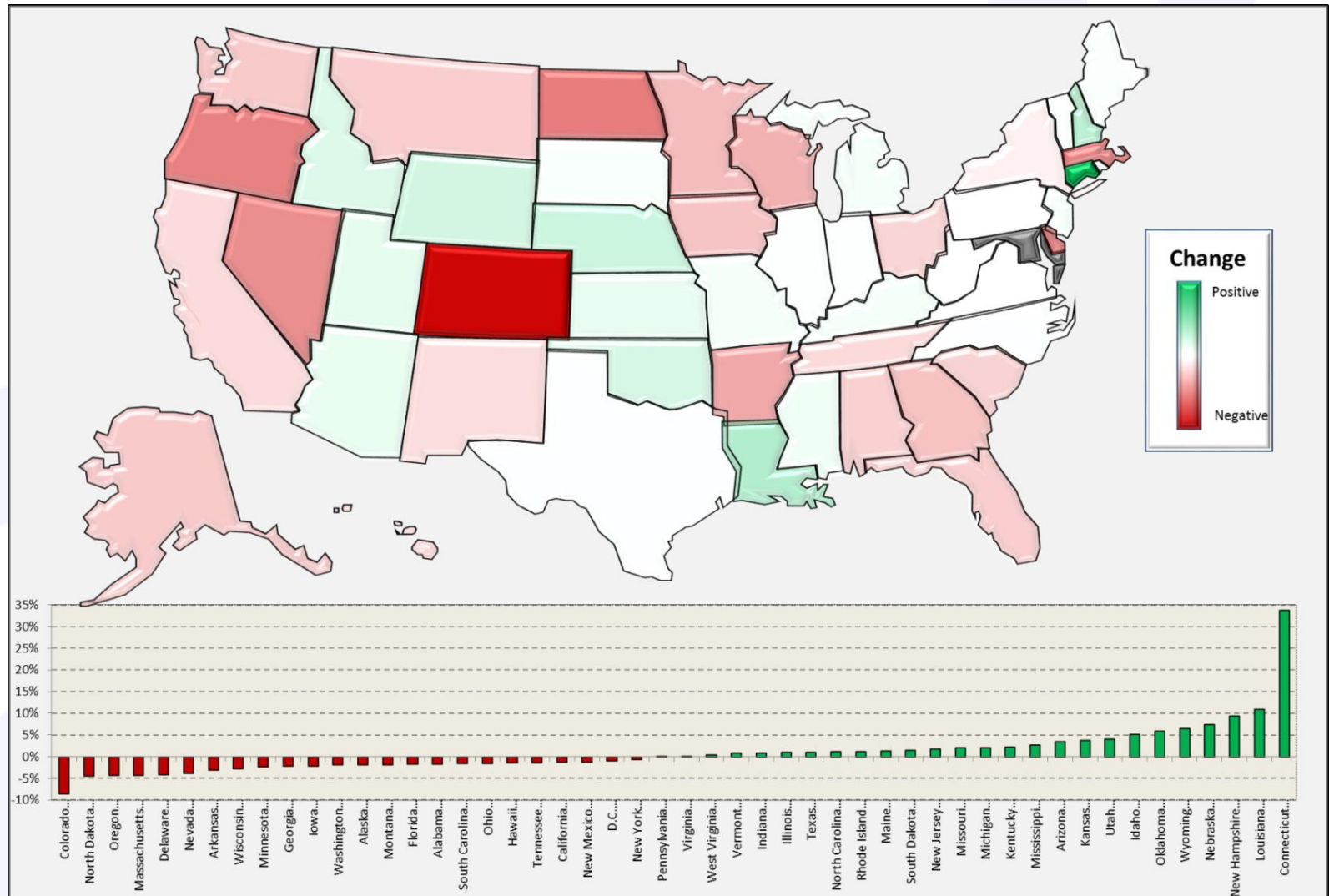
Current Policy (FFY 2016)

- Factor 1 (program funding)
 - \$10.058 B
- Factor 2 (program reductions)
 - 36.31% cut
 - \$6.406 B pool for uncompensated care payment
- Factor 3 (uncompensated care payment)
 - Low income patient days as proxy
 - FFY 2011/2012 Medicare Cost Reports (March 2015 Update)
 - FFY 2013 SSI Ratios
 - Factor 3 based on single year

Proposed Policy (FFY 2017)

- Factor 1 (program funding)
 - \$10.671 B
- Factor 2 (program reductions)
 - 43.26 % cut
 - \$6.054 B pool for uncompensated care payment
- Factor 3 (uncompensated care payment)
 - Low income patient days as proxy
 - **Factor 3 based on three years of data**
 - FFY 2011/2012/2013 Medicare Cost Reports
 - FFY 2013/2014 SSI Ratios

DSH: 3-Year Averaging of Factor 3 vs. Current Methodology





FFY 2018

Proposed S-10 Transition

- Phase in of Worksheet S-10, Line 30 (Charity Care and Non-Medicare Bad Debt Expense), to begin FFY 2018 with FFY 2014 cost report data
- Would utilize three-year Factor 3 averaging currently proposed for FFY 2017

	Proxy Data	S-10 Data
FFY 2018	FFY 2012 Medicaid Days + FFY 2013 Medicare SSI Days FFY 2013 Medicaid Days + FFY 2014 Medicare SSI Days	FFY 2014 S-10, Line 30
FFY 2019	FFY 2013 Medicaid Days + FFY 2015 Medicare SSI Days	FFY 2014 S-10, Line 30 FFY 2015 S-10, Line 30
FFY 2020	Phased-out	FFY 2014 S-10, Line 30 FFY 2015 S-10, Line 30 FFY 2016 S-10, Line 30



Proposed S-10 Transition: Cost to Charge Ratio

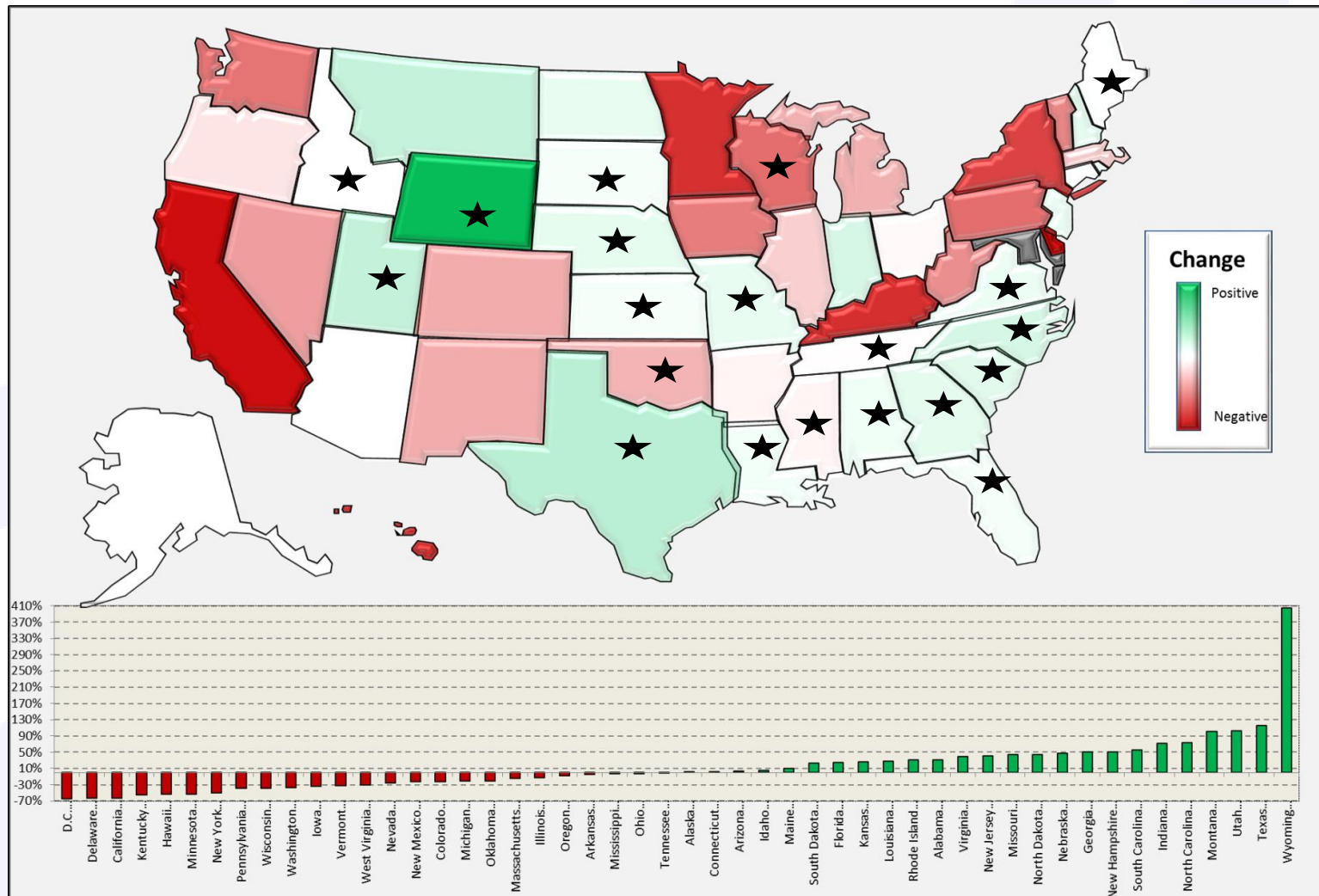
- “Double Trim” methodology proposed to control data anomalies in CCRs used to calculate Line 30
 - Would assign statewide average CCR to hospitals with CCRs more than 3 standard deviations from the national geometric mean
- Alternative method would utilize the high-cost outlier trim process, and use urban and rural average CCRs by state



Proposed S-10 Transition: Other

- Charity care presented on Line 20 based on write-off date, not date of service.
- Responded to requests to add GME costs to numerator of CCR calculation.
 - Did not propose to add GME cost to numerator
 - GME charges are included in denominator, further reducing value of Line 30 for teaching hospitals

DSH: S-10 Transition vs. Current Methodology (YEAR 3)



* Based on FFY 2017 Proposed Rule Factors using 1 year of data vs second year of S-10 transition (2014 S-10 data)



California DSH Breakout

¹ Detail on DSH UCC Payment Changes

The table to the right provides detail on DSH payment changes specific to the UCC component of the DSH program. National DSH program information is from the FFY 2016 IPPS final rule and FFY 2017 IPPS proposed rule. Hospital-specific UCC payment factors are from the FFY 2016 and FFY 2017 DSH Supplemental files published with those same rules.

	FFY 2016	FFY 2017	Change
Total Funding for UCC Payments	\$10.058 Billion	\$10.671 Billion	+\$0.612 Billion
ACA-Mandated Reduction	-36.31%	-43.26%	-6.95%
Redistribution Pool	\$6.406 Billion	\$6.054 Billion	-\$0.352 Billion
Hospital Specific Payment Factor	Hospital-Specific		
Hospital UCC Payment Amount	\$796,064,000	\$756,857,200	(\$39,168,200)

California DSH Breakout

Estimated Impacts of CMS' Proposals Related to Distribution of the DSH Uncompensated Care Pool

	Est. UCC Revenue	Est. Total Revenue	Impact (\$)	Impact (%)
FFY 2017 Calculation Maintained at Single Year of Data (Current)	\$767,106,300	\$10,887,038,200		
FFY 2017 Calculation Based on Proposed Three Year Data Average	\$756,857,200	\$10,876,832,300	(\$10,205,900)	-0.09%

- CMS is proposing to utilize Medicaid Days from FFY 2011, 2012, and 2013 Medicare Cost Reports; and Medicare SSI Days from FFYs 2012, 2013, and 2014 in the calculation of the FFY 2017 DSH UCC distribution factors. As FFY 2014 Medicare SSI Days are not yet available, the proposed rule uses FFY 2013 as a proxy. The "Single Year" calculation is based a sum of FFY 2013 Medicaid Days and FFY 2013 Medicare SSI Days.

CCR Methodology	Transition Year	Factor 3 Data Mix	Est. UCC Revenue	Est. Total Revenue	Impact (\$) vs Current Proxy Distribution	Impact (%)
FFY 2014 S-10 Using Current CCR Calculation	1st	2 Proxy, 1 S-10	\$617,744,600	\$10,738,030,000	(\$149,008,200)	-1.37%
	2nd	1 Proxy, 2 S-10	\$481,605,900	\$10,602,186,500	(\$284,851,700)	-2.62%
	3rd	3 S-10	\$338,855,700	\$10,459,760,400	(\$427,277,800)	-3.92%
FFY 2014 S-10 After Applying Proposed Double-Trim Methodology to Hospital CCR	1st	2 Proxy, 1 S-10	\$598,473,100	\$10,718,741,300	(\$168,296,900)	-1.55%
	2nd	1 Proxy, 2 S-10	\$443,062,800	\$10,563,609,200	(\$323,429,000)	-2.97%
	3rd	3 S-10	\$281,041,000	\$10,401,892,400	(\$485,145,800)	-4.46%



Previous CHA Comments

Previous CHA Comments	CMS Status (FFY 2017 IPPS Proposed Rule)
Supportive of CMS Proxy of Medicare SSI and Medicaid Days	MedPAC and CMS have long believed the S-10 is a better source for uncompensated care
S-10 needs improvement prior to use	CMS has agreed in previous years, however believes by FY 2018 hospitals will have had sufficient time to have revised and improved data
Update and revise instructions	CMS has proposed one minor change; charity care will be reported based on date of <u>write-off</u> and not based on the date of <u>service</u>
CMS should audit S-10 data (similar to area wage index data) prior to use	CMS has not articulated any plans for data audit at this time
Include Medicaid shortfall in calculation of uncompensated care	CMS does not agree that Line 19 of the cost report should be included – and proposes Line 30 only
Include GME costs in CCR	CMS does not believe that it is appropriate to modify the calculation of the CCR Line 1 of Worksheet S-10 to include GME costs



CHA Next Steps

- Top priority for CHA
- CHA has convened a technical expert workgroup to help shape our comments on Medicare DSH
- Currently modeling various options to mitigate impact
- Collaboration with other stakeholders including those in California as well as other state and national hospital associations
- CHA seeks your feedback



Medicare Outpatient Observation Notice (MOON)

- NOTICE Act requires Medicare patient notification when observation services last more than 24 hours
 - Effective August 6, 2016
- CMS is proposing a required standard notice, the MOON
 - Within 36 hours of start of observation
 - Written and verbal notification
 - Verbal notice discussion absent from NPRM
 - Additional manual guidance forthcoming
 - Signature required

View notice and instructions at <https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10611.html?DLPage=1&DLEntries=10&DLSort=1&DLSortDir=descending>



Medicare Outpatient Observation Notice (MOON)

- CHA Case Management and Payer Relations Committee Review
- Concerns expressed to date:
 - Length of notice; too long and too complex
 - Cost sharing information will be difficult to communicate to patients
 - May require two notifications – one for the state and one for federal
 - Who will be able to provide this notice?
 - What if the patient is unable to sign that they understand?
 - Verbal Notice – no guidance released; what does that entail?



Proposed State Law Regarding Observation Status Notification

- SB 1076 (Hernandez) would do the following:
 - Requires notification to the patient that they are on ‘observation status’ and that it could impact their coverage reimbursement, as soon as practicable after being moved to an inpatient unit or an observation unit.
 - Define observation services.
 - Define observation units (with signage and ED staffing ratios) and authorizes hospitals to provide observation services in an inpatient unit or ED.
 - Adds ‘observation services’ data to the OSHPD reporting requirements.

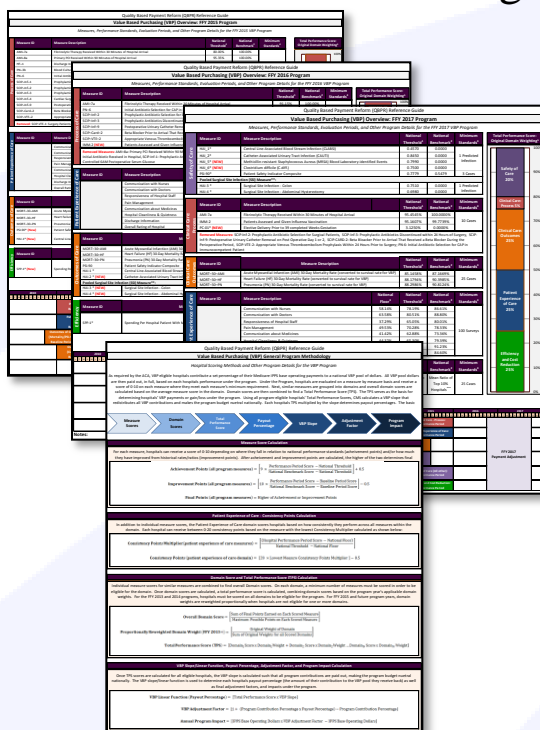


Medicare Outpatient Observation Notice (MOON)

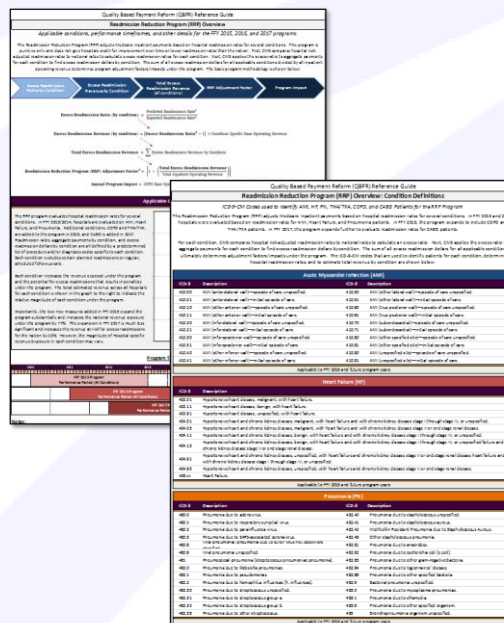
- CHA Comments under consideration:
 - Request a period of non-enforcement to allow for system and process changes, education of hospital staff
 - Need additional information regarding verbal notice, also require notice and comment
 - Would like to see notice streamlined
 - No requirements regarding staff that administer notice
 - Request CMS do broad outreach to Medicare beneficiaries regarding the topic

CHA Quality Matrix and Program Reference Guide

- Imbedded in CHA Quality Matrix is a Quality Program Reference Guide with complete program detail
 - Measure details and links to specifications
 - Year over Year Program Changes (Measures, Domains, Domain Weights)
 - General Program Methodology



The image shows a stack of overlapping screenshots of the CHA Quality Matrix and Program Reference Guide. The top screenshot displays a table with columns for 'Measure', 'Domain', 'Weight', and 'Score'. Below this, other screenshots show detailed program information, including 'Program Description', 'Program Objectives', and 'Program Evaluation'. The bottom screenshot shows a 'Program Evaluation' table with columns for 'Program', 'Measure', 'Weight', and 'Score'.



The image shows a screenshot of the CHA Quality Matrix and Program Reference Guide. The top section is titled 'Quality Based Program Reference (QBR) Reference Guide' and includes a 'Readmission/Reduction Program (RRP) Overview: Condition Definitions'. Below this, there is a table with columns for 'Measure', 'Domain', 'Weight', and 'Score'. The table lists various measures and their corresponding domain weights and scores.





VBP Program Snapshot

Budget Neutral Program funded by annual contributions

- FFY 2014: 1.25% base operating dollars
- FFY 2015: 1.5% base operating dollars
- FFY 2016: 1.75% base operating dollars
- FFY 2017: Capped @ 2%
- FFY 2017 Program = approx. \$1.7 Billion

Dynamic program causes variation in hospital-specific impacts

- FFY 2014-2015
 - 397 Hospitals went from winning under the program to losing
 - 559 Hospitals went from losing under the program to winning
- FFY 2015-2016
 - 317 Hospitals went from winning under the program to losing
 - 425 Hospitals went from losing under the program to winning
- FFY 2016 Winners and Losers
 - 1711 hospitals broke even or won
 - 1372 hospitals lost



2010												2011												2012												2013												2014												2015												2016											
J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D												
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IPPS FFY 2017 VBP

- New Domains for FFY 2017 (previously adopted)
 - Patient Outcomes Domain split into Clinical Care: Outcomes and Safety of Care
 - Safety of Care includes PSI-90 and HAI Measures
 - Clinical Care: Outcomes includes morality measures
 - Process Domain (renamed Clinical Care: Process) is almost gone with little weight

FFY 2016 Domain	Domain Weight
Process of Care	10%
Patient Experience of Care	25%
Patient Outcomes	40%
Efficiency	25%



FFY 2017 Domain	Domain Weight
Clinical Care: Process	5%
Patient Experience of Care	25%
Clinical Care: Outcomes	25%
Safety of Care	20%
Efficiency	25%



FFY 2018 VBP Program Timeframes

2009				2010				2011				2012				2013				2014				2015				2016				2017				2018																							
J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
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FFY 2019 VBP Program Timeframes (proposed)

2009												2010												2011												2012												2013												2014												2015												2016												2017												2018												2018																																																											
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												Clinical Care - Outcomes (Mortality): Baseline Period ⁶																																				Clinical Care - Outcomes (Mortality): Performance Period ⁷																																																																																																																																			
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Proposed Changes for VBP

- **Proposed PSI-90 Measure & Performance Period Change for FFY 2018**



- Previously finalized as July 1, 2014 – June 30, 2016
- Proposed to shorten to July 1, 2014 – September 30, 2015
- Plan to propose to adopt modified version PSI-90: Patient Safety and Adverse Events Composite, with the addition of PSI-9, PSI-10, PSI-11 and removal of PSI-7

- **Proposed Expansion of CAUTI and CLABSI Measures for FFY 2019+**



- Current Measure: Adult, pediatric, and neonatal intensive care unit (ICU) data only
- Expanded Measure: Adds non-ICU adult or pediatric medical, surgical, and medical/surgical wards

- **Proposed HCAHPS Domain Name Change for FFY 2019+**




- Previously “Patient and Caregiver Centered Experience of Care/Care Coordination”
- Proposed to change to “Person and Community Engagement”




Proposed Changes for VBP


- **Proposed updates to existing measures for FFY 2021+**

- 
- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Pneumonia Hospitalization (NQF #0468)
 - Proposed expanded cohort to include patients with a principal discharge diagnosis of pneumonia, aspiration pneumonia, and sepsis (excluding severe sepsis) with a secondary diagnosis of pneumonia coded as present on admission

- **Newly proposed Efficiency measures for FFY 2021+**

- 
- 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 be added to the Efficiency and Cost Reduction Domain

- **Newly proposed measures for FFY 2022+**

- 
- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery (NQF #2558)



Future Considerations

- CMS is also **considering** adopting a **value measure** in future program years
 - Methodology would assess quality and efficiency measures together to produce a composite score
 - CMS is considering two approaches:
 - Specific measures of value developed and incorporated into the Hospital IQR program and then the Hospital VBP program through the measure development process;
 - Use of the Hospital VBP Program's scoring methodology to incorporate value based on the performance of hospitals by either comparing scores on specific quality and cost measures or comparing quality and efficiency domain scores



- 41

2011				2012				2013				2014				2015				2016				2017				2018																															
J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
				FFY 2016 Program Performance Period (All Conditions)																FFY 2016 Program Payment Adjustment																																							
						FFY 2017 Program Performance Period (All Conditions)														FFY 2017 Program Payment Adjustment																																							
												FFY 2018 Program Performance Period (All Conditions)												FFY 2018 Program Payment Adjustment																																			

Readmission Reduction Program

- Refinement to Pneumonia Measure (**previously adopted**)
 - Currently measures patients Principal Diagnosis of Viral or Bacterial Pneumonia
 - Refined measure adds patients with principal diagnosis of sepsis or respiratory failure in addition to secondary diagnosis of Pneumonia



$$\text{Excess Readmission Ratio (by condition)} = \frac{\text{Predicted Readmission Rate}^1}{\text{Expected Readmission Rate}^2}$$

$$\text{Excess Readmission Revenue (by condition)} = [\text{Excess Readmission Ratio}^3 - 1] \times \text{Condition Specific Base Operating Revenue}$$

- Effects of refinement:
 - Δ Predicted & Expected Readmission Rates
 - National Readmission Rate increases 0.9%
 - Δ Excess Readmission Ratios
 - Δ Condition Specific Base Operating Dollars
 - Likely increases impacts under the program



Readmission Reduction Program

- Major Program Expansion for FFY 2017 due to addition of CABG and expansion of pneumonia measure:

1740

Hospitals' penalties
estimated to double (or
more) from
FFY 2016 to FFY 2017

37

Hospitals estimated to
see penalties that hadn't
in 2015 or 2016

\$441 million

Estimated Increase to national cut
due to addition of CABG and
expansion of pneumonia measure

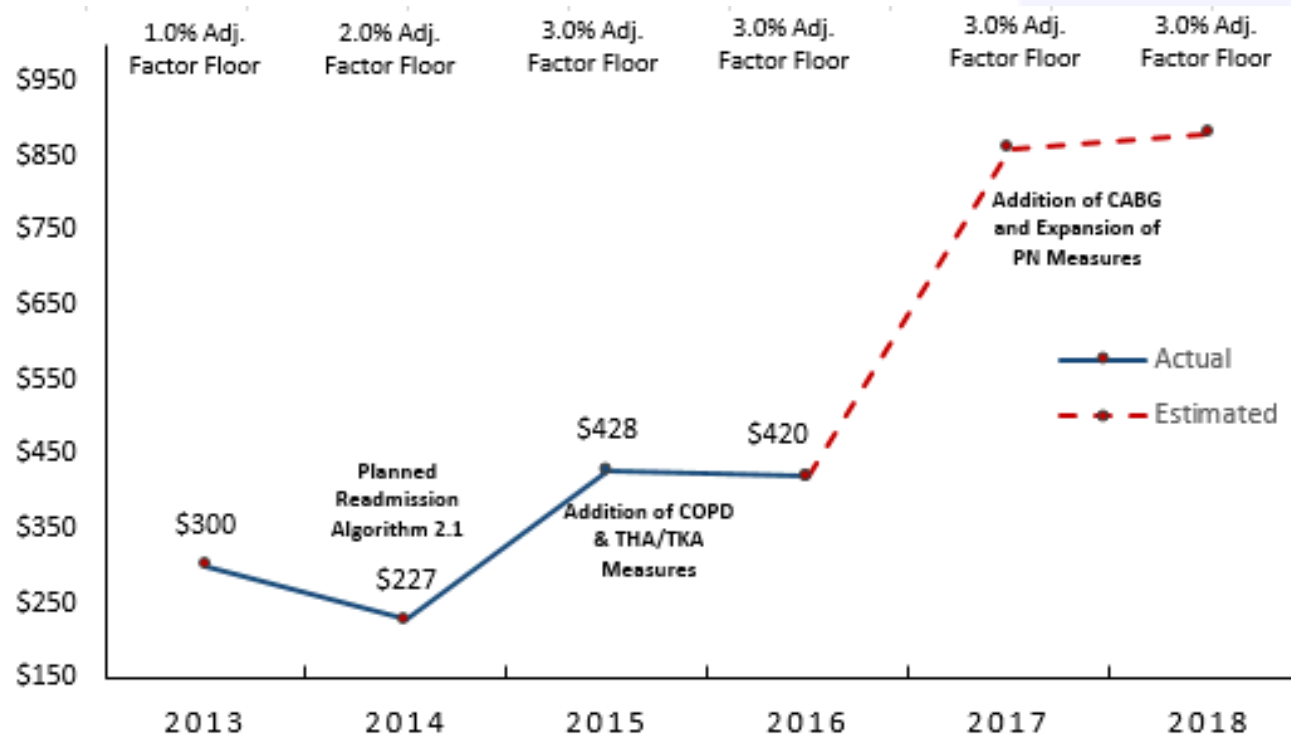
-0.94%

Estimated average
hospital payment penalty,
up from:

-0.50%

Readmission Reduction Program

- Increasing National Cut:





HAC Reduction Program

- 1.0% payment penalty applied to hospitals in the worst performance quartile of Total HAC scores
- Payment Reduction applied to Total Medicare FFS Payments, including:
 - Capital (inclusive of DSH/IME)
 - Operating (inclusive of DSH/IME, VBP and RRP)
 - Uncompensated Care
 - Outlier Payments
- Currently evaluated on three measures across two domains:
- Due to ties, only 22.9% of eligible hospitals receive a payment penalty for 2016
 - Estimated \$340 million national cut



- | 2012 | | | | 2013 | | | | 2014 | | | | 2015 | | | | 2016 | | | | 2017 | | | | 2018 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|---|---|------|---|---|---|--|---|---|---|------|---|---|---|--|---|---|---|------|---|---|---|--|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| M | J | J | A | S | O | N | D | J | F | M | A | M | J | J | A | S | O | N | D | J | F | M | A | M | J | J | A | S | O | N | D | J | F | M | A | M | J | J | A | S | O | N | D | J | F | M | A | M | J | J | A | S | O | N | D |
| FFY 2016: Domain 1
Performance Period | | | | | | | | | | | | | | | | FFY 2016 Program
Payment Adjustment | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| | | | | | | | | FFY 2016: Domain 2
Performance Period | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | FFY 2017: Domain 1
Performance Period | | | | | | | | | | | | | | | | FFY 2017 Program
Payment Adjustment | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| | | | | | | | | FFY 2017: Domain 2
Performance Period | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| | | | | | | | | FFY 2018: Domain 1
Performance Period | | | | | | | | | | | | | | | | FFY 2018 Program
Payment Adjustment | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| | | | | | | | | FFY 2018: Domain 2
Performance Period | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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HAC Reduction Program

- Measure Updates and Modifications:
 - CLABSI/CAUTI Measure Expansion (FFY 2018+) (previously adopted)
 - Currently measures adult, pediatric, and neonatal ICUs only
 - Expansion added medical, surgical, and/or medical/surgical wards
 - **Proposed PSI-90 Composite Measure Expansion (FFY 2018+)**
 - 10 component indicators instead of 8

PSI-3	Pressure Ulcer Rate
PSI-6	Iatrogenic Pneumothorax
PSI-7	Central Venous Catheter-Related Blood
PSI-8	Postop Hip Fracture
PSI-12	Postop PE or DVT
PSI-13	Postop Sepsis
PSI-14	Postop Wound Dehiscence
PSI-15	Accidental Puncture or Laceration



PSI-3	Pressure Ulcer
PSI-6	Iatrogenic Pneumothorax
PSI-8	Postop Hip Fracture
PSI-9	Postop Hemorrhage
PSI-10	Physiologic and Metabolic Derangement
PSI-11	Postop Respiratory Failure Rate
PSI-12	Postop PE or DVT
PSI-13	Postop Sepsis
PSI-14	Postop Wound Dehiscence
PSI-15	Accidental Puncture or Laceration



HAC Reduction Program

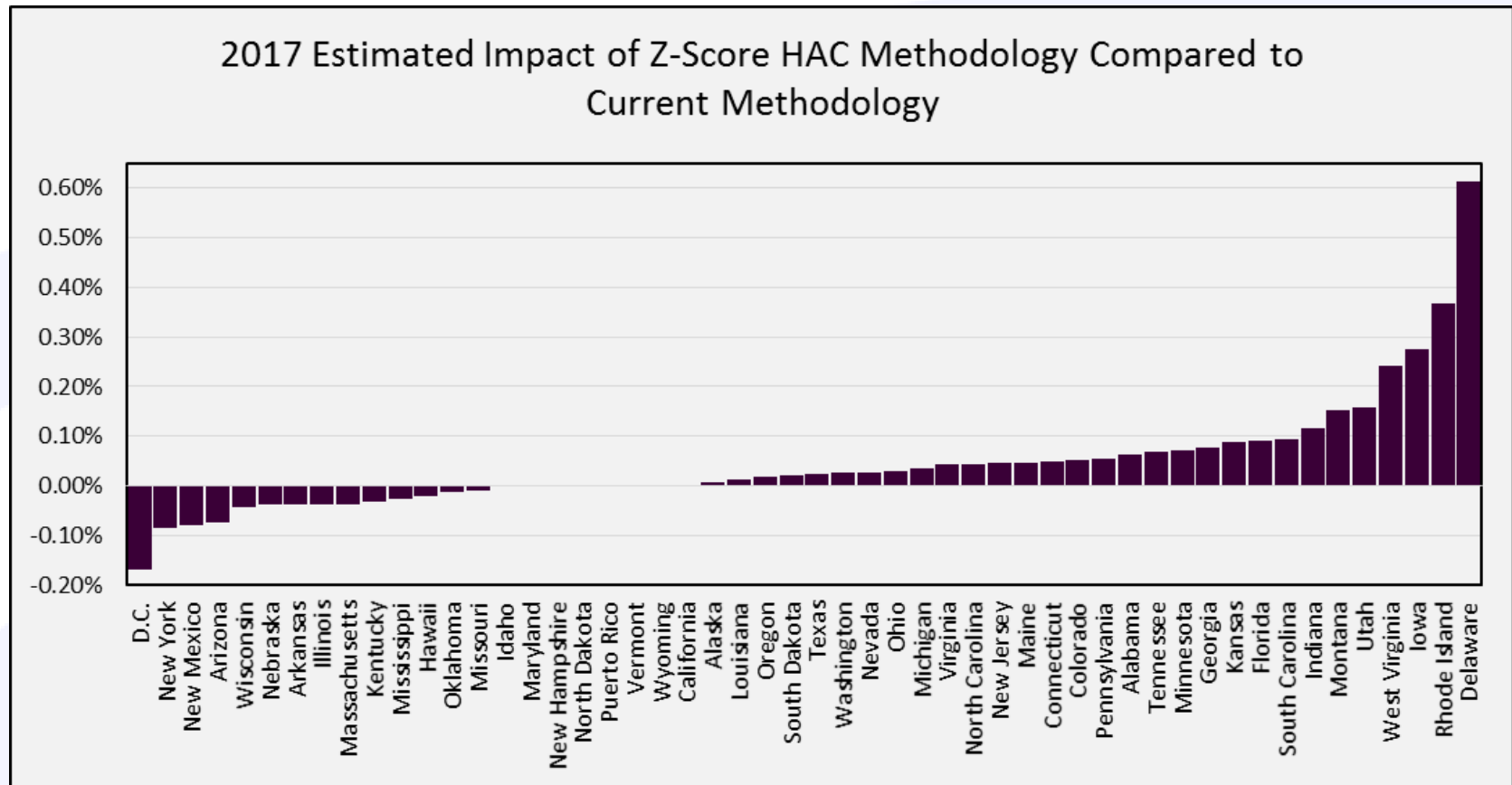
- Proposed scoring methodology change for FFY 2018+
 - Currently assigns points using a decile-based methodology to each measure and then calculates Total Performance Score (TPS) by weighting each domain score and adding the domain scores together
- Proposed FY 2018 methodology would evaluate hospitals based on a **z-score**
 - Continuous measure score rather than forcing measures into deciles
 - Units of standard deviation
 - Represents a hospital's distance from the national average for a measure
 - Poor performance is a **positive** z-score
 - Good performance is a **negative** z-score
 - Z-scores for Domain 2 will be averaged, Domain 1 will be assigned the PSI 90 z-score
 - Domains will still be weighted together to determine Total HAC Score

$$\text{Z-Score} = \frac{(\text{Hospital's Measure Performance} - \text{Mean Performance for All Hospitals})}{\text{Standard Deviation for All Hospitals}}$$



HAC Proposed Z-Score Methodology

- Data from 4Q2015 Hospital Compare
- Assumes all hospitals at-or-over the 75% percentile breakpoint will receive penalty





CHA DataSuite Overview

- FFY 2017 IPPS reports provided to C-suite contacts the week of May 16
- The report analysis description provides information on data sources and assumptions in making IPPS impact estimates
- This report is an estimate and should not be used for budgeting purposes
- Questions regarding CHA DataSuite Reports can be sent to Lindsay Montano, at lmontano@calhosptial.org

IPPS Model – Hospital Report

	Operating		Capital		Total	
	Dollar Impact	% Change	Dollar Impact	% Change	Dollar Impact	% Change
Estimated FFY 2016 IPPS Payments	\$534,076,600		\$38,207,100		\$572,283,700	
(1) Marketbasket Update (Includes Budget Neutrality)	\$13,686,700	2.6%	\$467,500	1.2%	\$14,154,200	2.5%
ACA-Mandated Marketbasket Reductions	(\$6,150,800)	-1.2%	Not Applicable		(\$6,150,800)	-1.1%
Forecast Error Adjustment	\$0	0.0%	(\$114,600)	-0.3%	(\$114,600)	0.0%
ATRA-Mandated Coding Adjustment	(\$7,495,400)	-1.4%	Not Applicable		(\$7,495,400)	-1.3%
2-Midnight Rule Adjustment	\$3,943,500	0.7%	\$308,900	0.8%	\$4,252,400	0.7%
Wage Index/GAF	(\$6,752,300)	-1.3%	(\$479,700)	-1.3%	(\$7,232,000)	-1.3%
DSH: Traditional DSH Payment Changes	\$0	0.0%	\$0	0.0%	\$0	0.0%
(2) DSH: UCC Payment Changes	(\$2,289,700)	-0.4%	Not Applicable		(\$2,289,700)	-0.4%
Change in Hospital Specific Rate	\$0	0.0%			\$0	0.0%
MS-DRG Updates	\$3,140,500	0.6%			\$3,386,800	0.6%
(3) Quality Based Payment Adjustments	(\$3,896,600)	-0.7%	(\$386,400)	-1.0%	(\$4,282,900)	-0.7%
Net Change due to Low Volume Adjustment	\$0	0.0%	\$0	0.0%	\$0	0.0%
Estimated FFY 2017 IPPS Payments	\$528,262,500		\$38,249,300		\$566,511,800	
Total Estimated Change FFY 2016 to FFY 2017 [¥]	(\$5,814,100)	-1.1% ▼	\$42,200	0.1% ▲	(\$5,771,900)	-1.0% ▼

[¥] The bottom line impacts shown in the table above do not include the impact of the 2.0% sequestration reduction to all lines of Medicare payment authorized by Congress through FFY 2025. It is estimated that the impact of sequestration on FFY 2017 IPPS-specific payments would be: -\$11,330,200.

IPPS Model – Hospital Report

¹ Detail on Potential IQR and EHR Penalties

Beginning FFY 2015, the IQR and EHR Meaningful Use marketbasket (MB) penalties are each a 25% reduction to the full MB increase. The EHR MB penalty increased to 50% of the MB in FFY 2016 and will increase to 75% of the MB in FFY 2017. The table to the right projects the potential value of each penalty if the hospital were to be impacted by this policy.

The unadjusted marketbasket value for FFY 2017 is 2.8%. Impact percentages displayed elsewhere in this analysis reflect the percentage value of the marketbasket when compared to total FFY 2016 revenues, which include UCC pool

FFY 2017 Full Marketbasket Update	Percent Increase	Value of Full Update
	2.8%	\$13,780,300
	EHR Penalty	IQR Penalty
FFY 2016 <u>Estimated</u> Penalty*	\$0	\$0
FFY 2017 <u>Estimated</u> Penalty	\$0	\$0

² Detail on DSH UCC Payment Changes

The table to the right provides detail on DSH payment changes specific to the UCC component of the DSH program. National DSH program information is from the FFY 2016 IPPS final rule and FFY 2017 IPPS proposed rules. Hospital-specific UCC payment factors are from the FFY 2016 and FFY 2017 DSH Supplemental files published with those same rules.

	FFY 2016	FFY 2017	Change
Total Funding for UCC Payments	\$10.058 Billion	\$10.671 Billion	+\$0.612 Billion
ACA-Mandated Reduction	-36.31%	-43.26%	-6.95%
Redistribution Pool	\$6.406 Billion	\$6.054 Billion	-\$0.352 Billion
Hospital Specific Payment Factor	0.006688	0.006699	0.000010
Hospital UCC Payment Amount	\$42,845,600	\$40,555,900	(\$2,289,700)

³ Detail on Quality-Based Payment Adjustments

The table to the right provides the adjustment factor values and impact estimates for performance under the VBP, Readmissions Reduction, and HAC Reduction Programs from FFY 2016 to FFY 2017. The proxy FFY 2017 Readmissions adjustment factors are from IPPS proposed rule Table 15, and were calculated by applying the FFY 2016 excess readmission ratios to claims data for the period July 1, 2012 to June 30, 2015. The list of hospitals that could potentially be subject to the FFY 2017 HAC Reduction Program penalty is derived from hospital quality data available with the December 2015 update of Hospital Compare (CMS did not provide this list with the proposed rule). Although CMS has stated that no more than 25% of hospitals will be penalized under the HAC program, this analysis assumes that all hospitals at or over the 75th percentile breakpoint will receive a penalty. As a result, HAC penalties may be overstated. The FFY 2017 VBP adjustment factor is estimated based on hospital quality data available with the December 2015 update of

	FFY 2016	FFY 2017
Base Operating Dollars Subject to Quality Programs	\$364,977,700	\$365,253,700
VBP Adjustment Factor	1.0004	1.0062
Dollar Impact	\$134,800	\$2,269,000
Readmissions Adjustment Factor	0.9971	0.9952
Dollar Impact	(\$1,058,400)	(\$1,753,200)
HAC Reduction Program Flag (1.0% Penalty)	N	Y
Dollar Impact	\$0	(\$5,722,300)
Net Impact of Quality Programs	(\$923,600)	(\$5,206,500)

IPPS Model – Hospital Report

Detail on Value of Small Hospital Programs

The table to the right displays the isolated value of the Medicare Dependent Hospital (MDH) and Low Volume Hospital (LVH) programs for FFYs 2015 and 2016 excluding adjustments due to the quality adjustment programs, **and each other**. Please be aware that, as a result of the Medicare and CHIP Reauthorization Act of 2015 (MACRA), these two programs are set to expire at the end of FFY 2017.

	Adjustment	FFY 2016	FFY 2017
Medicare Dependent Hospital Program		\$868,600	\$940,400
Low Volume Hospital Adjustment	2016: 14.38% 2017: 14.73%	\$620,400	\$634,500
Combined Value of Both Programs		\$1,613,900	\$1,713,400

	Adjustment	FFY 2016	FFY 2017
Medicare Dependent Hospital Program		\$868,600	\$940,400
Low Volume Hospital Adjustment	2016: 14.38% 2017: 14.73%	\$620,400	\$634,500
Combined Value of Both Programs		\$1,613,900	\$1,713,400

IPPS Model – Hospital Report

Operating Rate			Final FFY 2016	Proposed FFY 2017	Percent Change FFY 2016 to FFY 2017
Federal Operating Rate Adjusted for Wage Index, VBP, Readmissions, IME, and DSH	a	Federal Operating Rate	\$5,467.53	\$5,511.79	0.8%
	b	Labor-Share	69.6%	69.6%	0.0%
	c	Wage Index	1.2991	1.2775	-1.7%
	d	Cost-of-Living Adjustment (COLA)	1.0000		-
	e	Federal Operating Rate Adjusted for Wage Index $[(a * b * c) + ((1 - b) * a * d)]$	\$6,605.73	\$6,576.34	-0.4%
	f	VBP Adjustment Factor	1.0031	1.0051	0.2%
	g	Readmissions Adjustment Factor	0.9944	0.9945	0.0%
		Intern and Resident to Bed Ratio (IRB)	0.0000		-
	h	Indirect Medical Education (IME) Adjustment	0.3125		-
		Disproportionate Share Hospital (DSH) Percent	45.5%		-
		DSH Eligibility (Based on CMS' FFY 2016 DSH Supplemental File)	Eligible		-
	i	DSH Adjustment	0.0669	0.0669	0.0%
	j	Federal Operating Rate Adjusted for Wage Index, VBP, Readmissions, IME, and DSH $[e * (1 + h + i + (f - 1) + (g - 1))]$	\$9,095.50	\$9,068.78	-0.3%
Per Discharge Amount	k	Case-Mix Index (adjusted for transfers)	2.1579	2.1704	0.6%
	l	Total Case Mix-Adjusted Rate $[j * k]$	\$19,627.17	\$19,682.89	0.3%
DSH Uncompensated Care (UCC) Payments	m	Factor 1: Total Funding for UCC Payments	\$10,058,322,396	\$10,670,529,596	6.1%
	n	Factor 2: ACA-Mandated DSH UCC Pool Reduction	-36.31%	-43.26%	-
	o	Total UCC Pool $[m * (1 + n)]$	\$6,406,145,534	\$6,054,458,493	-5.5%
	p	Factor 3: Hospital-Specific UCC Payment Factor	0.003168316	0.003167816	0.0%
	q	DSH UCC Payment $[o * p]$	\$20,296,693	\$19,179,413	-5.5%
Total Payment	r	Medicare Cases Billed (adjusted for transfers)	13,822	13,830	0.1%
	s	Low Volume Hospital Adjustment	0.0%	0.0%	-
	t	Estimated Operating Payments Subject to HAC Reduction $[(l * r + q) * (1 + s)]$	\$291,583,434	\$291,393,751	-0.1%
	u	HAC Penalty Determination	Not Penalized	Not Penalized	-
	v	HAC Penalty Impact (1.0% Reduction to Payments)	\$0	\$0	-
	w	Estimated HAC-Adjusted Operating Payments $[t + v]$	\$291,583,400	\$291,393,800	-0.1%



IPPS Model – HAC and DSH Impacts (NEW)

Estimated Impact of CMS' Proposal to Score HAC Measures Using Z-Scores Instead of Deciles

			Estimated 75th Percentile		6.45				Estimated 75th Percentile		0.2759
Measure	Rate	Est. Decile Score	Domain Score	Total Score*	Penalty?	Est. Z-Score	Domain Score	Total Score*	Penalty?		
Patient Safety Indicator Composite Ratio	0.580	1	1.00	5.76	NO	(1.2421)	(1.2421)	0.0297	NO		
Central Line Associated Blood Stream Infection (CLABSI) SIR	0.893	9	6.60			0.9608	0.2541				
Catheter Associated Urinary Tract Infection (CAUTI) SIR	1.073	7				0.1604					
Pooled Surgical Site Infection (SSI) SIR	0.906	6				0.0009					
Methicillin-resistant Staphylococcus Aureus (MRSA) SIR	0.331	2				(0.8994)					
Clostridium difficile (C.diff.) SIR	1.257	9				1.0478					

* For calculation of the FFY 2017 Total HAC Score, Domain 1 is weighted at 15% while Domain 2 is weighted at 85%.

- This proposal would be effective starting with the FFY 2018 HAC Program. This analysis uses FFY 2017 program estimates, based on the December 2015 update of Hospital Compare, as a proxy. Dollar impacts include CMS' proposal to utilize the average of 3-years of data in the calculation of the DSH UCC distribution factor.

Estimated FFY 2017 IPPS Revenue under Decile Method	\$48,871,800
Estimated FFY 2017 IPPS Revenue under Z-Score Method	\$48,871,800
Impact	\$0

IPPS Model – HAC and DSH Impacts (NEW)

Estimated Impacts of CMS' Proposals Related to Distribution of the DSH Uncompensated Care Pool

DSH Eligibility: Projected to Receive FFY 2017 Uncompensated Care Pool Distribution

	Est. Factor 3	Est. UCC Revenue	Est. Total Revenue	Impact (\$)	Impact (%)
FFY 2017 Calculation Maintained at Single Year of Data (Current)	0.00660328	\$39,979,300	\$565,941,000	\$570,800	0.10%
FFY 2017 Calculation Based on Proposed Three Year Data Average	0.00669851	\$40,555,900	\$566,511,800		

- CMS is proposing to utilize Medicaid Days from FFY 2011, 2012, and 2013 Medicare Cost Reports; and Medicare SSI Days from FFYs 2012, 2013, and 2014 in the calculation of the FFY 2017 DSH UCC distribution factors. As FFY 2014 Medicare SSI Days are not yet available, the proposed rule uses FFY 2013 as a proxy. The "Single Year" calculation is based a sum of FFY 2013 Medicaid Days and FFY 2013 Medicare SSI Days.

CCR Methodology	CCR	FFY 2014 Line 30 Worksheet S-10	Estimated Factor 3
FFY 2014 S-10 Using Current CCR Calculation	0.3072	\$60,615,329.94	0.00247899
FFY 2014 S-10 After Applying Proposed Double-Trim Methodology to Hospital CCR	0.3072	\$60,615,329.94	0.00254260

CMS is proposing to phase-in Worksheet S-10 data as part of the proposed three year averaging process for Factor 3; i.e. an average of 2 years of proxy data (2012 and 2013) and 1 year of S-10 data (2014) for FFY 2018 DSH payments, 1 year of proxy data (2013) and 2 years of S-10 data (2014, 2015) for FFY 2019 DSH payments, and 3 years of S-10 data for FFY 2020 DSH payments and thereafter. As FFY 2014 is the most recent cost report data available, it was used as a proxy in the outer years of the S-10 transition. This analysis utilizes the Worksheet S-10 data provided by CMS in it's analysis of the Double-Trim methodology.

CCR Methodology	Transition Year	Factor 3 Data Mix	Est. Factor 3	Est. UCC Revenue	Est. Total Revenue	Impact (\$) vs Current Proxy Distribution	Impact (%)
FFY 2014 S-10 Using Current CCR Calculation	1st	2 Proxy, 1 S-10	0.00523666	\$31,705,200	\$557,790,400	(\$8,150,600)	-1.44%
	2nd	1 Proxy, 2 S-10	0.00385375	\$23,332,400	\$549,542,100	(\$16,398,900)	-2.90%
	3rd	3 S-10	0.00247899	\$15,008,900	\$541,342,600	(\$24,598,400)	-4.35%
FFY 2014 S-10 After Applying Proposed Double-Trim Methodology to Hospital CCR	1st	2 Proxy, 1 S-10	0.00525787	\$31,833,500	\$557,919,800	(\$8,021,200)	-1.42%
	2nd	1 Proxy, 2 S-10	0.00389616	\$23,589,100	\$549,800,900	(\$16,140,100)	-2.85%
	3rd	3 S-10	0.00254260	\$15,394,000	\$541,730,900	(\$24,210,100)	-4.28%

- For comparison purposes, this analysis uses the FFY 2017 DSH pool for all 3 transition years. To reflect this, transition years are labeled as 1st, 2nd, and 3rd instead of 2018, 2019, and 2020.



Next Steps

- Continue review IPPS provisions with CHA Centers and Committees
- Develop and vet Medicare DSH comments with CHA workgroup
- Draft comments available via CHA News approximately 1 week prior



Upcoming CHA Federal Regulatory Member Forums

- FFY 2017 **SNF PPS** Proposed Rule: May 26, 10 – 11 am PT
- FFY 2017 **IPF** Quality Reporting Program: May 31, 1 – 2 pm PT
- FFY 2017 **MACRA** Physician Payment – MIPS and APMs
Proposed Rule: June 6, 12:30 – 1:30 pm PT
- FFY 2017 **IRF PPS** Proposed Rule: June 13, 12 – 1 pm PT

Register for forums at www.calhospital.org/regulatory-tracker

Contact Brian Artusio at bartusio@calhospital.org



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Due June 3, 2016



- ONC RFI on Measuring Interoperability**

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- FFY 2017 IPPS Proposed Rule**
 - CHA Summary
 - Register for CHA Member Forum (May 24) IPPS Provisions
 - Register for CHA Member Forum (May 31) IPF QR Provisions
- FFY 2017 LTCH PPS Proposed Rule**
 - CHA Summary
 - CHA Member Forum, May 23 11am (PT)

Due June 20, 2016

- FFY 2017 IRF PPS Proposed Rule**
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